Revenue Cycle Management – Front-End Processes:

Revenue Cycle Management (RCM) is the financial process that healthcare facilities use to track patient care episodes from appointment scheduling and registration, to the final payment/reconciliation of account balances. The revenue cycle begins at the first patient contact. Time management and efficiency are important elements in RCM.

The reception area of a health clinic is a busy intersection where staff and patients interact. There are a number of tasks that need to be completed. Developing processes and workflow is essential. When tasks are successfully completed at the front desk, the needs of patients and those of the business office can be fulfilled.

Demographics, Insurance Eligibility and Benefit Verification

Whether the first contact with the patient is a scheduled appointment or a walk-in, there is important information that needs to be collected and verified. Incorrect patient demographics and incomplete/wrong insurance information are common problems that lead to denied insurance claims.

- Patient demographics, insurance and income information:
    - Patient complete the Patient Registration Form
        - First and last name *(as it appears on the insurance card)*
        - Insurance member ID number(s)
        - Date of birth
        - Complete address and phone number(s)
    - Obtain applicable signed patient consent, release, HIPAA, accept assignment/permission to bill payer forms, etcetera

- Insurance coverage:
    - Obtain a copy of the patient's insurance card *(scan/copy)*
    - Obtain policy holder/subscriber information
    - Verification of Benefits - covered and non-covered services
    - Determine the patient co-pays, coinsurance, and deductible information
    - Coordination of Benefits/Multiple insurance coverage (inquire whether patient has more than one insurance plan)
        - If yes, determine primary insurance
        - If the patient has a commercial insurance and Medicaid
            - The commercial payer is always the primary payer
            - Medicaid is always the payer of last resort
            - Dual eligible Medicare-Medicaid, Medicare is the primary coverage

Demographics, Insurance Eligibility and Benefit Verification (continued)

- Pediatric patients:
  - If both parents have commercial insurance coverage for their child(ren) then apply the birthday rule to determine which payer is primary payer:
    - Whichever parent's birthday falls earliest in the calendar year determines the primary insurance

Financial responsibility

Collecting co-pays and other patient financial obligations prior to services rendered can be tricky because staff may not know all of the services needed before patients are seen by a nurse or provider. When possible, collect payment in advance. Remember: no one is turned away due to inability to pay.

- Inform patients of the clinic's financial and payment policies
- Obtain proof of income (scan/copy):
  - Apply the appropriate sliding fee scale (requirements will vary depending upon program)
  - The patient's income may qualify them for Medicaid – provide the patient with the appropriate applications or refer them to the navigator
- When payments are collected, post payments in the Practice Management system
  - Provide all patients with a receipt
  - Prepare charge/service documentation
  - Reconcile/compare all payments collected:
    - To the money collected (cash, check, credit card)
    - To the Practice Management (PM) system report
    - To the receipts

Eligibility and Benefit Verification Tools - tools used to verify Eligibility and Benefits vary widely, such as:

- EVS Medicaid
- MCO web-sites or call to verify coverage
- Insurance ID cards – ask if they received a new card this year even if the payer has not changed
- Payer websites
- Practice Management systems electronic eligibility
- Clearinghouses electronic eligibility
- Customer Service or Interactive Voice Response (IVR) via telephone