Revenue and Time Study of One Practice Using Trojan Professional Services Benefit and Eligibility Services

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Over many years I have seen a positive impact on many offices when their processes are streamlined. One of the easiest and quickest ways is to implement a supportive service or tool that specializes in specific functions, such as payroll, collections, claims processing, billing, and insurance benefit coverage. When using these “specialized” support services, offices experience a heightened level of expertise at a lesser cost than if the services were performed internally. One such way to streamline processes is to use a support service to gather patient insurance benefit information. Staff then has more time available to develop operational systems, and patients feel their dental office is well prepared and knowledgeable.

This study found that implementation of a support service specialized in gathering patient benefit information resulted in positive impact in several areas. And although challenges were also identified, the largest obstacle was the mere task of adopting a new process. Once that hurdle was overcome the staff and the office experienced positive results from this tool.

By MaK Concepts

FINDINGS

Replacing the original process with using Trojan's Benefit Service and Eligibility programs produced the following results:

1. **Increased Productivity**. Staff spent 27% less time researching benefits and eligibility, yet obtained benefits and eligibility for 35% more patients. The office also treated 7% more patients. The eligibility service allowed the practice to check eligibility on an average of one to two minutes per patient, as compared to doing this internally where staff spent up to 20 minutes on hold with insurance representatives.

P-1=Period One (1st two-weeks of study) P-3=Period Three (3rd two-weeks of study)

	P-1	P-3	Chg	%
Time Researching Benefits (Min)	1,208	884	(324)	-27%
# Patients Benefits Obtained	139	187	48	35%
# Patients Treated	184	196	12	7%
Time Per Patient (Min)	8.7	4.7	(4)	-46%

2. **Decreased Staff Time**.

	P-1	P-3	Chg	%
Total Staff Time (Hrs)	143	126	(17)	-12%

3. **Increased Production**. Production increased by 9% in period three. Although production revenues increased by 9%, the increase cannot be directly traced to activities related to reactivation and delayed treatment calls.

	P-1	P-3	Chg	%
Production (2 Weeks)	39,789	43,295	3,506	9%
Production (Est. Monthly)	86,210	93,806	7,596	9%

4. **Clearly Defined Financial Responsibility**. Patient perception that financial responsibility is ultimately the responsibility of the patient increased. The Benefit Service and Eligibility printouts became a critical tool for the staff. By sharing the printouts with the patients, staff was better equipped to show utilization, accountability, and estimation of patient fee portion.

5. **Maximized Production**. The printouts added weight and clarity to the presentation, creating a powerful dialogue with the patient. They helped to focus on a higher level of customer service and to maximize benefits.

6. **Generated Goodwill**. The staff experienced positive patient feedback. Because patients rarely receive an understandable explanation of what their benefits cover from their employer, they appreciated the effort and information. Additionally, this positively affected the conversation between the staff and the patient. By using documented hard data, staff was better prepared to explain what the benefits were, how they were covered, and that they were provided by the employer. This put the conversation in a more objective mode, completely relieving the staff of being responsible for the "quality' (or lack thereof) of the patient's benefits, and promoted a more positive interaction compared to similar conversations experienced under the original process.

7. **Decreased Number of Claims Resent**. Insurance Tracking accounted for 3% of the overall time spent on tasks during period one. However, during this study outstanding insurance claims decreased 72% and time spent declined 91% from period one to period three, even though production increased during period three (“after implementation”). Additionally, the total number of submitted claims “over 60 days” old decreased 23% (not shown). Again this reduction was experienced even though production increased. We contribute the results to two factors. One, staff worked heavily on this task just prior to the start of the study, thus the need to follow up as much was reduced. Secondly, the information provided by the Benefit and Eligibility service was useful in its entirety by increasing the clarity of benefits and coverage, leading to a reduction in the denial of claims. Thus the need for less followup on certain non-covered benefits. The information provided by Trojan had a positive impact on claims submission and tracking and the combination of the two factors produced the 67% reduction in Time per Claim.

	P-1	P-3	Chg	%
Time Insurance Tracking (Min)	197	18	(179)	-91%
# Claims Resent	18	5	(13)	-72%
Time Per Claim (Min)	10.9	3.6	(7)	-67%

CONCLUSION

This study concluded Trojan’s Benefit & Eligibility Services created a positive impact even in the brief two-week time study following implementation. Not only did the practice experience timesavings, they also were able to incorporate a wealth of information for benefit utilization, which appeared to create more opportunities to increase revenues.

Although- customer service is less measurable in dollars, we know over the long-term that a strong customer service approach serves as a strong foundation to a successful practice. The value of effective tools in a practice is too commonly measured only in the clinical environment. Doctors invest in intra-oral cameras, digital x-rays, Cerec and other advanced tools, while front office teams are rarely trained on the practice management software. The teams are often stuck with antiquated systems and outdated or non-existent tools and resources. While clinical advancements often contribute toward increasing revenue, it should be understood that administrative functions of the front office can and should equally contribute to increased revenue. The bottom-line, the short and long-term goal is to weigh in on missed revenue opportunity throughout the entire business.

What was demonstrated during this study was the importance of integrating effective tools and services for the front office team, which in turn decreases costs in time and labor, and redirects focus to revenue generating systems. Trojan’s Benefit and Eligibility services go far beyond insurance benefit and eligibility information when properly integrated and trained in conjunction with practice systems and superior service.

OVERVIEW OF STUDY

This study was performed to gather empirical data in order to evaluate the effects of introducing Benefit and Eligibility services provided by Trojan Professional Services to a typical dental front office for the purpose of evaluating whether or not the services add value to a practice.

PRACTICE CHARACTERISTICS

- 1 Primary Doctor treating patients 4 days per week
- 1 Associate treating patients 1 day per week
- 2 Hygienists performing 5 days of hygiene per week
- 2 Back office assistants
- 2 Front office staff
- 3 Operatories

STUDY CHARACTERISTICS

This study was performed over three two-week periods.

1. The first two-week period (Period 1) consisted of observation and data gathering. No changes were introduced nor was coaching provided.
2. The second two-week period (Period 2) consisted of (a) implementing Benefit and Eligibility services, (b) training the staff on the functionality of those services and how the services integrate into the practice management software, (c) using the Benefit and Eligibility data received to its fullest, and (d) modification of existing systems, which entailed retraining the two front office staff on how to use and rely on the Benefit and Eligibility services.
3. The final two-week period (Period 3) consisted of coaching the staff to not revert back to the original system and continue using the new system.

During the first and third periods, a time study was conducted. The staff was required to log their time throughout the day and later segment by task. The first time period tracked segments under original system procedures and the third period tracked segments under the new modified system procedures.

The time segments measured were Collections (Calls Made/Amount Collected), Patient Conversion (Delayed Treatment or Recare Calls / Added Production), Patient Benefits (Time to Process and Gather), Confirming Appointments (Number of Calls Made and Confirmed), Tracking Insurance (Number of Patients Tracked and Resent), Hours on Front Office Tasks, Staff numbers of Hours Worked in the Day, Daily Hours of Operation, Daily Production Numbers, Accounts Receivables, Outstanding Insurance Claims, and Other.

PROBLEM

The front office operation consists of multiple systems heavily reliant on time management and staff/team resources. Critical problems that negatively impact practices are two-fold: staff reduction due to overhead constraints, resulting in time limitations for important tasks and

systems, many of which impact revenue opportunity and lack of training and resources to consistently target all revenue generating systems.

One heavily weighted front office task is researching and verifying insurance benefits on behalf of the patient. This practice alone spent an average of 11%-14% of their total front office time in just this one area. If the front office remains the "heartbeat" of the practice with the lifeblood running through systems, why limit the potential in revenue by failing to maximize the support team and resources?

An obvious and significant example is the Financial Arrangement System, which has a tremendous impact on practice revenue. The front office team member must have resources and information to effectively and successfully have a conversation about patient options and financial responsibility for recommended treatment. Since insurance benefit utilization remains a high focus to the consumer it is not an option to avoid or misstep this presentation. In fact, most front office teams would agree that patients expect them to have expertise and knowledge about insurance benefits.

The inherent problem is the time available to research and obtain the information to optimize this most important system. If the Financial Coordinator is unprepared, there is a potential loss in revenue opportunity. Conversely, if the Financial Coordinator has spent valuable time to research and obtain benefit information, the business experiences potential revenue loss because other important revenue stream systems have been neglected; Reactivation and Delayed Treatment, Recare/Continuing Care, and Marketing, to name a few.

ANALYSIS

Period One

The staff, during period one, was observed using a combination of calling insurance carriers directly or accessing carrier websites to obtain benefits and eligibility status. Most calls made to the carrier resulted in obtaining an abbreviated set of data (eligibility status, percentage and category breakdown, frequency information, coverage and exclusions). Staff experienced long on hold times, interruptions with patient calls, and patients checking-in or out. The priority to serve the patient, usually lead to terminate the call, resulting in a call back or extended wait time on hold. This consequently increased the amount of time having spent on this task.

Accessing carrier websites also resulted in an abbreviated set of data. The carrier websites lack comprehensive detail and also patient information for some carriers is completely unavailable. Next, once the patient information is obtained from either resource (call or carrier website), the task of entering the insurance data into the practice software contributes further to time management issues.

Period Two

The office installed Eligibility and Benefit Service programs and trained staff on use.

Period Three

At the start of period three, the staff was introduced to a patient friendly dialogue for the successful execution of benefit presentation, financial arrangements and patient accountability. The office staff would now delegate to Trojan part of insurance efforts, similar to that of an employee.

Training began with the two front office staff by tasking the first staff to focus on linking Trojan's data to the patient insurance data field in their practice management software, which was as simple as depressing a button. The time spent linking plans replaced the more labor-intensive task of manually entering each field into the practice management software, which allowed the staff to prepare for the appointment by printing the Benefit Service data for use in addressing financial arrangements and benefit utilization with the patient. Two copies of the benefits documents were printed; one for the chart, and the other for to the patient as a disclaimer, estimate, and basis for Financial Arrangements. Also, when eligibility was in question, the staff used the Eligibility service to get that information. Finally, the staff was redirected to call Trojan instead of calling the carriers. Any time benefit information was needed for a patient, that task was delegated to the Trojan services team, eliminating calls to insurance carriers altogether.

The second staff was directed to focus on patient service in the daily flow as well as dedicate time on revenue generating systems such as scheduling and recare.

Both staff was trained to work with the patient in a partnership capacity to maximize their benefits. During the meeting with patients, the staff used a copy of the plan printout and would highlight the phone number of the Employer and Insurance Carrier in front of the patient. This helped clarify that the agreement is between the subscriber and their choice of insurance carriers, not the practice.

Also, by giving a copy of the document to the patient, this allowed the patient quick reference to their carrier for inquiries. It also made the patient the responsible party while upgrading the standard of service.

Challenges

During the study, we encountered four challenges necessary to surmount for a successful adoption of the service.

1. **Learning Curve**. Finding plans and having Trojan research then link them.
2. **Download Updates**. The Dentrix program had been timing out during the updates. This appears to be an isolated incident with this office and was overcome by having all users log out of the Dentrix system prior to performing the update process.
3. **Maximizing the Service Benefit**. It is challenging to train a team in one week on how to truly benefit from most processes. Even though the overall TIME was reduced, it will be further reduced after the learning curve (they agreed it has already), but for maximizing production with the saved time, they would need to train on several systems and have that part of the daily tasks. This office in my opinion will not fully maximize the potential of the practice due to contentment of patient flow and revenue.
4. **Adopting New Processes**. The "old ways" and time-consuming habits of the staff were a challenge. One staff member required redirection from the propensity to pull charts and review the benefits, as she had done for 30-years.

Cost of Service

At the minimum, using the Benefit and Eligibility services the office saved 17 hours of time during a two-week period. Assuming a staff rate of $20 per hour and a continuous saving, the office is estimated to save $736 each month.

Staff time. Savings of seventeen hours during a two-week period of increased production ($20 per hour) adjusted monthly	$ 736	$ 736
Increased Production	-	7,596
	736	8,332
Less Cost of Benefit and Eligibility Services (as used)	210	210
Total Est. Monthly Net Additional Benefit	$ 526	$ 8,122

MaK Concepts, Inc. is a fast growing company with a rich history of delivering realistic solutions and innovative coaching services for the dental profession. We believe in uncovering great leaders in our doctors and unleashing powerful support teams. Our goal is to translate doctor's vision into reality. We do this by identifying the hidden opportunity within the doctors, teams and the systems in the practice. Our success in delivering superior performance for practices is based on years of first-hand experience coupled with a strong desire to invoke positive change. Our business philosophy and core training encompasses patient-centered systems that instill loyalty. We are best known for helping doctors and teams discover personal greatness and financial victory while supporting their visions and dreams.