Is Your Patient Flow Helping or Harming Your Revenue Cycle Process?

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The revenue cycle process starts with a patient referral. Regardless of whether a patient is a referral from another practice, a result of consumer marketing, or a referral from an insurance company, to maximize the revenue cycle process you must ensure you capture and verify all relevant information. Not only is it critical to capture all relevant information related to a patient, but you also need to verify and confirm all of the information is accurate, from initial scheduling to checkout. In this newsletter I will discuss the importance of maximizing your patient flow and how it impacts your overall revenue cycle process.

Patient flow is the movement of patients through a healthcare facility.[1] While patient flow typically focuses on maintaining quality and patient/provider satisfaction in hospital-based settings, for the purposes of this discussion I will be focusing on how patient flow impacts your revenue cycle process. Patient flow issues are common in growing practices. While you may be able to get by with following general steps at the onset of starting your practice, by the time you are a few years in you will need to implement strict patient flow protocols, or the results can wreak havoc on your revenue cycle process.

First, make sure the same information is taken each time you receive a patient referral, regardless of the source. **I do not recommend creating an exhaustive list of all possible information you may need with a patient referral. Instead, I would recommend the opposite.** Create a list of key information you need to load the patient into your practice management system, while limiting the hardship on potential referral sources. If you have a thirty-item list of information you need before seeing a patient, you are going to face resistance from your referral sources. I recommend you work with your revenue cycle team, along with your practice manager, to identify the key pieces of information which are necessary. By keeping both the front end and back end processes in mind, you will be able to maximize the utility of the information you gather while limiting the burden on referral sources.

Next, **make sure the information you gather from each patient referral is entered in to your practice management system correctly and in the same manner each time.** It is not acceptable to have employees following different intake processes, as it will create headaches later in the revenue cycle process. Instead, try to limit the intake process to three data entry and scheduling steps.

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[1] (Catalyst) https://catalyst.nejm.org/what-is-patient-flow/

My best advice is to have your scheduler (hopefully, this is a set team or person) enter patient demographic information, insurance information, and the reason for the appointment in your practice management software during the initial call. By entering this information directly into your practice management system, your office staff has started a process they can later verify, which will improve your frequency of first-pass claims submitted by your revenue cycle team.

Third, **when a patient arrives for their appointment, verify that all information is accurately loaded in the practice management system (including spelling)**. Once verified, make sure your staff takes the patient's valid government issued photo identification and insurance card. Once your staff has scanned the front and back of both items, they should utilize this information to again confirm all of the information that has been entered in the practice management system is accurate. I cannot stress how important it is to get front and back copies of a patient's insurance card. There are some Medicaid MCO plans that may supply patients with information to print and bring with them to the appointment, but even with this information, your staff should obtain and scan the patient's actual insurance card. I have seen this become an issue when a state has multiple sites where claims are processed, and without the claim submission information on the back of the patient's insurance card your revenue cycle team is left guessing where to submit a claim. This issue can be avoided by collecting and scanning the patient's insurance card (front and back) at the time of the visit.

At this point, the patient has been taken to be seen by the rendering provider. During this time, vitals and pre-encounter related information should be properly documented by the medical assistant or nurse. The rendering provider will then complete the encounter note and should enter relevant diagnoses codes, document all services rendered by CPT code, and have a clear treatment plan that outlines any additional diagnostic testing, lab work, or other items that need to be completed prior to the patient's next appointment.[2]

Once this information has been entered and the patient is checking out, the checkout staff should confirm what additional tests need to be conducted with the patient based on the provider's charge sheet. Once this information is confirmed it should enter the work que of the pre-authorization clerk if any additional tests are needed.

[2] Typically, I encourage all of our clients to keep a simple charge sheet in paper form so they can check applicable ICD-10 codes, CPT codes, and document any tests ordered.

If the rendering provider does not order any additional tests and no follow-up appointment is needed, the checkout clerk should document this information and schedule a follow-up satisfaction survey. These surveys are important in all patient settings.

If additional tests have been ordered in the above scenario, the orders should go to the preauthorization clerk. It is important to build work ques or alerts for known services and tests that require preauthorization based on particular insurance companies. Most practice management software systems should allow you this capability, and it will prevent claims from being denied for lack of preauthorization. Based on my experience, denials for "no prior authorization" can be costly given the high charges associated with many tests which require preauthorization. For this reason, it is vital that you have staff dedicated to the preauthorization process, and that they have open communication with the checkout clerks to ensure all ordered tests have proper preauthorization.

Finally, your practice manager should have monthly meetings with your front-end staff, as well as your revenue cycle team, to discuss patient flow. The revenue cycle team can communicate what information is routinely missing and the front office staff can play a role in determining the most efficient steps to include this information into the existing flow. By ensuring that your revenue cycle team has a voice in the patient flow process, you will preempt many denial-related issues that stem from improper workflow. These steps will also increase the number of first pass claims your office submits.

At Commonwealth Billing, we regularly consult with clients to help maximize patient flow, thereby helping their revenue cycle process become more efficient. In my years consulting with medical practices, I have found many denials to be predicated on poor patient flow and poor communication between front office staff and revenue cycle management teams.

If you have questions about your current processes or would like to discuss any of our service offerings, please email me directly at eric@commonwealthbilling.com or give us a call at:

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