

MAKING SENSE OF PREVISITS

GET IT RIGHT AND BOOST YOUR BOTTOM LINE

BY GAVIN HOOPES



What's the single-most financially critical phase of patient interaction? No, it's not collections. It's actually the previsit. That's because the information you gather at this stage saves time and money at every step down the line through to payment. Doing it well is part of what we call preventive management, and it is one of the fundamental principles of the Unified Theory of practice management introduced in this column last month.

Claim problems get more expensive and less likely to be resolved the longer they go on. The concept of preventive management simply says that the most cost-effective approach is to detect and address problems as quickly as possible, and prevent them completely wherever possible.

The previsit phase, then, is all about prevention. If you know *that* you will be paid, *how* you will be paid, and *what* you will be paid for the visit before the patient arrives, you are well on the way to maximizing collection with minimal fuss. Specifically, good previsit procedures net benefits in four areas:

1. Improved patient throughput

The right set of previsit procedures will help ensure that every patient you expect to be in the office on a given day also has the same expectation themselves, and that translates into fewer no-shows, less need for calls to track down and reschedule patients, less effort around collecting missed appointment fees, and a higher average of patients seen per day. That additional revenue adds up, but just as important is the

reduction in wear and tear on your front desk staff.

2. Increased time-of-service (TOS) collections

Setting patient expectations does not stop at making sure they plan to make their appointment; it also includes clarifying their financial responsibilities. Knowing each patient's financial responsibility and communicating that effectively prior to the visit can dramatically improve your TOS collections. Better TOS collections correlates directly to increased total collections and improved cash flow, and it reduces your costs associated with self-pay collections, including generating statements, making phone calls, etc.

3. Higher patient satisfaction

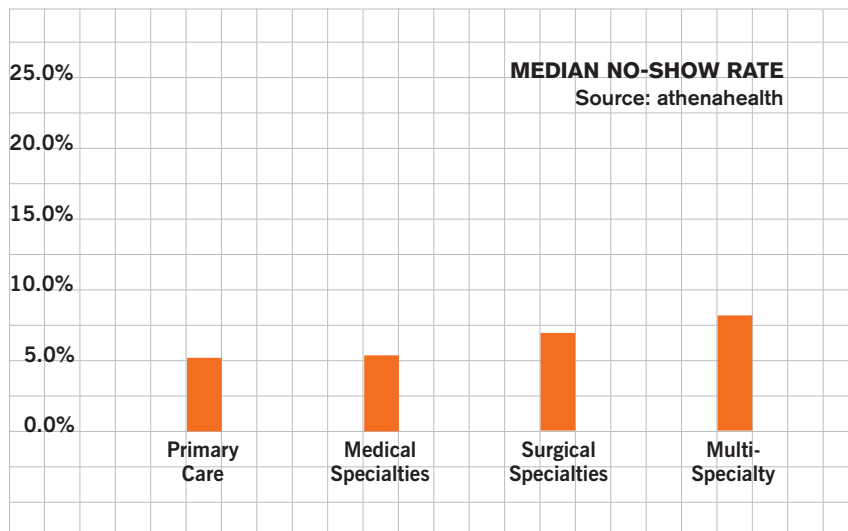
Previsit readiness is not just about collections, though; it can also be a great way to improve your patients' overall experience. When patients clearly know what to expect and

what to bring (such as payment or records), they are more likely to comply without frustration. The personalized previsit communication you use to set patients' expectations also makes patients feel like the practice knows them.

As you improve your ability to accurately forecast no-shows and other scheduling factors, your wait times are also going to improve. Below are some benchmarks for what your no-show rate should look like.

4. Fewer Denials

Previsit routines that focus on eligibility, preauthorizations, and referrals can have a dramatic effect on claim denial rates, and by reducing denials, you not only increase revenue, but also lower your costs associated with denial management and resubmissions.



In our experience, the average practice should be doing preauthorizations on 5.5 percent of its claims, and referrals for 27.5 percent of its claims. (These are difficult numbers to pin down precisely because guidelines can be somewhat hazy for certain payers. In any case, the percentages can be much higher, depending on the types of practice.)

PREVISIT BEST PRACTICES

So if previsit prep is so important, what are the best practices for previsit routines and procedures? Looking at the performance of thousands of practices across the country, we have identified the tips and tricks that work best to get patients to their appointments, on time, almost all of the time and with their paperwork and payments in line.

Previsit work breaks down into these areas:

- Eligibility.
- Appointment reminders and no-shows.
- Authorizations and referrals.
- Chart prep.

Eligibility

We'll examine this complex topic in the fullness it requires next month. For now, it's sufficient to say that eligibility-related denials are the most common variety, and that previsit is the ideal time to establish eligibility.

Appointment Reminders and No-Shows

Reminders can be a time-consuming process, but compared to the time wasted on no-shows and preventable collections activities alone, they are among the most cost-effective uses of staff-time.

Here are some tips for doing them right:

- If possible, contact all patients 24 to 48 hours prior to their appointments.
- Prioritize reminders by appointment type (medical need, dollar value, etc.)

- Use technology to generate appointment reminders.
- Develop, document, and implement standardized appointment reminder policies and procedures.
- Patients with high balances should be scheduled to meet with the practice financial counselor 15 minutes prior to their next visit. These patients should be "flagged" so the practice financial counselor can prepare prior to the visit.
- Generate a report/worklist for upcoming appointment reminders. And here are some pointers for dealing with no-shows:
 - Develop, document, and implement standardized no-show policies and procedures.
 - Track no-shows and monitor them frequently to identify "high risk" patients.
- Contact all patients who do not show up for their visit at least 24 hours after their appointment. For some specialties — cardiology, for example — there may be a substantial risk of liability if patients are not contacted.

Preauthorization and Referral

It is very important to develop, document, and enforce standardized policies and procedures for obtaining preauthorizations and referrals prior to a visit. These procedures will necessarily be customized to the unique circumstances of your patient and payer mix, but consider including the following:

- Identify all visits that could require preauthorizations and referrals.
- Document preauthorization and referral information immediately to facilitate charge entry and reduce duplication of efforts.
- Segment required preauthorizations and referrals by payer. This will increase efficiencies by allowing staff to obtain multiple preauthorizations and referrals at the same time via a phone call or

payer Web site.

Chart Preparation

Having a documented and standardized set of chart prep policies and procedures is also a critical success factor for improving your previsit readiness. As you develop your policies, consider including these:

- Prepare charts the night prior to the visit.
- Flag charts and patient accounts that are missing the following information:
 - HIPAA signatures for Privacy Notice Given, Release of Information, and Notice of Privacy.
 - Copy of insurance card and drivers license.
 - Other relevant forms (e.g., ABN form, etc.).
- Place charts near the check-in desk but out of sight of patients.
- The billing slip should be printed at check-in, not when the chart is being prepared. Thus the billing slip will show up-to-date patient demographic information and time of service balance/amount collected information.

Contacting all of your patients previsit will yield great rewards. Contact as many top-priority patients as possible in person and use postcards or technology for the rest. ■

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