Increase Cash Flow and Reduce Denials with Eligibility Services from NextGen Healthcare

Consistent eligibility verification also helps lower costs and increase patient and staff satisfaction

Medical practices must closely monitor their revenue and eliminate any possible risks that threaten collection of money earned—especially as payers continue to reduce reimbursement rates. One troubling trend: An increase in claim denials.

In a recent survey of 200 healthcare professionals who work in claims, 42% said denials are increasing.[1] According to the Healthcare Financial Management Association (HFMA), **inaccurate eligibility and registration are among the top reasons why denials occur.**[2] Without proper eligibility verification, your claim is dead before it gets out the door.

Support for greater consistency and accuracy

Eligibility Services from NextGen Healthcare can help your practice implement a consistent, accurate verification process. Optimizing eligibility verification will:

- **Decrease eligibility-related denials**
- **Accelerate cash flow** – when denials are fewer, more cash flows
- **Improved staff efficiency** – when staff is not bogged down with issues related to eligibility, they focus better on other tasks
- **Better patient experience** – patients are happier because issues with insurance coverage are less common, and staff can be more attentive to their needs
- **Lower administrative costs**

Services include optimization of NextGen Healthcare's automated eligibility verification tool. This solution connects with third-party payer systems online. It allows you to validate patient benefit eligibility, determine coverage, and estimate patient responsibility via online access.

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ELIGIBILITY SERVICES FROM NEXTGEN HEALTHCARE

Service	How it works	Benefits
Optimization of NextGen Healthcare's automated eligibility tool	• Enables automated eligibility verification 3 to 5 days before a patient appointment based on service or event type • Auto-populates insurance maintenance screen and records payer response in the patient chart	• Front desk staff has eligibility verification completed prior to patient check-in • Alleviates manual insurance queries
Validation of patient payer coverage	• Reviews and confirms that benefits cover the service or procedure for the patient • Confirms coordination of benefits	• Provides a detailed confirmation of the insurance coverage for scheduled service • Medical practices typically review for only an "Active" response and do not usually have to review the payer response and verify against the scheduled service
Insurance and benefits update notifications and communication	• Communication to front desk staff via tasking or chart notes regarding missing or partial information; for example, missing policy number or copy of insurance card • Randomized quality audits of your insurance verification process • Provides feedback through analysis of claim rejections and denials	• Allows front desk staff to work eligibility exceptions before or during patient check-in

NEXT STEPS

We want to help you streamline operations and achieve better financial outcomes. If your medical practice already uses NextGen Healthcare solutions, reach out to your account manager. You can also contact NextGen Healthcare at **855-510-6398** or **results@nextgen.com**

1 The State of Claims Survey 2022, Experian Health. https://www.experian.com/healthcare/resources-insights/thought-leadership/white-papers-insights/state-claims-report?cmpid=healthcare-blog. **2** 4 Proven Strategies for Optimizing Revenue Cycle Performance, Healthcare Financial Management Association, July 8, 2022. https://www.hfma.org/finance-and-business-strategy/4-proven-strategies-for-optimizing-revenue-cycle-performance/.

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