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26 Epic workflows to optimize

(Before considering bolt-ons)

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Get what you paid for by maximizing the power of your Epic investment.

Don’t bolt on.

Before you consider spending more on additional technology, make sure you’re leveraging the full power of existing Epic workflows to maximize your investment and improve financial performance.

Top 26 workflows to optimize in Epic

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01 Front Office Optimizations

01

Pre-service collections

What it is	Key questions to ask	Why it matters
Embedded patient co-payment and collection screens appear at the end of the scheduling and registration workflow to prompt end users to collect payments. Utilize in conjunction with the dialer to follow-up with patients needing collection or co-payment.	Are point-of-service (POS) collection screens present for your front-end staff? Have department-level workflows been adapted to support pre-service collections? Do you have follow-up work queues established for missing registration information? Have you added columns to the DAR so front desk is able to quickly identify who still needs collection?	**Increase patient collection rates.** **Display patient collection information prominently during registration process.** **Utilize reporting and dashboards to monitor effectiveness of POS collections.**

Ensemble client results after optimization:

31% increase in POS collections for $425k in 8 months

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02

Automated patient estimates

What it is	Key questions to ask	Why it matters
Automatically create, populate and finalize patient liability estimates for many services. Automatically include procedures from scheduling or historical information for emergency services, surgeries, and service scheduled from orders. Automatically populate benefit information based on the type of service.	Do you have Orderable/Procedure/Chargeable (OPC) charge linking and surgical procedure setup to enable certain estimate automation? Do you have accurate and discreet benefit information by service type?	**Improve accuracy + save time by automatically generating and populating estimates with procedures + correct benefits.** **Reduce errors by removing decision points from a user workflow.**

Ensemble client results after optimization:

80k estimates per month auto-created + populated

7.5 FTEs time savings

$39M pre-payments collected

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03

Referral-based scheduling

What it is	Key questions to ask	Why it matters
Auto-generate referrals for active, ready-to-be scheduled outpatient orders. Create work queues to house referrals ready for scheduling.	What process is in place for inpatient orders that do not have auto-generated referrals? How are you keeping procedure categories and orders up to date?	**Increase schedule accuracy, flexibility and routing.** **Order information automatically pulls over to the referral, allowing for authorization.** **Automatically attach the order and referral to the upcoming appointment.**

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04

Pre-registration process

What it is	Key questions to ask	Why it matters
Registration screen appears after every scheduling instance to prompt pre-registration. Create work queues to follow up on any missing registration items that can be completed prior to the patient's arrival.	Are you using the missing registration follow-up work queue in conjunction with the dialing campaign? Do you have registration confirmation warnings and hard stops to complete guarantor and account information? Are owners reassigned to registration information?	**Increase information gathering prior to patient arrival and monitor errors.** **Accelerate authorization process and increase accuracy due to up-to-date registration information.** **Accelerate check in and reduce wait times for patients at facility.**

Ensemble client results after optimization:

80% increase in pre-registration in combination with the dialer over 8 months

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05
Real-time authorization

What it is	Key questions to ask	Why it matters
Utilize RTE vendor through an interface to feed back to Epic. Automated authorization feedback based off procedure and insurance. Automatically query and file authorizations by payor and procedures.	Is your RTE vendor integrated? Have you tested your clearinghouse interface? Are proper orders and codes up to date for accurate RTA generation? Have you established work queues to catch any accounts with errors to correct for RTA?	**Streamline pre-visit workflows.** **Increase authorization productivity due to not touching unnecessary accounts.** **Reduce denials for procedures that can be auto authorized.**

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06

Real-time eligibility + benefits filing

What it is	Key questions to ask	Why it matters
Streamline the registration workflow by automatically querying a patient's insurance eligibility and benefits.	Is your RTE vendor integrated? Do you have a dashboard for interface and RTE functionality management? What is your workflow for RTE downtime?	**Reduce denials caused by inaccurate insurance information on file.** **Ensure accurate authorizations and estimates.** **Eliminate manual phone calls by authorization team to validate insurance information.**

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07
Surgical authorizations + IP-only procedures requirements

What it is	Key questions to ask	Why it matters
Require CPT codes at the time of OR case scheduling. Create work queues to follow up on CPT codes that were authorized but changed post surgery or during coding.	Are you prepared to support the change management required for surgeons and their offices? How will we configure OpTime OR procedures and accurately map CPT codes? What is the workflow when CPT codes change? Who is responsible for following up? Do we have the necessary access for upcoming surgical appointments if utilizing OpTime?	**Reduce denials for IP-only procedures + wrong CPT code authorized.** **Automate patient estimates with CPT codes.** **Prevent authorization team from following up or guessing when CPT code is not present.**

Ensemble client results after optimization:

$5M reduction in related denials in one year

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08

HAR advisor configuration

What it is	Key questions to ask	Why it matters
Automatically assign or recommend the correct Hospital Account (HAR) to end users within the registration workflow. Auto-create the HAR upon scheduling in many situations.	Are the series account settings correct? Is workflow and training in place to validate HAR that is being assigned? What workqueue rules are in place to ensure appropriate HAR was assigned prior to billing?	**Reduce denials by reducing account assignment errors.** **Reduce consecutive accounts requiring manual combination.** **Improve workflow efficiency.**

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09

Patient self-service pre-registration + registration

What it is	Key questions to ask	Why it matters
Allow patients to check-in online or through kiosks. Utilize MyChart and online portals so patients can update their registration information prior to the appointment. Create workqueues to validate the accuracy of information updated by the patient.	Are ready-to-schedule workqueues available? (refer to Referral-based scheduling) Do you have a dialer vendor in place with feedback capabilities? What staffing is required to manage your outbound dialing capacity? Are regional dialer area codes leveraged for increased successful call rates?	**Increase schedule utilization.** **Decrease wait times and improve the patient experience.** **Increase pre-registration productivity and accuracy.** **Expedite check-in times and reduce outbound calls to patients prior to appointment.**

Ensemble client results after optimization:

36% increase in scheduling calls in 8 months – 22 FTE impact

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10 Pre-access + customer service dialer workflows

What it is	Key questions to ask	Why it matters
Outbound dialing campaign for orders that need to be scheduled.	Are workflows and ownership over workqueues established for patient-updated information? Are validation workflows in place for sites where patients can check in themselves online or via a kiosk? What are the welcome kiosk costs? Is MyChart setup to notify front desk staff for verification?	**Increase schedule utilization for departments.** **Reduce scheduling delays with proactive patient outreach.** **Record responses and notify physicians if order is not scheduled.** **Report on unscheduled orders to prevent leakage.**

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02 Middle Office Optimizations

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Revenue Guardian

What it is	Key questions to ask	Why it matters
A tool to help identify accounts that may be missing charges. Billing edits, workqueues, and/or reporting tools to hold and follow-up on accounts.	How will you identify scenarios that predictably have certain charges that might be missing? Are you prepared to engaged your clinical application team for system build requirements? Have you conducted a security analysis to ensure clinical teams can work edits? How will we confirm Revenue Guardians are flagging missing charges as expected before turning on billed edits to hold accounts?	**Increase gross revenue by preventing missing charges.** **Uncover root causes for missing charges, including problematic charge capture workflows.** **Ensemble client results after optimization:** $7.6M in missed charges captured in 13 months

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Observation carve-out

What it is	Key questions to ask	Why it matters
Carve-out observation times using Charge Router based on best practice procedure code list.	How will you manage tiered pricing structure? Adjustment of bed charge billing structure may be required.	**Significantly reduce the number of FTEs needed to manually review and carve-out observation times on accounts.** **Ensure consistent and compliant billing per a CPT-based carve-out policy.**

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Simple visit coding

What it is	Key questions to ask	Why it matters
Automatically code hospital accounts based on ADT and diagnosis information entered upstream in the revenue cycle.	How will you address coding-related errors?	**Reduce outpatient coding FTEs by automatically code >80% of outpatient hospital account volume.** **Ensemble client results after optimization:** >71k accounts auto-coded monthly – 16 FTEs reallocated to other coding projects

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Dropping ancillary charges from order completion

What it is	Key questions to ask	Why it matters
Automatically trigger charges leveraging Epic orders with a direct relationship to charges. Hold charges until orders reach a completed status. Allow users to add modifiers and answer order-specific questions to use in Charge Router to hold or automatically edit charges.	Do you have the clinical and charging knowledge required to map orders to charge codes? How clean is your order database prior? What third-party systems are in place to update order statuses?	**Promote charge capture accuracy and reduce time spent following up on missing charges.** **Standardize ordering workflows across an organization; embed charge capture in native clinical workspaces.**

Ensemble client results after optimization:

58% reduction in EKG tracing denials after implementing order-based charging for EKGs

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IP bedside charging via Flowsheet Rows

What it is	Key questions to ask	Why it matters
Embed charge capture for inpatient bedside procedures within flowsheet documentation rows native to clinical workflows.	Do you have the necessary analyst resources available? Estimate 170 hours from hospital billing, orders, and clinical documentation teams. How will you engage your Revenue Cycle leadership to identify in-scope charges and standardize the chargemaster? What ability will clinical leadership have to advise on documentation workflows?	**Reduce missed charges and clicks to capture charges by linking charges directly to clinical documentation.** **Make charging more intuitive by using symbols to remind clinicians which procedures are chargeable.** **Standardize charging workflows and charge codes across an organization.**

Ensemble client results after optimization:

200% gross revenue increase for bedside procedures in first month (sustained for full year)

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03 Back Office Optimizations

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Claim statusing

What it is	Key questions to ask	Why it matters
Scrub clean claims against payer sites to bring back 277 statuses. Import statuses into system with claim dispositions and route to the appropriate area.	Have you scheduled the appropriate wait time for payer receipt of claim to ensure a viable status is received on initial scrub? How many days post Pending Payment status will you wait to route to associates for follow-up if no payment is received? Will you build workqueues to capture particular statuses and split by payor/financial class?	**Boost FTE productivity by focusing them on accounts not pended for payment.** **Notify staff of pending denials so they can begin work prior to receipt of remittance.**

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Claim processing

What it is	Key questions to ask	Why it matters
Automatically add claim codes such as *value, occurrence, condition*, and *span* based on system logic. Automate claim splits and claim form overrides (UB vs. 1500). Automate payor-specific alternate revenue codes and CPT codes. Create and send claim attachments such as Medical Records or Itemized Statements to the clearinghouse without any intervention.	Is there any clearinghouse functionality that will limit advanced automations such as claim attachments?	**Reduce the number of billers needed to manually update and correct claims.** **Lower DNFB and accelerate payment times with improved claim accuracy.**

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Billing edit and DNFB optimization

What it is	Key questions to ask	Why it matters
Proactive review of claim edits and DNBs for validation of ownership, system logic, and fine-tuning of system settings (fire DNBs before min days, etc.). *Note: Key compliance edits such as correct coding initiative (CCI), local coverage determination (LCD), and outpatient coding errors (OCEs) are available in Epic to maintain decreased clearinghouse error rate.*	Have you budgeted 10 weeks of recurring stakeholder time to review edits? Have you requested access to error reports with edit volumes from Epic and the clearinghouse in advance?	**Ensure edits are firing appropriately and as early as possible.** **Improve clean claim acceptance rate at clearinghouse.** **Identify automation opportunities, optimized edit resolution workflows, and clearinghouse claim edits that can be built directly in Epic.**

Ensemble client results after optimization:

86% reduction in claim errors totaling $2.6M savings

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Downgrade workflow

What it is	Key questions to ask	Why it matters
Manage status downgrades occurring prior to discharge and meeting required criteria. *Note: Medicare may still make payment for certain Part B services under inpatient Part B benefits if the determination that the patient should not have been admitted is not made until after the patient has been discharged, or other criteria for use of condition code 44 is not met, or if the admission is denied due to lack of medical necessity.*	What account classes are available at the client, i.e. OP in a bed? What are your SAD write-off policies? Do you have established acute revenue integrity observation review workflows?	**Decrease the number of FTEs required by automating workflows.** **Ensure accurate reimbursement based on accurate patient status.**

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20 Underpayments + contractual adjustments

What it is	Key questions to ask	Why it matters
Variances are created when remittance is lower than expected reimbursement in Epic. Adjustments are posted based on payer remit for all accounts unless payment includes denials. **Route underpayments to workqueues for staff to review and begin working once all denials are closed.**	Do you have a company policy on variance thresholds? Which discrepancy amount is worth pursuing vs not? Will you net down to expected at time of claim accept or keep full balance until payment is received?	**Automatically close variances with System Action build to make staff more efficient.** **Allow staff to more readily identify trends in underpayment and contract issues in the system.**

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Payment + adjustment review workflow

What it is	Key questions to ask	Why it matters
Workflows to help Payment + Adjustment Review (PAR) teams focuses on correcting account issues that can arise from system, user, or payor errors. Example scenarios include accounts with balances greater than total charges, accounts with mixed insurance and self pay balances, and accounts with adjustments that are higher than an expected threshold. System Automatic Actions are used to automate PAR tasks wherever possible.	Do you have an established PAR team? If not, this workflow is not for you.	**Enable the PAR team to work accounts that might otherwise remain unresolved.** **Improve PAR team efficiency with System Automatic Actions.** **Ensemble client results after optimization:** 2825 PAR accounts automated per month, saving one FTE

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Recurring account billing acceleration

What it is	Key questions to ask	Why it matters
Many organizations have chosen to bill recurring services on a monthly basis even if CMS would allow more frequent billing. Ensemble has found that by switching those services allowed by CMS from monthly to daily cycles we can accelerate billing and cash collection. Examples of eligible recurring services include Infusion, Medical Oncology, and Wound Care.	Are coders prepared for the potential increase in workload resulting from accounts being billed more frequently? Will billers need to work more edits?	**Reduce billing cycle length from 30 days to 1 day for services not considered repetitive by CMS (specifically infusion, oncology, wound).** **Improve POS collection when the recurring account drops for billing.**

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Credit processing

What it is	Key questions to ask	Why it matters
Automatically resolve credits for both insurance and self-pay.	Will you include Finance at the beginning of the project due to increase in refund automation? Is there a significant credit backlog? If so, can you identify of large groups of transactions to mass void / reverse credits?	**Focus end users on more complex credits and allow the system to handle the easier ones.** **Increase user productivity with streamlined workflows.**

Ensemble client results after optimization:

5-day reduction in undistributed days, $7.4M reduction in undistributed payments, $5.0M reduction in credits >90 days

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Provider-based billing

What it is	Key questions to ask	Why it matters
A Provider Based Billing clinic is a physician clinic that has filed a CMS Form 855 with Medicare in order to be eligible to bill for and receive payment for facility fees separately from professional fees. Leverage information entered in the Ambulatory Revenue Cycle to seamlessly create Hospital Accounts, Charges, Coding Information, and UB Claims in order to fully take advantage of PBB eligibility.	Which payors are eligible to be billed on the technical side? What best practice charging logic will you implement to fully take advantage of PBB eligibility?	**Reduce the number of users needed to manually create hospital accounts, enter and review charges, and complete coding information for PBB scenarios.**

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Denials workflows –BDC record automation

What it is	Key questions to ask	Why it matters
Functionality within the Denial that will route to either Technical or Clinical teams (AR or Denials). Updates within the Denial record itself that allows staff to filter by owning area, priority, etc.	How will you manage technical and clinical splits based off CAS codes? Will am RN appeal denial escalation group / workflow be implemented? How will you determine which which CARC/RARC should open a denial (BDC)?	**Prioritize shorter appeal windows based on payor.** **Eliminate a communication step between AR and Denials by automatically routing to the appropriate team.** **Ensure accurate and consistent denials reporting.**

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Consecutive account automation

What it is	Key questions to ask	Why it matters
Granular automatic combination of consecutive accounts within a specified amount of days specific to payor/plan, account base class to catch accounts that need review or auto-combine.	How will you determine all account scenarios where accounts would be auto-combined or excluded? How will you determine the need for auto-combine coding and when coders will need to review the accounts? What testing plan do you have in place to ensure all accounts needed are captured and process is working properly to your guidelines?	**Reduce time FTEs spend on manually combining consecutive accounts.** **Reduce AR days by getting and submitting claims to payors quicker.** **Reduce denials due to accounts possibly missed that need combining.** **Reduce time that HIM would spend combining coding on combined consecutive accounts.**

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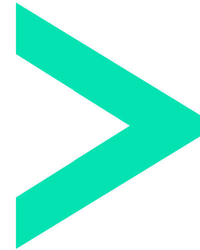
Make the most of your Epic investment.

Let us take this off your plate. Take the guesswork out of redesigning Epic workflows and streamlining processes to maximize your investment and improve financial performance. We have more than 60 Epic-certified healthcare operators ready to bridge the gap between clinical and revenue cycle teams to guide workflow optimizations and address your specific operational requirements.



75+

Epic hospitals managed daily by our operators

130+

Epic application certifications

10+

Average years of experience of Ensemble Epic Services leaders

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