RETHINK YOUR ELIGIBILITY PROCESS

Kari Kemper
Marketing Communications Manager
Provider Advantage NW, Inc.

In today's tumultuous healthcare climate, establishing responsibility for payment, accurately billing and collecting on services rendered, and maintaining a patient-friendly billing environment while increasing the hospital's bottom line is difficult. The majority of hospitals have gaps in their revenue-cycle processes. A high-performing revenue-cycle strategy is necessary to drive top performance at the front end, while reducing back-end rework.

First and foremost, you must verify insurance eligibility before the patient presents (Scheduling or Pre-registration) and/or before leaving the registration area.

Eligibility accuracy is critical for successful registration. Verifying over the phone or accessing payer websites is inefficient, and rarely happens at the point-of-registration. Some facilities continue to photocopy insurance cards and place in the patient file each time the patient registers for treatment not verifying eligibility until days later. All of these methods hinder the ability to collect money from the patient during registration, contribute to a high probability of denials based on data entry errors and waste valuable time and dollars reworking the denied claims at the back end.

To improve revenue-cycle processes, registration staff need to verify eligibility on every patient. In order to immediately obtain accurate information, eligibility requests must be real-time. In addition, and what makes a significant impact to immediate collections without adding additional time to registration, eligibility responses should be customized and easy-to-understand so registrars view only the benefit data essential to that visit.

Launching the 270 inquiry at the earliest point in the registration flow, and returning a customized, easy-to-understand 271 response allows registration staff to follow the next steps based on facility rules without ever leaving the registration system. Registration staff now has the opportunity to collect co-pay and deductible amounts up-front or, if payment is not possible, guide the patient to a financial counselor to establish payment expectations, thus lowering the amount of accounts sent to collections.

Verifying eligibility at the point-of-service has gained acceptance for most hospitals. However, a comprehensive view of your patient's financial health during registration is critical to revenue cycle improvement. Launching transactions based on the information returned in the 271 and your business rules such as patient demographic verification, patient's ability to pay, qualification for Medicaid/charity care, and pricing estimation increases cash flow. This approach improves patient to provider relations, by educating the patient on their financial responsibility from the beginning, allowing financial planning with no surprises.

The result? A reduction in claim denials, decreased A/R days, increased staff productivity and improved patient-hospital relations.

To send your comments or inquiries, please email Kari Kemper at karikemper@provider-advantage.com or visit www.revenue360.net