PRE-REGISTRATION:
WORKING THE HEALTH CARE
REVENUE CYCLE AT THE EARLIEST
PATIENT ENCOUNTER
Executive Summary
According to publications from the Healthcare Financial Management Association (HFMA), rework accounts for up to 80 percent of hospital billing office time. Errors and oversight on the front end create unnecessary back end work. More importantly, they adversely impact revenue by increasing days in A/R, generating denied and rejected claims and adding to bad debt write-offs.

These errors cannot be absorbed when gross hospital margins are at best 3 to 4 percent. In a weak economy every unpaid service is a pronounced blow to the bottom line.

For these reasons a consensus is growing that Patient Access is the most critical component of the health care revenue cycle. Money is made or lost in Patient Access before care is ever delivered, and more hospitals are putting emphasis on improving front end administrative and financial operations.

Pre-registration is the first patient encounter beyond scheduling when efficiency and accuracy directly impacts revenue. Using pre-registration to clear patients financially before they ever arrive for treatment protects payer reimbursements, creates opportunities to collect patient payments and improves patient satisfaction.
**Best Practices**

The more advance administrative work that is completed prior to a scheduled appointment, the more focus and resources that are devoted to delivering care when the patient arrives face-to-face.

A pre-registered patient account is typically considered as having met the following minimum criteria 24 hours or more in advance of a scheduled appointment:

- Demographic data verified
- Insurance coverage and benefits verified
- Patient notified of financial responsibility

The overall goal for most organizations is to pre-register as many scheduled visits as possible, and according to HFMA's key performance indicator benchmarks there is little slack.

### Preregistration/Preauthorization

<table>
<thead>
<tr>
<th>Metric</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>Overall pre-registration rate of scheduled patients</td>
<td>at least 98%</td>
</tr>
<tr>
<td>Overall insurance verification rate of pre-registered patients</td>
<td>at least 98%</td>
</tr>
<tr>
<td>Deposit request rate for co-payments and deductibles</td>
<td>at least 98%</td>
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<tr>
<td>Deposit request rate for elective admissions/procedures</td>
<td>at least 100%</td>
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<tr>
<td>Deposit request rate for prior unpaid balances</td>
<td>at least 98%</td>
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<td>Data quality compared with pre-established department standards</td>
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*Source: HFMA*

The definition of “pre-registered” varies by organization.

Some hospitals or systems may consider an account complete after just demographic and insurance information is validated. Others require a longer check list that may include pre-authorizations and cash collections. Each organization sets its own policies regarding what must be in place before the patient arrives.

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**DEMOGRAPHIC VERIFICATION**

Every pre-registration for every scheduled appointment should include a review of the social security number and other demographic data to confirm that the information on file or provided by the patient is legitimate and matches any existing account records.

Medical identity theft is increasingly common, especially during economic down cycles, and verifying a patient’s identity allows the organization to detect and avoid potential fraud. A survey conducted by the Federal Trade Commission (FTC) found that 5 percent of all identity theft victims - some 450,000 people annually - have experienced some form of medical identity theft. Thieves access health care using other people’s benefits and the provider is left holding the bag of bad debt.

- Identity theft is the driving focus of the FTC’s Red Flags Rule, set to go into mandatory compliance effect during 2010. The Rule explicitly calls for hospitals and health care providers to develop and implement plans to mitigate identity theft, or be subject to fines and penalties. Incorporating demographic and address verification in the pre-registration process helps meet these requirements.

Validating a current address authenticates the patient’s identity and ensures that the provider will be able to reach the patient for any reason after service, including sending follow up payment invoices.

- According to the U.S. Postal Service, approximately 3 percent of all mail is returned as undeliverable. If a 200-bed community hospital encounters 5,000 outpatients per month and the average patient portion due per visit is $200, then the total monthly patient A/R would be $1 million. If just 3 percent of the total A/R is uncollectable after service because the patients cannot be located, then the hospital could lose $30,000 in revenue for the month.
INSURANCE VERIFICATION

Arguably the most critical and probably the most common pre-registration activity is insurance eligibility verification. Once an appointment is scheduled for an insured patient, the facility should cross-reference his or her information with the respective payer(s).

- Verify that the patient is indeed enrolled with the payer and plan as presented
- Determine benefits, including co-pays, deductibles and co-insurance
- Discover and obtain any required referrals and/or pre-authorizations
- Discover secondary and/or unknown coverage, including Medicare/Medicaid

These benchmarks for eligibility, published by HFMA, are indicative of the broad brush approach providers are aiming for in terms of percentage of scheduled encounters. There are number of ways hospitals and providers verify insurance eligibility, some more efficient than others.

- At one time the only way to verify eligibility was to call the payer directly via phone. This can still be done but is not practical for hospitals and large physician groups. The usual complaint associated with payer call centers is long wait time. Plus, there is always a risk of inadvertent human error, such as a hospital employee transposing numbers or other vital information.
- Faxes are sometimes quicker than phone but still rely on manual processes that can lead to errors.
- More payers are offering free portals on their Web sites to allow hospitals and providers to access eligibility information about patients. This is usually more efficient and accurate than phone or fax but still time-consuming for staff to visit multiple Web sites, especially for large organizations with a diverse payer mix.
- Third party vendors offer Web-based solutions that provide clearinghouse-style access to patient information directly from the insurer. This provides workflow value by delivering a single source for all eligibility, provided the vendor has connections to the desired payers.

The newest and most efficient method of eligibility verification is integrated solutions from third party intermediaries. Electronic Data Interchange and other automated transactions work in tandem with the Health Information System (HIS) and can post response information directly into the patient record, further streamlining workflow and essentially eliminating human error.

Still, according to estimates from the Council for Affordable Quality Healthcare’s Committee on Operating Rules for Information Exchange, only half of claims are verified for eligibility.

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<td>Overall insurance verification rate of pre-registered patients</td>
<td></td>
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<tr>
<td>Insurance verification rate of unscheduled inpatients within one business day</td>
<td></td>
</tr>
<tr>
<td>Insurance verification rate of unscheduled high-dollar outpatients within one business day</td>
<td></td>
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This research is surprising and concerning given the potential ramifications of not verifying eligibility. Denied claims are lost revenue, and even the slightest discrepancies in claims can generate rejections that drain the organization of valuable resources tied up with re-work and resubmission costs.
For example, increasingly high co-payments and deductibles may mean a patient will owe $2,500 for a scheduled visit. Or, if an elective service is not covered by the insurer the pre-registration department should notify the patient that he or she will be responsible for the full amount.

More hospitals are making efforts to provide up-front pricing, but many rely on homegrown manual processes that are inefficient and not too accurate.

Recent breakthroughs in health care technology have produced software that calculates more detailed patient payment estimates. Third party vendors have designed front end solutions to produce quick and accurate patient payment estimates by merging patient insurance benefits data, hospital chargemaster data and payer contracted rates.

According to a study by America’s Health Insurance Plans (AHIP) 24 percent of pending or delayed claims are due to eligibility-related issues and create an additional 10 days of lag time.

Any CFO will agree that days in A/R is a key barometer to the financial performance of the organization. Outstanding payments have the potential to turn to bad debt. Verifying insurance eligibility and benefits up front protects insurer reimbursements so the provider can focus on collecting the patient’s balance with confidence the rest of the claim will be paid.

Financial clearance and Up-Front Collections
Hospital CFOs and medical group managers should recognize the financial importance of pre-registration beyond insurance eligibility verification.

Eligibility verification yields a patient’s benefits, including co-pay and deductibles. After obtaining this information, pre-registration should determine any patients who may need additional follow up or advance financial counseling. Some patients are uneducated about their own insurance coverage and most appreciate being made aware of their financial liability in advance.

Proactive Patient Access departments can identify patients’ financial issues before services are provided and it is too late to recoup expenses.

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### Reasons for Pended/Delayed Claims

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<tr>
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<th>Percentage of Pended/Delayed Claims</th>
<th>Average Number of Days Pended/Delayed</th>
</tr>
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<tbody>
<tr>
<td>Duplicate Claims Submitted</td>
<td>35%</td>
<td>9</td>
</tr>
<tr>
<td>Lack of Necessary Information</td>
<td>12%</td>
<td>11</td>
</tr>
<tr>
<td>No Coverage Based on Date of Service</td>
<td>8%</td>
<td>11</td>
</tr>
<tr>
<td>Non-covered/Non-network Benefit or Service</td>
<td>7%</td>
<td>5</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)</td>
<td>5%</td>
<td>14</td>
</tr>
<tr>
<td>Coverage Determination</td>
<td>4%</td>
<td>8</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>3%</td>
<td>10</td>
</tr>
<tr>
<td>Authorization</td>
<td>3%</td>
<td>20</td>
</tr>
<tr>
<td>Pre-existing Condition Review</td>
<td>1%</td>
<td>16</td>
</tr>
<tr>
<td>Invalid Codes Submitted</td>
<td>1%</td>
<td>25</td>
</tr>
<tr>
<td>Other*</td>
<td>21%</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

*Source: AHIP*
Patient satisfaction

The intangible but always important benefit of pre-registration is a contribution to improved patient satisfaction.

Wait time is generally cited at or near the top of reasons why a patient becomes dissatisfied with his or her visit. Sitting with a registrar discussing insurance and payment can be overwhelming and even aggravating for someone concerned about matters of health. A patient who is pre-registered and financially cleared moves quicker through the front door and into clinical departments, creating a better overall experience.

Being hit with an unexpected bill during an appointment or even 30 to 60 days following service can turn an otherwise positive experience into an unpleasant ordeal for a patient. If all scheduled patients are pre-registered and financially cleared, then they should have been contacted with an estimate before they arrive and will be prepared to pay something up front. There should be no surprises for the patient or the provider.
Diving deeper on accounts, he said, means eventually being able to complete all pre-registration and financial clearance activities before the date of service for every patient.

- Employees have a check list of criteria to meet and when everything has been done the account is flagged as green.
- Yellow indicates missing criteria that requires follow up but may not affect treatment.
- Red means there is a problem that must be resolved before the patient is treated.

Because the color-coded stoplight system is easy to understand it improves communication throughout the facility, said Wade. If an admissions employee sees an account flagged red, then the patient should be stopped before being treated.

“If we can mark more accounts as ‘green’ before they walk through the door it takes burden off our registration staff and is less for patients to deal with,” said Wade. “We want the patient to walk in, and be able to proceed directly to treatment because we have cleared the account and obtained payment pre-service.”

Future plans at Orlando Health are to move from batch to a real-time process that will trigger account activity as soon as an appointment is scheduled. The hospital is also in the process of adding software capabilities to automatically post response information directly into a patient account, which will create even more workflow efficiency and accuracy.

**Case Study**

**Orlando Health**

The pre-registration department at Orlando Health ran an effective but tedious manual process.

- Reports of scheduled patient visits were extracted daily from within the HIS and exported into Microsoft Excel spreadsheets.
- The spreadsheets were printed, divided into sections using a paper cutter and distributed among employees.
- Staff worked to verify insurance eligibility for every account assigned to them using a Web-based tool and payer Web sites or via telephone calls.
- Each account was updated manually in the HIS.

The system upgraded its pre-registration processes and installed integrated software to automatically pull scheduled visits from the HIS and trigger eligibility verifications based on defined rules. Daily batch files are sent to a third party for overnight processing and returned the next morning in a work list indicating which accounts contain errors. Employees are able to bypass clean accounts and work only those that need follow up.

- The new software and process created a more efficient workflow and enabled the department to absorb a 27 percent reduction in the number of employees performing insurance verification. As staff left voluntarily or were assigned to other projects there were only 20 employees handling pre-registration for the entire system.

“At first our employees were working only specific payers but now every staff person is able to work all insurances,” said Richard Wade, Manager of Scheduling and Pre-Registration for Orlando Health. “The efficiencies we gained have enabled us to get through more total accounts and dive deeper on each account.”

**About Orlando Health:**

Orlando Health is one of Florida’s most comprehensive private, not-for-profit healthcare networks, serving nearly two million Central Florida residents and 4,500 international visitors annually. The system was founded in 1918 and includes eight hospitals totaling nearly 1,800 beds. Orlando Regional Medical Center is Central Florida’s only Level One Trauma Center.
CONCLUSION

The old health care revenue cycle began after a patient was treated and a claim was sent to the insurer.

The new health care revenue cycle begins as soon as the appointment is scheduled.

Protecting payer reimbursements and increasing patient collections has to occur on the front end or it will not occur at all. Thus, pre-registration is the most important phase of revenue cycle management. It is the bridge between scheduling and admission that guards the financial interests of the health care provider and offers convenient service to the patient, creating a better experience for all.

RETURN ON INVESTMENT EXAMPLE

The workflow efficiencies alone gained from Patient Access software are more than enough to justify pre-registration. Following is an example of the value created by advance patient demographic and insurance eligibility verification.

Using the same example of a 200-bed community hospital with 5,000 outpatient encounters per month, it is reasonable to believe the facility could save or reallocate $10,000 or more in monthly labor expenses.

5,000 encounters x 10 minutes = 50,000 minutes

50,000 minutes x $0.25 = $12,500 total front end labor expenses

$12,500 x 80% = $10,000 MONTHLY FRONT END LABOR SAVINGS

Assumptions:
- Assume average 10 minutes of pre-registration work per scheduled visit
- Assume employee wages at $15/hour (including benefits) = $0.25/minute
- Assume automated batch software and daily worklist queue of results allows staff to rectify errors and follow up on only 20% of total accounts and bypass the remaining clean accounts, or 80% (Passport internal research)

CREDITS

- U.S. Postal Service: Undeliverable-as-Addressed (UAA) Mail Cost Study, 1999
- Council for Affordable Quality Healthcare: CORE Phase I Measures of Success, 2009
- Orlando Health
- Passport Health Communications Inc. internal research
ABOUT PASSPORT HEALTH COMMUNICATIONS INC.

Passport Health Communications Inc. creates software and solutions to enable hospitals and health care providers to improve business operations and secure payment for their services. Founded in 1996 and headquartered in Franklin, Tenn., the organization is among the nation’s fastest-growing Software-as-a-Service companies. Its eCare® brand of revenue cycle management solutions are available across multiple platforms and are delivered to one in three U.S. hospitals and more than 5,000 other health care facilities in all 50 states.