WHITEPAPER

How Patient Access Services Impact Revenue Cycle Performance

Why Most Denials Are Created Before the Patient Is Seen

The registration desk decides more of a practice's financial performance than the billing office does. This guide covers where patient access failures originate, what each one costs downstream, and how to build a front end that prevents denials rather than creating them.

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1. Executive Summary

When a practice has a denial problem, attention goes to billing. Staff are added to follow up, denial reports are reviewed, appeal processes are tightened. All of it is downstream work on problems that were created before the patient was seen.

A large share of preventable denials originate in patient access: a coverage detail not verified, a policy number mistyped, an authorisation not obtained, a benefit not checked. Each one becomes a denial three weeks later, then rework, then an aged balance.

> **The core finding**
>
> The front desk is a **revenue function**, not an administrative one. It is usually the lowest paid, least trained and highest turnover role in the practice, and it determines more of the financial outcome than any other single position.
>
> Practices that reduce denials durably almost always did it by investing in patient access rather than by expanding billing capacity.

2. What Patient Access Actually Covers

Function	What it involves	Revenue consequence if it fails
Scheduling	Capturing reason for visit, provider, service type	Wrong service scheduled, authorisation missed
Registration	Demographics, subscriber and coverage detail	Claim rejects or denies on identity or coverage
Eligibility verification	Confirming active coverage and benefit detail	Denial for terminated or non covered service
Prior authorisation	Obtaining and documenting approval	Denial with limited appeal prospects
Financial clearance	Establishing patient responsibility	Balance ages, collection probability falls
Point of service collection	Collecting known patient portions	Enters the slowest part of the ledger
Referral management	Confirming referral on file where required	Denial for missing referral

Read the third column as a cost schedule. Every one of those failures is cheaper to prevent than to resolve, and several are close to unrecoverable once they occur.

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Before the visit
Where most preventable denials originate

Front desk
The role with the largest revenue influence

Cheapest fix
Prevention costs a fraction of appeal

3. The Cost of Failure, Stage by Stage

The same error costs progressively more the later it is caught.

Caught at	Cost
Scheduling	A phone call. No delay
Registration	Minutes of staff time. No delay
Pre-submission scrub	Minutes of billing time. No delay
Clearinghouse rejection	Rework plus a few days
Payer denial	Rework, resubmission, 30 or more days of delay
Appeal	Documentation, follow up, 60 to 90 days, uncertain outcome
Never worked	The full claim value, written off

The number worth putting in front of a practice owner

Not the denial rate. The dollar value written off last quarter to denials that originated in patient access.

A percentage is abstract. A figure representing care that was delivered, documented and never paid for is not, and it is usually larger than expected.

4. Registration and Data Capture

A significant share of preventable denials trace to something as simple as a transposed policy number or a date of birth that does not match the payer's record.

- **Capture the subscriber, not just the patient.** Where the patient is a dependant, subscriber name, date of birth and relationship are required and are frequently omitted.
- **Verify identity against the insurance card and a photo ID**, rather than relying on verbal confirmation.
- **Scan the card front and back at every visit.** Plans change, and a card on file from eighteen months ago is not evidence of current coverage.

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- **Capture coordination of benefits where secondary coverage exists.** Incorrect primary and secondary ordering is an entirely avoidable denial.
- **Confirm the service address and place of service**, since these affect payment for several service types.
- **Update demographics at every visit**, not only at first registration.

Where to start if you only change one thing

Rescan the insurance card at every visit and re-verify coverage, rather than relying on what is on file.

Coverage changes silently. The patient is usually unaware. The practice discovers it when the claim denies, weeks after the service was delivered.

Find Out What Your Front End Is Costing You

Our free RCM audit traces your denials back to their originating stage and quantifies how much of your denied revenue was created before the patient was seen.

Request Your Free RCM Audit

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Valued at $1,500. No obligation. USA physician-owned and managed.

5. Eligibility Verification

Verification is the highest return activity in patient access, and the one most often reduced to a coverage active or inactive check.

Verify ahead, not at the desk

Verification 48 to 72 hours before the appointment leaves time to resolve a problem, contact the patient, or reschedule. Verification at the desk leaves a patient in the waiting room and a decision that will be made under pressure.

Verify benefits, not just coverage

Check	Why it matters
Active coverage and effective dates	The baseline, and insufficient on its own
Plan type and network status	Out of network status changes the entire financial conversation
Service specific benefits	Many services carry separate benefit categories and limits
Deductible met to date	Determines what the patient owes today
Copay and coinsurance for this service type	Enables accurate point of service collection
Visit or frequency limits	Common cause of denial on recurring services
Authorisation requirement for the planned service	Identifies the requirement while there is still time
Coordination of benefits	Establishes correct payer ordering

This level of verification also enables an accurate financial conversation before the visit, which is where point of service collection actually comes from.

6. Prior Authorisation at the Front End

Authorisation failures are distinctive because they are often unrecoverable. A coding error can be corrected. A procedure performed without required authorisation is frequently written off regardless of medical necessity.

- **Maintain a requirement matrix by payer and procedure.** Requirements differ by payer, by plan within a payer, and change without notice.
- **Make the authorisation check a hard stop in scheduling**, not a task completed later.
- **Record the authorisation number, approved units and valid date range** in the record. Payers deny for unit and date mismatches even where authorisation exists.

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- **Track expiry.** A procedure rescheduled beyond the authorisation window needs re-authorisation, and this is a common and avoidable loss.
- **Assign ownership.** Authorisation needs a named owner with a tracked queue. Shared responsibility defaults to nobody.

7. Financial Clearance and Patient Responsibility

Patient balances age longer and collect worse than any payer balance. The decisive factor is whether a financial conversation happened before the service.

Approach	Typical outcome
No discussion before service	Balance enters the slowest part of the ledger. Collection probability falls sharply
Estimate provided and portion collected at service	Highest collection rate. Fewest complaints
Estimate provided, payment plan arranged in advance	Strong outcome on larger balances. Preserves the relationship
Statement sent after the fact with no prior discussion	Lowest collection rate. Highest complaint and dispute volume

Practices frequently avoid these conversations out of concern that they feel transactional. Handled well they do the opposite. A patient told in advance what a procedure will cost is better served than one who receives an unexpected statement six weeks later.

8. Staffing, Training and the Turnover Problem

The structural contradiction

Patient access influences revenue more than any other role in the practice, and is usually the lowest paid, least trained and highest turnover position in it.

A practice that will not fund training or retention for this role, and then funds additional billing staff to work the resulting denials, is paying more for a worse outcome.

- **Train on the revenue consequence, not just the procedure.** Staff who understand that a mistyped policy number becomes a denied claim treat the field differently.
- **Document the process.** High turnover roles need written procedures, not knowledge held by whoever has been there longest.
- **Build a verification checklist** so completeness does not depend on memory during a busy clinic.

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- **Measure at the individual level and feed it back.** Registration accuracy and verification completeness are measurable and improve when visible.
- **Fund retention.** The cost of turnover in this role is paid downstream in denials, and it is rarely attributed back to its source.

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9. Technology That Helps, and Technology That Does Not

Function	What technology does well	What still needs people
Eligibility verification	Batch checking ahead of appointments at scale	Resolving discrepancies and unusual coverage
Identity and address validation	Catching format and matching errors at entry	Judgement on genuine mismatches
Authorisation requirement lookup	Flagging that authorisation is required	Obtaining it and negotiating with the payer
Cost estimation	Calculating from benefit and fee data	The conversation with the patient
Card scanning and data extraction	Reducing transcription error	Verifying the extraction is correct

Automation applied to a broken process

Automating verification in a practice that does not act on the result produces faster confirmation of problems nobody addresses.

Fix the process, then automate it. The reverse order produces cost without benefit and discredits the technology.

10. What to Measure

Metric	What it tells you	Cadence
Registration accuracy rate	Whether data capture is reliable	Weekly
Eligibility verification completion rate	Whether verification is actually happening	Weekly
Verification lead time	Whether it happens early enough to be useful	Weekly
Authorisation obtained before service rate	The most expensive failure to prevent	Weekly
Denials attributable to front end causes	The headline measure of patient access performance	Monthly
Point of service collection rate	Whether financial conversations are happening	Monthly
Clean claim rate	Downstream confirmation of front end quality	Weekly

The fifth row is the one that connects this function to the financial statement. Categorising every denial by originating stage, and reporting the share created before the patient was seen, is what turns patient access from an administrative cost into a measurable revenue function.

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11. Self Assessment

Registration

- ☐ Insurance cards are scanned front and back at every visit
- ☐ Subscriber detail is captured where the patient is a dependant
- ☐ Coordination of benefits is established where secondary coverage exists
- ☐ Demographics are updated at every visit, not only at first registration

Verification

- ☐ Eligibility is verified 48 to 72 hours before the appointment
- ☐ We verify service specific benefits, not just active coverage
- ☐ Deductible status and patient portion are established before the visit
- ☐ Visit and frequency limits are checked on recurring services

Authorisation

- ☐ A payer and procedure requirement matrix is maintained and current
- ☐ Authorisation is a hard stop in scheduling, not a later task
- ☐ Authorisation number, units and date range are recorded
- ☐ Expiry is tracked when appointments are rescheduled

Financial and measurement

- ☐ Patients receive an estimate before high value procedures
- ☐ Known patient portions are collected at the time of service
- ☐ Every denial is categorised by originating stage
- ☐ Front end staff see their own accuracy and completion metrics

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12. Frequently Asked Questions

What share of denials originate in patient access?

It varies by practice and specialty, but in most organisations the front end is the single largest originating category once denials are traced back properly. The important step is measuring it in your own practice rather than relying on a benchmark. Categorise every denial by the stage where the cause arose, and the concentration becomes visible within a month.

How far in advance should eligibility be verified?

Forty eight to seventy two hours before the appointment for most services. That leaves time to resolve a coverage problem, contact the patient, or reschedule if necessary. Verification at the desk provides the same information too late to act on it, which converts what should have been a phone call into either a denied claim or a difficult conversation in the waiting room.

Should we collect payment before the service?

Collect the known patient portion at the time of service wherever it can be established in advance. Collection probability falls substantially once the patient has left, and patient balances age longer and collect worse than any payer balance. Provide an estimate beforehand so the amount is expected rather than a surprise at checkout.

Is it worth investing in front desk training if turnover is high?

It is worth investing in both training and retention, because the cost of turnover in this role is paid downstream in denials and is rarely attributed back to its source. Practices that fund additional billing staff to work denials created by an undertrained front desk are paying more for a worse outcome. Documented procedures and checklists also reduce the cost of turnover when it does occur.

Can patient access be outsourced?

Verification, authorisation and financial clearance can be supported externally and frequently benefit from the capacity and payer knowledge a specialist team brings. Registration and the in person financial conversation usually remain with the practice, since they happen at the point of contact. Many practices use a hybrid model, keeping the desk in house and moving verification and authorisation to a partner with dedicated capacity.

13. How StafGo Health Helps

StafGo Health is a USA physician-owned revenue cycle management company working with medical and dental practices nationwide. Patient access is where most preventable revenue loss originates, which is why our engagements usually begin there rather than in billing.

- **Denial origin analysis.** Tracing your denials back to the stage where the cause arose, and quantifying the share created before the patient was seen.

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- **Insurance verification and eligibility checking.** Full benefit verification ahead of appointments, at the depth described in section five.
- **Prior authorisation management.** Requirement matrices, dedicated capacity and tracked queues, including expiry monitoring.
- **Financial clearance support.** Cost estimation and patient responsibility establishment before the service.
- **Process design and training material.** Documented procedures and checklists built for a role with high turnover.
- **Measurement.** Monthly reporting on the metrics in section ten, with denials categorised by originating stage.

Fix the Denials Before They Happen

In 30 minutes we will trace your denials back to where they originate, show you how much is being created at the front end, and outline what to change first.

Book Your Free RCM Audit

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