Ideal Medical Practice Workflow

8 Key Steps To Maximize Reimbursement

ClinicSpectrum would like to share with you our concept of “Ideal Practice Workflow” to increase your practice revenue and reduce costs.

“Workflow” is an engineering term meaning any series of steps, consuming resources, and achieving goals. More specifically, workflow is your organization’s series of steps, consuming your time, effort, and money, to achieve great clinical outcomes, satisfied patients, and maximum revenue and cost performance. In effect, workflow is the “user interface” between all the members of your team, between your team and your IT systems, and between your IT systems. The key to making everything work together, to achieve all three of your goals, is workflow, which is why we are absolutely fanatically obsessed with understanding, supporting, and improving your professional and practice workflow.

What ClinicSpectrum Can Do For You

With our innovative Hybrid Workflow Model, we help medical practices, billing companies and other healthcare facilities reduce operational costs and increase revenue.
Our Hybrid Workflow Model combines the best collaborative efforts to create efficiency in your organization.

Let us analyze an ideal practice workflow and steps in engaging the patient effectively not only for clinical reasons but for financial reasons as well.
One! Appointment Call Received

Workflow begins with the patient appointment. When a patient calls to make an appointment, certain key parameters are essential to obtain over the phone for the success of efficient management of clinical and financial workflows. Key parameters include:

- Patient's Demographics
  - Name
  - Phone numbers
  - Date-of-birth
  - Gender
- Insurance Company Name
- Insurance ID for Primary and secondary insurance
- Primary Physician if any
- Reason for visit

The above items are essential to obtain over the phone in order to determine eligibility of the patient and define a preliminary care plan for the patient at the time of service. Patient information such as address, guarantor, work type, job and employer can be obtained when patient arrives in office.

This data drives and enables subsequent practice workflows.
Two! Eligibility Team Verifies Benefits

A back-office insurance eligibility team works on verifying eligibility of all patients depending upon his or her reason for the visit. Fast track or basic eligibility can often be verified using your Electronic Health Record/Practice Management System (EHR/PMS) but certain visit types may require calling an insurance company representative to verify detailed
benefits and authorization and/or referral requirements. We recommend detailed telephone verification for all new patients. For returning or existing patients, the practice may use online or EHR/PMS options.

Depending upon eligibility verification, the back-end eligibility team creates a financial plan, including patient responsibility, and communicates to front office team for further action.
Three! Patient Check-In/Out

Upon patient arrival and check-in, information obtained during the phone call is double-checked, additional data is collected, and the patient is informed and educated.

- Verify date & time of last office visit.
- Update demographic information.
- Update email and cell phone number.
- Activate patient portal and email brief video tutorials.
- Addresses alerts for financial and insurance issues.
- Collect patient co-insurance, co-pay, and deductible.
- Schedule next appointment upon patient’s check-out.
- Confirm tests, procedures, referrals, and authorizations.

Again, as noted in the previous section on patient check-in and check-out, these data and activities drive and enable successful execution of many subsequent workflows.
3. Patient Check-in Process and check-out person (Front Desk)

- Makes sure that Demographic Information is up to date including email/cell.
- Verifies the date & time of last office visit.
- Addresses any system Alerts for Financial/Insurance Issues.
- Activates Patient portal and provides a brief video tutorials through email.
- Completes Appointment Scheduling upon patient’s check-out.
- Collects patient balances due to co-insurance/Co-pay (or) Deductible.
Four! Pre-Physician Patient Engagement

Every minute a physician isn’t gathering information relevant to making future decisions (that no one else can gather), or actually making those decisions is a waste of a physician’s more valuable asset, his or her time, and directly reduces practice revenue. So far, we have covered the initial workflows of the patient calling for an appointment and checking in at the front desk. Just as those data and activities drive and enable important workflows, the data and activities of clinical assistants are even more important for great clinical outcomes, satisfied patients, and maximum revenue and cost performance.

Shifting as much work as possible, from the physician to the right nurse or physician/clinical assistant, can dramatically increase practice productivity. However, this is only practical if the right workflows are in place to make sure the work is done correctly and according to physician intentions.

Physicians should able to simply walk into an exam room, review patient information and decide whether tests and procedures completed by their clinical assistant team were truly necessary and if so, decide to bill them.

- Validate primary reason for visit.
- Take detailed history.
- Confirm current meds taken by patient.
- Documents allergies and current vitals.
- Review clinical alerts.
Preventive tests based on conditions and treatments.
Document test & procedure medical necessity.
Execute relevant clinical protocols.

4. Patient Engagement by Clinical Assistants such as Nurses/MA

First she validates primary reason for visit.

Then she establishes detailed history to save physician’s time in examination room!

Then she generates Medication Reconciliation to confirm current meds taken by patient.

Reviews any Alerts for clinical reasons, such as preventive test (OR) recall based on conditions and previous treatments (OR) Procedures.

Reviews clinical protocols or evidence based treatment protocol and makes a list of procedures required to perform on this patient before physician arrives to examine.

Distributes Pre-Visit and/or Medical Necessity Questionnaire for Diagnostic Tests and Procedures.

It may appear that THIS IS IMPRACTICAL or EXTREMELY TIME CONSUMING, however it definitely saves 15 mins per patient for physicians. We can always do the MATH to calculate whose time is more costly?
This workflow plan removes gaps in care plan management and improves risk management. This workflow helps in increasing medically necessary tests and procedures to avoid unnecessary referral and hospitalizations. In a nutshell, this is what we call "Accountable Care" wherein the clinical team truly follows clinical guidelines to take care of patients.

**Five! Do What You Do Best: See Patients!**

The physician walks into the exam room with a strong preparation done by his clinical assistants. She or he reviews complete history, allergy, and reason for visit, and completed tests and procedures based on clinical protocol. Physicians lose up to 40% productivity due to EHR “clickarrhea.” Therefore electronic chart is then completed through a hybrid workflow of dictation and/or Dragon-based speech recognition, and minimal EHR template clicks.
5. Physician’s workflow

The physician walks in the exam room with a strong preparation done by his clinical assistants.

He reviews complete history, allergy, and reason for visit, and completed tests/procedures based on clinical protocol.

It becomes easier for him to review everything quickly and perform the physical exam, diagnostic tests or referrals for better decision making.

The electronic chart is completed by him through HYBRID dictation and/or Dragon Medical Software or Point-N-Click EHR.

Recent articles published indicate that physicians lose up to 40% productivity due to point-n-click EHR at times.

Six! Billing Team Generates Bill

After the chart is completed, billing information is transferred through via the electronic superbill to the billing
team. Many practices submit claims in random order, disrupting cash flow. The following cycle of billing workflow is key to predicting ultimate cash flow.

The billing team should submit claims daily to forecast daily and weekly cash flow. They can maintain a gap of four days from date of service, providing enough time for physicians to finish charts, however the cycle of billing must be kept intact. Identifying gaps in billing and engaging patients for financial purposes is essential to your practice’s financial health. The billing team must follow a strict (but well-thought out) financial protocol-driven workflow. This workflow includes:

- Submit claims daily for at least one day of service minimum (though some short gaps are allowed).
- Post daily payments and bill balances to insurer or patients. Don’t wait for the end of the month.
- Process denials within 72 hours. Keep them in work queue for follow up in 6-7 weeks.
- Communicate to patients about high deductible, coordination of benefits, and health plan questionnaires.
- Audit outstanding claims monthly and create action plans for follow up within six weeks.

Physician has completed the chart and the information for billing is transferred through Electronic Super bill / Paper Super bill or Auto generated Claims through an EHR to the billing team. It is essential to build a cycle in business in order to predict Cash Flow.

Billing team in Medical Practice should submit claims daily in order to forecast daily/weekly cash flow.

Billing team should have something called a FINANCIAL PROTOCOL to be followed internally. This includes the following steps:

1. Submit claims daily for at least 1 day of service minimum.

2. Post daily payments and bill balances to secondary or patients.

3. Work on Denials within 72 Hours and keep them in work queue for follow up in 6-7 weeks.

4. Communicate with patients’ for high deductible / clinical questionnaire sent by health plans.

It is most important to follow up on OUTSTANDING claims once in 6 weeks for optimum cash flow. It is essential to identify gaps in billing and engage patients’ for financial purposes.
Seven! Operations Team Finds Cost Reductions

The operations team, usually comprised of an office manager and key physicians in a practice, continually identify the use of technology or outsourcing to reduce costs. This team will conduct monthly meetings.

In our hybrid workflow model, tasks delegated to back-office team members result in savings of up to 30% or more.

Eligibility Verification

With high deductibles on the rise, proper eligibility verification is more crucial than ever. While about 60% of verifications may be completed online, detailed verifications for various procedures, and more specific templates customized to specialty, require a live representative call. Hybrid workflow allows a collaborative verification effort resulting in cost savings and decreased risk of claim denials.

Appointment Confirmation

Using a hybrid workflow model and outsourcing various tasks a practice can reduce significant operational cost all while becoming more efficient. Our automated engine schedules appointment confirmation calls, text messages, and email notifications, while the back-office team provides appointment confirmation for high value procedures through live representative calls.
Scanning and Indexing

EHR document management modules can receive in-bound faxes and compile scanned images, however those documents may accumulate over time and still must be indexed to the patient’s chart. This can be a time-consuming task. An outsourced back-office team can reduce the cost of indexing by 40% or more. The average cost of indexing per page or file done in-house is 50 cents. Outsourced it costs 10 to 25 cents per image or file.

7. Operation Team

Operation Team often comprised of an office manager and key physicians in practice.

This team will do MONTHLY meetings.

They will try to find out available options to reduce operational costs through Automation or Outsourcing Services.
Eight! Generate Clinical Reminders

The clinical reminders team data mines the EHR/PMS to identify patients for practice growth and required visits in office. They send reminders to patients through the patient portal, email, SMS, automated calls and live representative calls. The clinical reminders team encourages medication adherence and compliance for outside tests and referrals for patients.

Pre-visit preparations, to be completed 24-hours before patient’s arrival by outsourced back office clinical reminders team, include:

- Look at problem list.
- Last test and procedures.
- Last lab results.
- Last annual well visit.
- Identify plan of care.
- List clinically necessary procedures based on current problem list and previous assessment.

Evidence-based recalls, diagnostic tests and procedures, and annual wellness visits contribute to better patient care and risk management. This can increase revenue ten percent, or more, through additional opportunities for visits and in-office procedures.
8. Clinical Reminder Team

This team’s main role is to do DATA MINING from EHR/Billing System to identify patients for Horizontal Growth as well as required visits in office.

They would send reminders to patients through Patient Portal, Email, SMS, Automated Calls and Live Representative calls.

This workflow plan can take a practice to next level in REVENUE / COST / RISK Management and make them truly accountable in care.

The Ideal Medical Practice Workflow S.Y.S.T.E.M.

The above workflow plan can take a practice to next level in managing revenue, cost, and risk, making them truly accountable to you. After all, your system of carefully calibrated and systematically improved workflows should ....
Save You Substantial Time, Effort, and Money.

SAVE

Minimize encounter length, wait times, staff idle time, mental and physical effort, and total cost of ownership.

YOU

You serve your patients; your workflow should serve you.

SUBSTANTIAL

A lot!

TIME

Save time: see another patient; spend more time with each patient; go home on time.

EFFORT

Minimize mental and physical effort to learn and use.

MONEY

Time is money. Save time, save money. Shift tasks from expensive personnel to less expensive personnel (but monitor task progress so nothing falls between the cracks).
Let us dramatically increase your revenue and Save You Substantial Time, Effort, and Money!

Contact us today!

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“ClinicSpectrum saved our practice!”

Silvia Barillas
Thalody Medical Associates
Elizabeth, New Jersey
About Vishal Gandhi, BSEE, MBA

Founder and CEO ClinicSpectrum Inc.

Vishal is a well-known and widely respected authority on the “nitty-gritty” of medical practice workflow and technology. His Hybrid Workflow Model is quickly becoming a new healthcare industry standard model for combining human and computer workflow, to maximize revenue and minimize cost. Most recently, Vishal has appeared in prominent health IT publications, authoring articles with such titles as:

- Getting Money in the Door: Streamlining Patient Collections
- Automated Billing: Increase Time with Patients, Practice Profitability
- The Eligibility Verification Time Suck
- How Does a Practice Deal with All These High Deductible Plans?
- Building Accountability and Consistency Into Your Healthcare Practice
- Outsourcing Selected Back-Office Tasks at Physician Practices
Education, Expertise, Developed Products

Bachelor of Engineering in Electronics with specialization in System Design, Masters in Business Administration (MBA), Certified Healthcare Auditor (CHA), Certified Healthcare Collector (CHC) 14 years’ experience in:

Hybrid Workflow in Healthcare for Revenue Maximization and Cost Reduction with use of Technology and back-office team members; Operational Efficiency and Accountability; Revenue Cycle Management; Healthcare Revenue Cycle and Workflow Management; 460+ employee team (and growing!); Credentialing Platform and Services; Benchmarking and Productivity Management; Providing Certified Electronic Health Record to physicians, IPAs and other healthcare facilities; Marketing and Product Management; Sales and Distribution including Channel Partners creation and management.

An Endorsement

Recently Vishal Gandhi was interviewed by Charles Webster, MD, MSIE, MSIS, also a well known health IT industry expert on healthcare workflow. This is what Dr. Webster said about Vishal:

“It’s not often I meet someone as (more?) obsessed with healthcare workflow as I am. I believe I’ve met my match in Vishal Gandhi of ClinicSpectrum.... Vishal, like all engineers, applies the kind of “systems thinking” that’s frequently wished for in healthcare. He conceptually (and sometimes really!) takes a system apart. Understands all the component subsystems. Understands the workflows among these components. And then puts them all back together, working faster, better, cheaper.”