Real-Time Eligibility Information Improves Both Practice Efficiency and Revenue Performance

Learn how a typical physician practice can use Revenue Performance Advisor to drive operational improvements and increase patient satisfaction.

Customer

Nancy is a practice manager for a family medicine clinic in the Midwest. It's a rewarding job, as she and her staff respect the physicians in the practice and enjoy helping patients.

Challenge

Difficulty accessing eligibility and benefits information impacts revenue and patient satisfaction

Products

Revenue Performance Advisor

Results

Fewer denials, better patient collections, and less stress

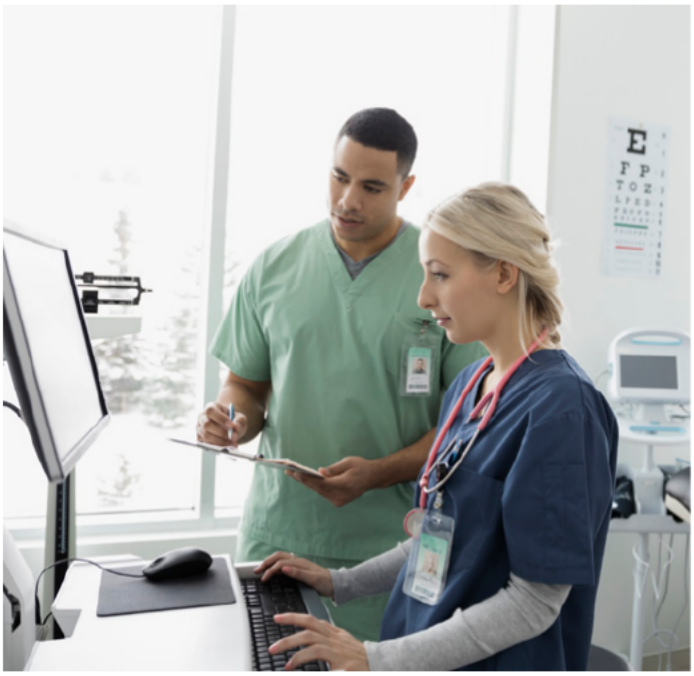
More than 5,800 physician practices currently use Revenue Performance Advisor. This 'Use Case' is not a specific customer's story, but rather reflects a common pre-and-post implementation scenario.

The Client

Nancy is a practice manager for a family medicine clinic in the Midwest. It's a rewarding job, as she and her staff respect the physicians in the practice and enjoy helping patients.

The Problem: Difficulty accessing eligibility and benefits information impacts revenue and patient satisfaction

Nancy and her team struggled with the mounting pressures of their day-to-day workload. Juggling all the behind-the-scenes challenges associated with making patient appointments run smoothly while keeping revenue performance on track had become overwhelming.



For example, staff knew verifying patients' eligibility and benefits was a top priority, but getting information from payers over the phone or from websites was time-consuming. It was a constant dilemma: time lags in obtaining information caused backlogs at the registration desk, but when staff didn't verify eligibility for every single patient, they ended up with a never-ending mound of denied claims.

Additionally, the clinic was changing its process for collecting patient payments. With so many individuals covered by high deductible health plans (HDHPs), the team was asked to transition from collecting co-pays to asking patients for their full share of the bill. Staff didn't feel fully confident in their calculations of patients' financial responsibility and usually ended up collecting only a fraction of the amount due. As a result, when patients received their statements in the mail, they were often caught off-guard because they didn't have the benefit of an in-office explanation – which then led to time-consuming calls back to the clinic.

Perhaps most frustrating was the tedious, time-consuming process of addressing denied claims. Staff resorted to prioritizing claims by amount due and only pursued those of highest value.

Meanwhile, the doctors were pressing Nancy for an explanation as to why so many claims were being written off, and why more wasn't being collected in the office. The entire situation made for unhappy patients and stressed-out staff.

The Solution: Quick access to eligibility and benefits information, and real-time edits for problem claims

Nancy asked a colleague at a similar practice how he was managing these challenges, and that's how she learned about Revenue Performance Advisor. This solution automates eligibility verifications and enables staff to run batches of requests overnight for the next day's roster, or to obtain the information within seconds during the check-in process. This facilitates a smooth flow at the point of registration and simultaneously reduces the risk of denied claims.

The solution also identifies potential 'problem claims' so staff can proactively make real-time edits and corrections, and re-submit claims with a few clicks. And when a denial occurs, the solution includes pre-populated appeals letters to help Nancy's team put together a customized appeals package within minutes; additional workflow tools allow for efficient follow-up with payers for faster appeal-turnaround times. These features help decrease staff's stress immensely and provide more control of the workload.

Revenue Performance Advisor also includes a feature to assist with the increased enrollment in high-deductible health plans. The solution estimates the patient's full financial responsibility with 90% accuracy*, enabling staff to explain the bill and answer questions while patients are still in the office. Now Nancy's team can ask for full payment or set-up payment plans, which can help both increase collections as well as reduce patient inquiries/phone calls.

The Result: Fewer denials, better patient collections, and less stress

Within a few months, Nancy's team could see how Revenue Performance Advisor had increased workflow efficiencies: denials decreased by 27%, collections increased with more than 75% of patients making payments while still in the office, and overall, revenue improved significantly. Nancy also used the solution to group common workflows and eliminate repetitive tasks so her staff could work more efficiently. This led to a reorganization of staff: a team member has moved from the billing area to the front desk to assist with registration and collections.

Staff no longer feels caught in a downward spiral. Instead, they are using the solution's reporting tools to review rejection and denial metrics to make continuous improvements.

* Internal Change Healthcare data, 2017.

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