INVENSIS

Patients Are the New Payers

Optimizing Front-end RCM Process for Maximizing Profitability

Executive Summary

In the evolving healthcare provider landscape, where patients now contribute 10-20% of providers' income, optimizing front-end revenue cycle management (RCM) has become a paramount priority for maximizing profitability. The relentless struggle to collect upfront payments from patients has long been exacerbated by the endless blame game between front desk staff, claims teams, and denial management teams, leading to aging accounts and write-offs.

At the crux of this challenge lies the inability of front desks to overcome hurdles to proper patient collections. This failure can be attributed to patients' lack of knowledge about copays and deductibles, coupled with staff's inadequate training in financial counseling and explaining the breakdown of overall charges. As a result, patients often arrive ill-equipped to present a clear financial liability picture, creating a ripple effect of inefficiencies throughout the RCM process.

To address this multifaceted issue, healthcare organizations must prioritize comprehensive staff training on financial counseling, copay explanations, and handling uninsured patients. However, given the well-documented difficulties in training and retaining staff, coupled with the indispensable nature of both billing teams and front desk teams, outsourcing front desk operations emerges as a compelling solution.

By partnering with third-party experts in front desk management, healthcare providers can bring specialized expertise in maintaining streamlined front desk operations, including prior verification and registrations that reduce wait times and enhance patient experiences.

Crucially, outsourcing front desk functions allows healthcare organizations to circumvent the inherent challenges of maintaining in-house teams, fostering a collaborative environment that keeps common front desk issues at bay. By keeping patients well-informed and simplifying the process of upfront collections, providers can pave the way for maximized profitability in an era where patients are the new payers.

The Key Lies in Patient-Centric Strategies

In today's healthcare landscape, the average health insurance premium for family coverage has surged 88 percent over the past 12 years. This increase has coincided with an 80 percent rise in patient financial responsibility. As high-deductible insurance plans become more common, 10 to 20 percent of accounts receivables now originate directly from consumers, who may take up to 90 days to pay. Consequently, hospitals must improve their strategies for collecting larger upfront payments or risk leaving substantial balances to be collected after insurance. Once an unpaid bill is sent to collections, the likelihood of recovering the full amount diminishes significantly.

Although patients spend more on healthcare than ever, they rarely know their financial responsibility upfront. However, nine out of ten consumers want this information, particularly as they increasingly approach healthcare as a retail experience, considering both price and quality. Providers face the challenge of offering transparency and high-quality care and integrating solutions that simplify the payment process. Patients who are informed of their financial responsibility in advance and provided with easy payment options are more likely to fulfill their payments promptly.

Patient Reaction to Front-desk Errors

Category	Percentage
Depressed	33%
Sad	39%
Abandoned or Betrayed	36%
Anxious	37%
Angry	50%
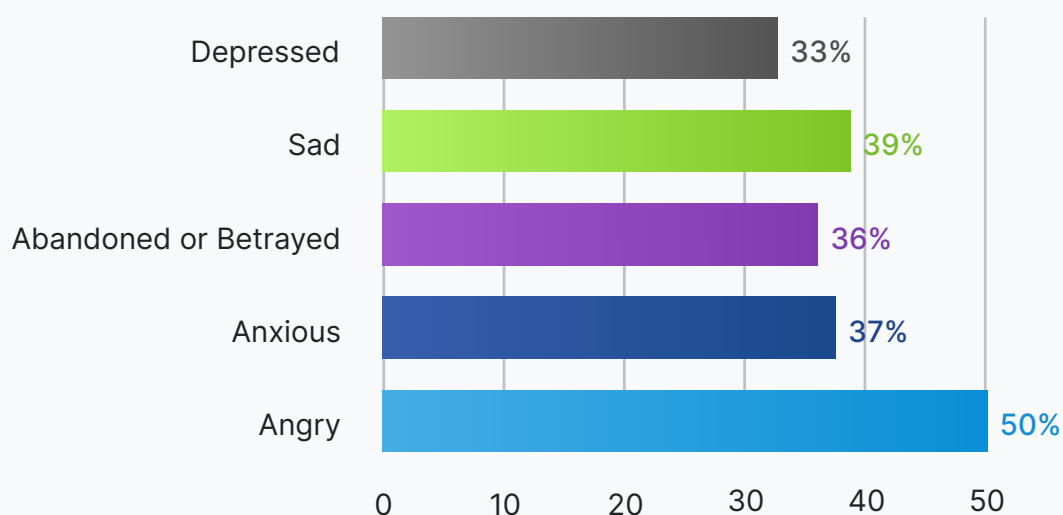
**Sample Data taken from 50 Patients Undergone Above Consequences

Achieving this goal requires providers to rethink their billing practices and patient engagement throughout the patient journey. This new approach should involve engaging patients from the initial visit and eligibility verification, through estimating their out-of-pocket expenses, to the final follow-up. By adopting this strategy, healthcare providers can securely and efficiently collect payments while enhancing the patient experience and ensuring positive financial outcomes. This method also enables providers to swiftly collect out-of-pocket expenses from patients with high-deductible plans, increase billing transparency to reduce patient frustration, and navigate the rise of consumerism to attract more patients.

> **"**
>
> According to a survey of retail healthcare consumers, **more than 50 percent of patients would be willing to pay at least $200 at POS if given a proper and neatly explained accounting**
>
> - McKinsey

The Essential Components of Front-end Revenue Cycle Management

Front-end revenue cycle management (RCM) in healthcare refers to the processes and activities that occur at the initial stages of patient encounters in a hospital/clinic, typically starting from pre-registration or patient scheduling through the point of service (POS) or patient admission. It encompasses various administrative and financial tasks aimed at optimizing revenue capture and ensuring the accurate and timely collection of payments for healthcare services rendered.

Key components of front-end RCM include:

- Financial Clearance
- Registration

Financial Clearance

Financial clearance in Revenue Cycle Management (RCM) front desk service refers to verifying and ensuring that a patient's insurance coverage and financial responsibility are clearly understood and confirmed before services are rendered.

It consists of the following steps:

- Insurance verification
- Referrals/ authorizations
- Pre-service collections
- Financial counseling

Insurance Verification

Insurance verification is a key step in the financial clearance process. It ensures eligibility for coverage before medical services are rendered. This involves confirming a patient's insurance details, coverage limits, and any copayments or deductibles. It also includes contacting the payer to check eligibility criteria such as active policy status, coverage for specific services, and in-network providers. Another important aspect of insurance verification is the coordination of Benefits (COB), which verifies which insurance plan is primary when a patient has multiple coverages.

Key Components of Insurance Verification & Benefits

Insurance Eligibility	Benefits Verification	Coordination of Benefits (COB)
Checks patient enrollment with an insurance provider for a specific service	Ensures the insurance plan benefits cover the services needed	Ensures that the correct insurance filing order is completed

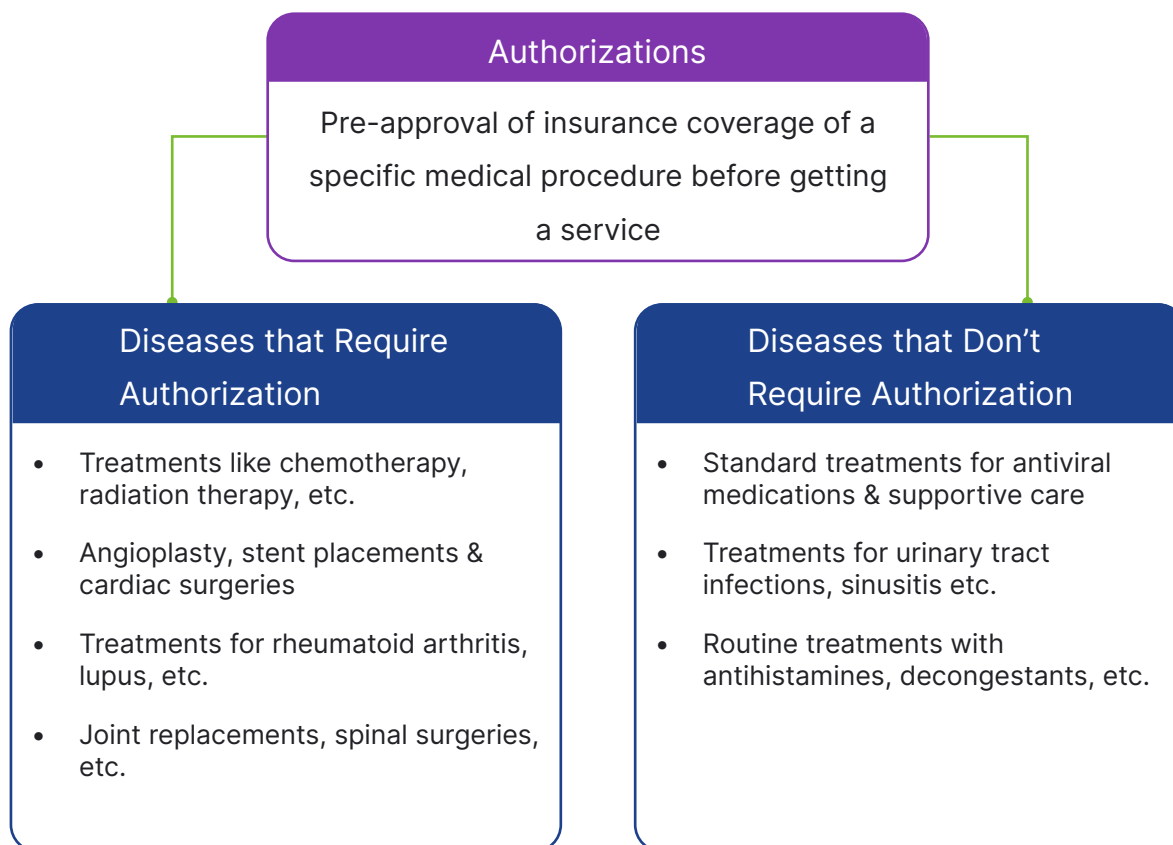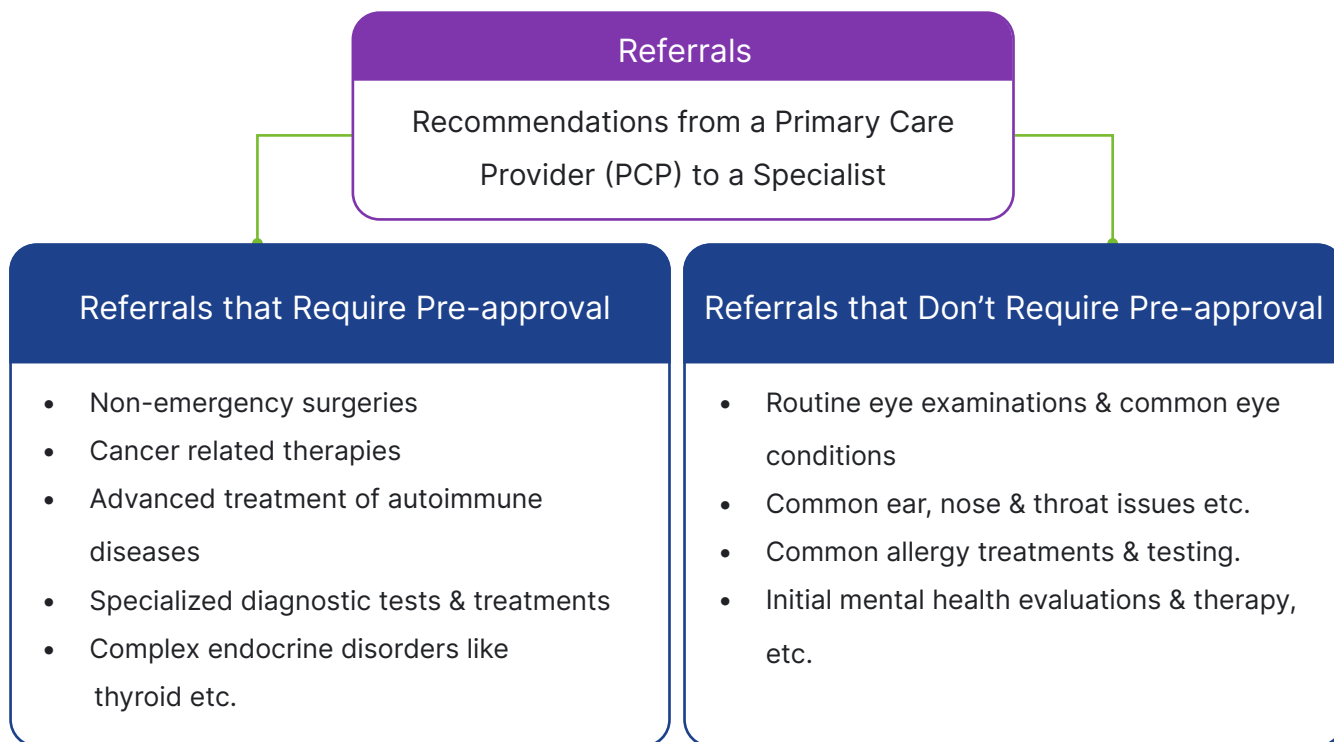|		
• Patient is eligible on the service date • Non-covered services aren't provided • Correct payers are billed	• Eligibility & Coverage • Copays & deductibles • Coinsurance	• Identifies primary payer • Reduces duplications • Prevents wrong payer denials

Common Insurance Verification Errors & Impact

Error	Impact
• Errors in Data Entry	• Claim delays or denials
• Lack of Expertise	• Incorrect verification of coverage and benefits
• Time-Consuming	• Less focus on critical tasks
• Missed Updates	• Inaccurate eligibility status
• Inconsistent Processes	• Wrong verification outcomes and billing issues
• Inadequate Follow-Up	• Unresolved coverage problems and unpaid claims

Referrals/Authorization

Referrals are recommendations from a primary care physician (PCP) for a patient to see a specialist for further evaluation or treatment. It facilitates the sharing of medical information between providers, enhancing continuity and quality of care. Authorizations on the other hand are approval from a health insurance company for a specific medical service, procedure, or prescription. It ensures that the proposed service is medically necessary and covered under the patient's insurance plan.

Referrals

Recommendations from a Primary Care Provider (PCP) to a Specialist

Referrals that Require Pre-approval

- Non-emergency surgeries
- Cancer related therapies
- Advanced treatment of autoimmune diseases
- Specialized diagnostic tests & treatments
- Complex endocrine disorders like thyroid etc.

Referrals that Don't Require Pre-approval

- Routine eye examinations & common eye conditions
- Common ear, nose & throat issues etc.
- Common allergy treatments & testing.
- Initial mental health evaluations & therapy, etc.

Authorizations

Pre-approval of insurance coverage of a specific medical procedure before getting a service

Diseases that Require Authorization

- Treatments like chemotherapy, radiation therapy, etc.
- Angioplasty, stent placements & cardiac surgeries
- Treatments for rheumatoid arthritis, lupus, etc.
- Joint replacements, spinal surgeries, etc.

Diseases that Don't Require Authorization

- Standard treatments for antiviral medications & supportive care
- Treatments for urinary tract infections, sinusitis etc.
- Routine treatments with antihistamines, decongestants, etc.

Common Errors in Referrals & Impact

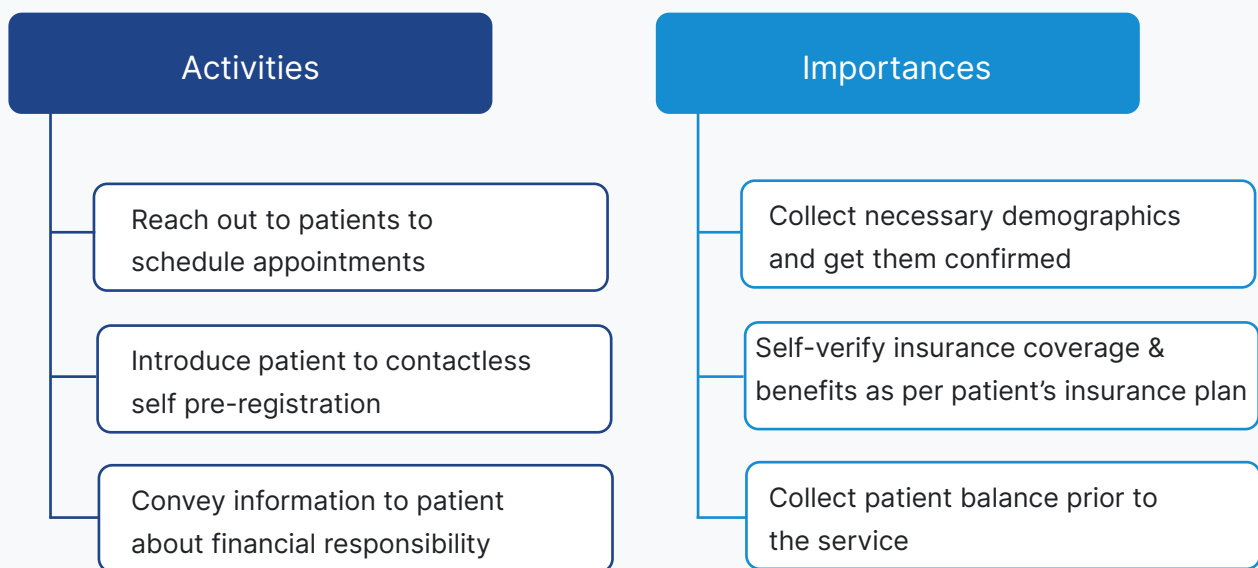| Referral	Impact
• Incomplete Information	• Delays or denials in specialist appointments
• Improper Specialist Selection	• Inefficient care and delayed diagnosis
• Lack of Communication	• Confusion or missed appointments
• Insurance Issues	• Claim denials or unexpected expenses
• Patient Disengagement	• Patient dissatisfaction and reduced trust in providers

Common Errors in Authorization & Impact

Error	Impact
• Incomplete Information	• Authorization denials leading to treatment delays
• Improper Coding	• Authorization denials; delays patient care
• Insufficient Documentation	• Authorization denials, prolonging health issues
• Delayed Submission	• Treatment delays, worsens health conditions
• Communication Breakdown	• Treatment delays and frustration for stakeholders

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Pre-registration and Pre-service Collections

Pre-registration and pre-service collections streamline the healthcare revenue cycle by securing patient payments before services are rendered. During pre-registration, patient information, insurance details, and eligibility are verified, ensuring accurate billing. Pre-service collections involve collecting copayments, deductibles, or deposits upfront, reducing financial risks and enhancing cash flow. This proactive approach improves patient satisfaction by providing clarity on financial responsibilities, minimizing surprise bills. The overall impact of this combined services is pre-registration and pre-service collections, reduced administrative burdens, decrease claim denials, and optimize revenue.

Pre-Registration: Activities & Importance

Activities	Importances
Reach out to patients to schedule appointments	Collect necessary demographics and get them confirmed
Introduce patient to contactless self pre-registration	Self-verify insurance coverage & benefits as per patient's insurance plan
Convey information to patient about financial responsibility	Collect patient balance prior to the service

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Common Errors in Pre-registration and Pre-service Collections and Impact

Error	Impact
• Inaccurate Patient Information Entry	• Billing errors and claim denials
• Incorrect Insurance Verification	• Non-coverage and payment delays
• Failure to Collect Due Payments Upfront	• Affects cash flow
• Miscommunication on Co-pays/ Deductibles etc	• Payment disputes
• Incomplete Pre-Registration Processes	• Process inefficiencies and delays

Financial Counseling

Financial counseling involves assisting patients in understanding their insurance coverage, out-of-pocket costs, and payment options. This is essentially a front-desk task in which counselors verify insurance details, explain copayments, deductibles, and offer guidance on financial assistance programs if needed. This proactive communication helps prevent surprise bills, reduces patient stress, and ensures timely payments. By addressing financial concerns upfront, healthcare providers can enhance transparency, improve patient trust, and maintain financial stability. It also has a direct impact on streamlining the billing process, minimizing claim denials, and supporting a positive healthcare experience.

Financial Counselling: Focus Areas

Liability Assessment

How much should
a patient pay and
evaluate ability to pay

Govt. Program Eligibility

Check if Medicaid,
Medicare, etc. can
cover treatment costs

Insurance Under ACA

Assist in availing health
coverage through the
marketplace

Other Funding Eligibility

Check availability of
charity care or financial
hardship treatment

## Common Errors in Financial Counseling and Impact

| Error	Impact
• Incorrect Documentation	• Financial stress/Interrupted access to care
• Inadequate Explanation of Benefits	• Choosing inappropriate plans/ rise in OoP expenses
• Overlooking Secondary Resources	• Introduce higher financial burdens than necessary

Patient Financial Counselling

Only 3 in 5 patients believe they have received correct financial counselling from providers

Are you satisfied with your provider's explanation of your payment responsibility?

Don't Know
5%

Yes
23%

No **72%**
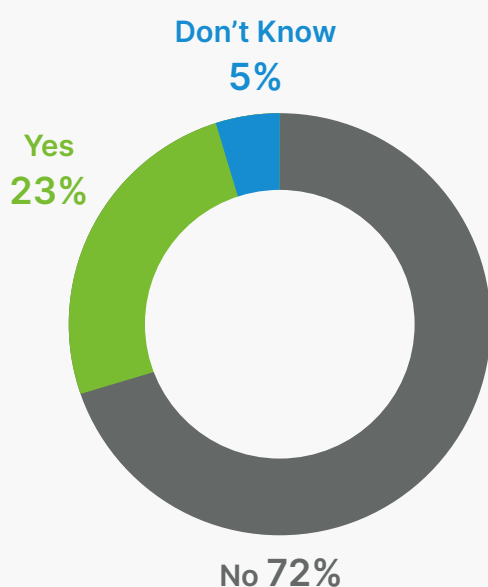
Did your provider reach out to you to admit error in financial counselling?

Don't Know
5%

Yes
9%

No **86%**
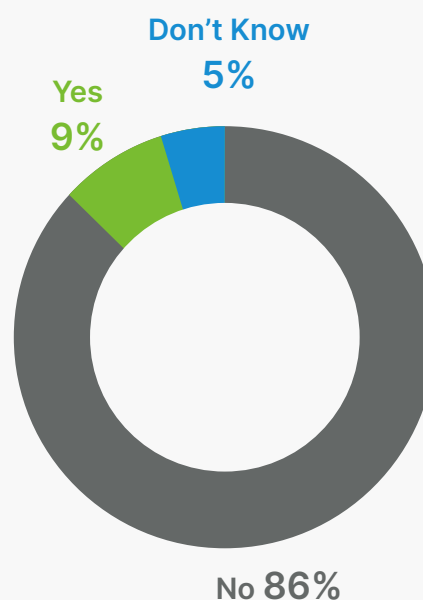
Registration

Registration in the front office of a medical billing service is a crucial process that involves collecting and verifying essential patient information to ensure accurate billing and efficient healthcare service delivery. Effective registration streamlines administrative processes, enhances revenue capture, and lays the foundation for a smooth healthcare revenue cycle workflow.

Key Components of Registration

- Verification of accuracy & correctness of captured patient information
- Utilization of registration forms such as patient consent, advanced beneficiary notice etc.
- Point of Service Collection of patient financial responsibility

Importance of Registration

- Avoid mixing of different patients' account information
- Optimize administrative procedures involved in billing process
- Correct errors identified during pre-registration process

Common Healthcare Setup Requiring Registration

- Inpatient Department
- Outpatient Department
- Ambulatory Office Visit
- Observation Stay
- Emergency Department
- Urgent Care
- Ambulatory Surgery Center

Why Outsourcing Front-end RCM Holds the Key to Effective Patient Payments?

Today's front-end staff faces increased demands and requires a different skill set and script for obtaining payment from the patient. They may be asked to do things they haven't done before, such as collecting much larger amounts of money upfront. Therefore, front desk staff must be better trained and equipped to discuss money with patients and educate them about their fees. All this calls for investments in continuous training.

> **Around 45 percent of Americans would have difficulty paying an unplanned $500 medical bill.**
>
> - Kaiser Family Foundation Poll

Outsourcing front-end tasks not only reduces the need for continuous staff training but also effectively tackles issues like staff attrition. The outsourcing partner manages personnel turnover, ensuring a stable and dependable workforce. This arrangement allows the in-house staff to concentrate more on patient care and less on administrative duties, thereby enhancing operational efficiency and generating cost savings for the healthcare provider.

Aside from this, outsourcing front desk operations offers several significant benefits. The biggest advantage is that most front office tasks (appointment scheduling, insurance verification, and pre-authorizations) are handled long before the patients arrive. This helps streamline the patient check-in process, reducing wait times and enhancing the patient experience. Because of this preemptive approach, any issues related to patient eligibility and coverage can be addressed in advance, minimizing billing errors and payment delays.

How Invensis Brings Expertise to All Your Front-desk Needs

In an era where patients are the primary payers, adopting a customer-centric approach to front desk management is the best approach to stop accounts receivables from growing. At Invensis, we prioritize patient satisfaction with the primary objective of enhancing the overall healthcare experience. We have a great track record of assisting providers in simplifying their check-in processes and providing personalized communication and real-time support to patients around eligibility, liability, and estimation; collect co-pays and deductibles money upfront with itemized billing, and patients feel valued and respected.

How We Make a Difference

Clinical Expertise

- **24+** years of clinical expertise in co-creating RCM solutions for healthcare providers in the US
- 100+ certified billers and coders and RCM domain experts
- Over 10+ specialized RCM solutions

How We Optimize Front Desk Efficiency:

Automated Check-In Systems: Implement self-service kiosks and online check-in platforms to reduce wait times and manual entry errors.

Real-Time Eligibility Verification: Utilize advanced software to instantly verify patient insurance eligibility and coverage details at the time of check-in, ensuring accurate billing and reducing claim denials.

Integrated Scheduling Tools: Use sophisticated scheduling software that syncs with the EHR/EMR systems to optimize appointment bookings, reduce no-shows, and improve patient flow.

Electronic Document Management: Deploy electronic systems for managing patient documents, such as consent forms and medical histories, to streamline data entry and retrieval processes.

Enhanced Patient Communication: Leverage automated communication tools (text, email, phone) to remind patients of appointments, collect pre-visit information, and follow up on post-visit actions, improving patient engagement and adherence.

Integrated Payment Solutions: Offer seamless payment processing systems that integrate with practice management software to collect co-pays and outstanding balances efficiently at the time of service.
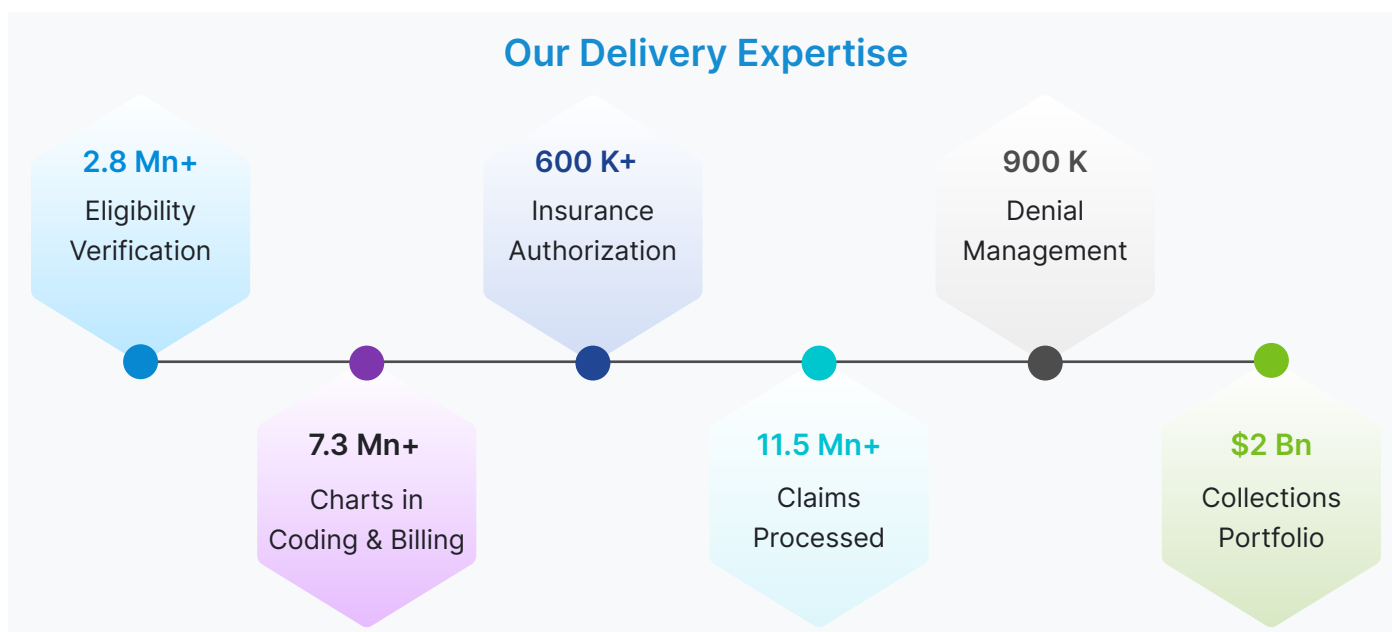
Data Analytics and Reporting: Provide advanced analytics tools to track front desk performance metrics, identify bottlenecks, and make data-driven improvements in operations

Training and Support: Provide ongoing staff training and support for front desk operations to ensure the team is proficient with the latest technologies and best practices.

Compliance and Security: Implement robust security measures and ensure compliance with healthcare regulations (such as HIPAA) to protect patient information and maintain data integrity.

Scalable Solutions: Offer scalable solutions that can adjust to the size and specific needs of the healthcare practice, ensuring efficient RCM operations regardless of practice growth or changes in volume.

Our Delivery Expertise

2.8 Mn+
Eligibility
Verification

600 K+
Insurance
Authorization

900 K
Denial
Management

7.3 Mn+
Charts in
Coding & Billing

11.5 Mn+
Claims
Processed

$2 Bn
Collections
Portfolio

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About Invensis

Invensis is an ISO 9001 & 27001 certified IT, Business Consulting, and Outsourcing Services headquartered in Bangalore. The company was set up in 2000 to build and sustain business relationships with competence, integrity, and dependability. During this span of 24 years, we have served over 1000 global clients supporting them across diverse domains, including custom brokerage, finance, accounting, factoring, RCM, insurance claims processing, risk reinsurance management, data analytics, etc. In 2015. Gartner recognized us as a Global Vendor for Freight Payment Solutions. Today, we are driven by over 5000 skilled professionals ably supported by modern-day infrastructure and highly advanced & secure VPN technology.

Invensis Snapshot

24+ Years of Experience

13+ Service Verticals

5000+ Trained Professionals

ISO 9001:2015 and **27001:2013** certified

HIPAA Compliant

Multiple Delivery Centers

1000+ Global Clients

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