TIPS OF THE WEEK

The Weekly *Wave*

Five revenue-cycle and network-performance currents worth catching this week — the questions health system and medical group leaders are actually asking, answered straight, with the workstream to fix it.

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TIME-OF-SERVICE COLLECTIONS: 39% of patient balances in 2022, up from 15% in 2019 — MGMA COLLECTION-AGENCY RECOVERY: 10–20¢ on the dollar once a

This week's currents all run through the same channel: money and patients leaking out of the network in the gap between "we know the right answer" and "we actually did it at the point of care." Below are five workstreams pulled straight from the field — each one a place where a small process fix protects real revenue.

WORKSTREAMS — 01 TO 05

01

SELF-PAY REVENUE

Pre-service or lose it

The organization is the only payer behind an uninsured claim.

Collect the Out-of-Pocket Portion — Before They Walk

"Why should we collect from uninsured patients at all?"

For an uninsured patient, there's no payer standing behind the claim — **the patient payment is the primary source of reimbursement.** The best shot at resolving that balance is before or at the time of service, while the patient is still engaged and the organization can explain cost, check for financial assistance, and set terms. This isn't "collect from everyone" — it's a sequence, done in the right order, that stays compliant with Good Faith Estimate and financial-assistance requirements.

Verify coverage → Screen Medicaid → Financial assistance → Provide estimate → Collect pre-service → Document payment plan

- ✓ Financial conversations start at scheduling for elective services — not after care is delivered.
- ✓ Every uninsured account gets screened for coverage and assistance eligibility before it's treated as self-pay.
- ✓ Estimates are documented and delivered wherever Good Faith Estimate rules apply.

Who's doing this well: UCHealth routes uninsured patients to financial counselors before service; Yampa Valley Medical Center expects non-emergent self-pay balances resolved pre-service with estimates available; Mayo Clinic pairs pre-service estimates with financial counseling and deposit requirements.

02

TIME-OF-SERVICE

39%

of patient-due balances collected at time of service, MGMA 2022 — up from 15% in 2019, but still the minority.

The Clock Is the Enemy of Collectability

"Why collect pre-service or at time of service specifically?"

Collectability doesn't fall off a cliff at a fixed percentage — but every national benchmark points the same direction: **the further a balance travels from the visit, the harder it gets to collect.** Once an account reaches outside collections, agency recovery typically runs only 10–20 cents on the dollar. Hospital self-pay-after-insurance collection rates fell from 76% in 2020 to 55% in 2021. Top-performing groups don't wait to find out — they concentrate collection effort in the first 30 days, before the balance ages into the bucket that quietly turns into bad debt.

Scheduling → Eligibility → Benefits → Estimate → Counseling → Pre-service $ → Time-of-service $ → Residual follow-up

- ✓ Know the patient's expected responsibility before they arrive — not after the claim adjudicates.
- ✓ Track first-30-day A/R capture as a KPI, not just total collections.
- ✓ Treat today's collectible balance as today's job — not next quarter's aged A/R report.

Who's doing this well: Banner Health sets the expectation that estimated copays and deductibles are due at time of service; UCHealth builds individualized estimates through its portal and a dedicated estimates team; Mayo Clinic combines estimates, counseling, and pre service deposits.

03

WORKERS' COMP

Complex ≠ Delayed

Extra fields are a workflow problem, not a reason to sit on a claim.

Complexity Is a Reason for Process — Not a Reason to Wait

"Why would we delay submitting workers' comp claims?"

We shouldn't. WC billing genuinely is more complicated — employer, carrier, claim number, date of injury, adjuster, authorization, supporting documentation all have to land correctly. But **a manual process still needs a turnaround-time standard.** Timely-filing requirements vary by jurisdiction, so a completed claim sitting in a queue is pure financial and compliance risk with no upside.

Daily WC ID → Fields complete at registration → Submit when ready → Weekly aging report → Adjuster follow-up → Escalate before deadline

- ✓ A named owner sits on every incomplete WC claim — not "whoever gets to it."
- ✓ Weekly reconciliation: encounters billed, claims paid, claims denied, and why.
- ✓ Aged claims escalate before statutory or payer deadlines, not after.

The core question: How many WC encounters occurred, how many were billed, how many were paid, how many remain outstanding — and why?

04

NETWORK RETENTION

Closed Loop

An ED or urgent care visit is a referral moment, not a dead end.

Triage the Patient Back Into the Network — Especially Ortho

"Why should ED and urgent care triage patients back into our network?"

A patient shows up with a fracture, sprain, or joint injury. Once they're stabilized, handing them a generic physician list and hoping they stay in-system is a missed handoff. **A deliberate pathway back to an in-network orthopedic provider** protects continuity of care, fills ortho capacity, and safeguards downstream imaging, therapy, and surgical revenue. Under value-based care, it matters even more: once a patient leaves the network, the organization can lose visibility into what happens next while staying financially accountable for their total cost of care.

Patient identified → ADT notification → Care team contacts patient → Specialist follow-up scheduled → Patient returns to network

- ✓ Every ED / urgent-care ortho encounter triggers a closed-loop referral — before or immediately after discharge.
- ✓ Real-time ADT feeds (e.g., Bamboo Health's Pings) flag attributed patients the moment they hit an outside ED or hospital.
- ✓ A named fracture-clinic or sports-medicine pathway exists, not just "see your PCP."

How it works: Bamboo Health's Pings platform uses real-time admission, discharge, and transfer data so care teams are notified the moment a patient hits an ED, hospital, or post-acute event — supporting lower ED overutilization, fewer readmissions, and stronger total-cost-of-care performance.

05

DRUG & BIOLOGIC REVENUE

Prove the Chain

If you bought and gave it, can you prove it reached the claim?

J-Code Capture and Reconciliation — Buy-and-Bill Can't Rely on Memory

"Why does J-code capture matter for drugs, biologics, and gels?"

Buy-and-bill drugs, biologics, injections, and orthopedic gels carry real acquisition cost. If the J-code, HCPCS units, NDC, or the JW/JZ waste modifier don't make it onto the claim correctly, **the organization eats the drug cost without the matching reimbursement.** CMS has required the JZ modifier on every no-waste single-dose claim since July 1, 2023, and expanded JW-modifier requirements for non-administering billing suppliers starting January 1, 2025 — the documentation bar keeps rising, and "someone remembered to enter the charge" isn't a control.

Purchased / inventoried → Administration documented → J-code + units submitted → Reimbursement received

- ✓ Weekly three-way reconciliation on high-cost biologics and gels; monthly financial summary by drug and practice.
- ✓ Every line checked: NDC/lot, correct billing units, dose given, waste with JW/JZ modifier, charge generated, claim submitted, payment received.
- ✓ Denials and underpayments on drug lines get worked, not written off.

The control question: If we purchased and administered the drug, can we prove the correct charge reached the claim — and that we got the reimbursement we were owed?

None of these are new problems.

They're just the ones still leaking revenue quietly enough to ignore — until now.

Each workstream above is a starting checklist, not a finished playbook. If one of these currents is running through your organization right now, that's exactly the kind of engagement Kontiki Strategic Health Advisors builds around.

Sources & further reading: HFMA, Medical Account Resolution & Financial Communication best practices · MGMA Stat, "Patient balance collection: What's moving the numbers" (TOS balance collection 15%—39%, 2019–2022) · MGMA Stat, "A structured approach to collecting patient A/R" (10–20% collection-agency recovery benchmark) · MGMA, self-pay-after-insurance collection rate trend (76% 2020 → 55% 2021) · CMS, Discarded Drugs — JW & JZ Modifier Policy and FAQs (cms.gov) · Bamboo Health, Pings — Real-Time Care Intelligence™ platform · UCHealth, Yampa Valley Medical Center, Mayo Clinic, and Banner Health public patient-financial-communication policies, cited as illustrative examples of pre-service collection and estimate practices.