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success under reform through revenue cycle excellence

Too many hospitals make hope a strategy in a reform era when they should be seeking opportunities for bottom-line improvement.

AT A GLANCE

Hospitals and health systems should take the following steps to improve their revenue cycle performance:

- > Collect patient responsibility amounts up front
- > Reduce credit balance accounts
- > Reduce preregistered patient no-shows
- > Identify and manage unbilled accounts receivable

Healthcare reform will bring about the most far-reaching changes to hospital operations since the inception of Medicare and Medicaid. Consequently, healthcare finance leaders need to intensely examine revenue cycle operations and health information management (HIM) and IT areas to manage those changes. Organizations that move quickly will gain a distinct strategic advantage as the healthcare landscape continues to change.

Although numerous strategies can help weather the challenges of healthcare reform, the revenue cycle presents unique opportunities for bottom-line improvement. As payment continues to decline, hospitals should take a renewed interest in improving their financial performance through the revenue cycle. A comprehensive self-assessment of the revenue cycle will disclose abundant opportunities for improvement, including revenue enhancement, expense reduction, and improved overall efficiency. The key is in knowing how all the interrelated parts function together and where to focus resources for maximum benefit.

Revenue Cycle Priorities to Focus on Now

Healthcare finance leaders need to thoroughly understand each component of a revenue cycle assessment to identify areas of opportunity and possible mistakes. Successful hospitals are brutally objective and realistic, use outside resources to staff deficit areas, and establish time frames that are relentlessly adhered to.

See a list of the potential impacts and risks of implementing ICD-10 and a sample work plan at www.hfma.org/hfm.

Many sources of data generate valuable information related to revenue cycle performance, such as:

- > Key performance indicators (KPIs)/financial performance reports
- > Published policies and procedures
- > Department budgets
- > Department training materials
- > All forms and documents used
- > Observation of process flow
- > Observation of system usage
- > Discussions with department management and staff

In preparation for self-assessment, hospitals should review all documented process flows, performance reports, forms and documents, policy and training information, and department budget performance.

Observation and documentation of current process flows and use of various systems is critical. Interviewing department management and staff helps to understand “all the moving parts” of the revenue cycle. A good way to begin is by comparing industry benchmarks with provider performance measurements to determine where potential opportunities exist. Quantifying the findings on unnecessary costs, lost revenue, and inefficient patient process flows will lead to documented recommendations related to projected

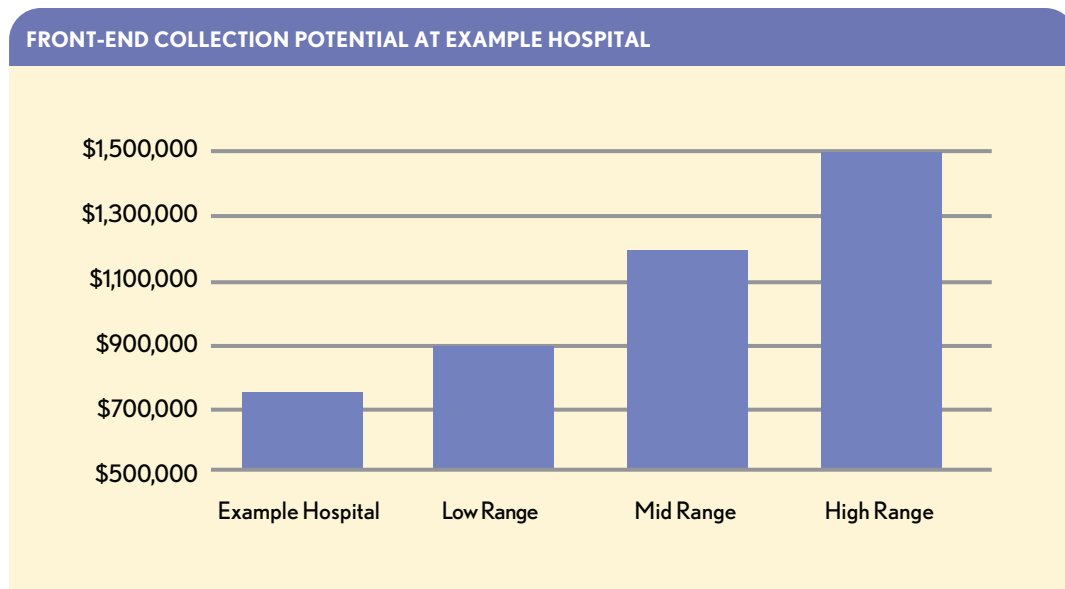
cost savings and revenue enhancements, and improved patient service.

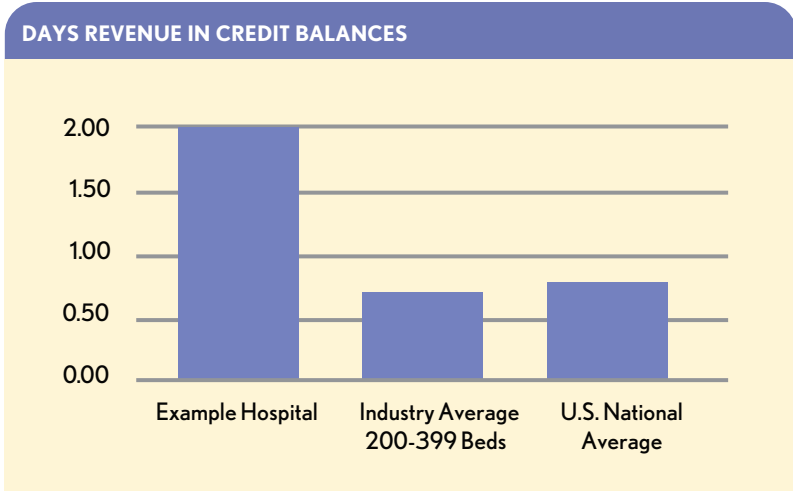
In all hospitals, the revenue cycle is composed of complex and inter-related parts. Each component may offer the potential to improve a hospital’s financial performance.

Taking the following steps can help hospitals improve their revenue cycle performance.

Collect patient responsibility amounts up front.

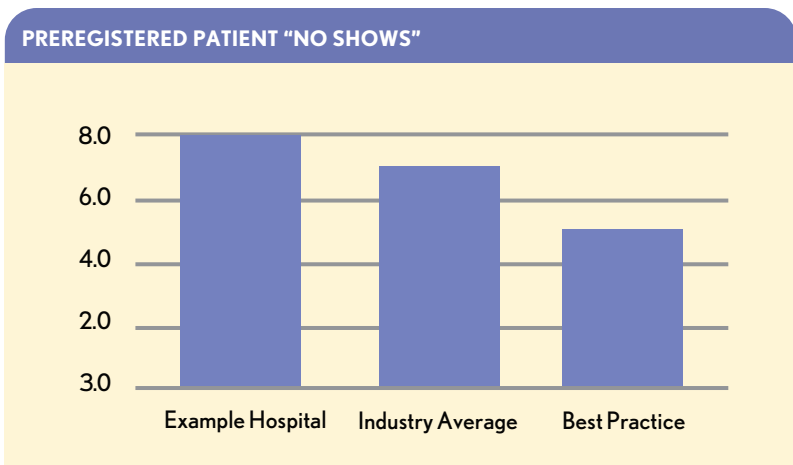
Based on Example Hospital summary data obtained from insurance remittances, the total amount of insurance deductibles, coinsurances, and copayments available for up-front collection is \$3 million. All Medicare cases have been excluded from these estimates as they typically carry a secondary insurance for coverage of these amounts. Medicaid cases were also excluded as the patient responsibility amounts are commonly routed to charity care. Aggregating and annualizing the remaining amounts enables the hospital to establish the potential collection ranges as low (30 percent), mid (40 percent), and high (50 percent), as reflected in the exhibit below. Example Hospital is collecting only \$750,000, or 25 percent of the applicable patient responsibility amounts.





\$1 million and average daily revenue totals \$500,000. This amount is significant compared with the national average for similar-sized hospitals, as suggested in the top exhibit at left.

Additionally, due to the age and volume of these accounts, the true aged accounts receivable (A/R) is being artificially reduced by credit balance accounts that reside in the respective age and payer categories. The related impact to the aged A/R can be significant because the percentage of discharged A/R over 90 days can be significantly lower with credits than it is when credits are removed.



To improve and monitor the above KPI for the A/R, monthly management reports should include credit balance dollars, number of accounts, and days revenue in credit balance. Additionally, a credit balance strategy should be identified to lower the credit balance dollars to the national average and best-practice levels.

Reduce preregistered patient "no shows." At Example Hospital, 80 out of 1,000 scheduled patients did not show between March 1 and March 31, representing an 8 percent no-show rate. The hospital's performance rate is 1.1 percent higher than the industry average of 6.9 percent and 2.7 percent higher than the best practice of 5.3 percent, as illustrated in the lower exhibit at left.

Hospitals should identify and collect any copayments and deductibles that may be due for services before or at the time of service. Front-end collections not only improve cash flow, but also help reduce patient statement costs and minimize associated bad debts.

Additionally, visible signs should be placed in the areas participating in front-end collections to inform patients of their responsibility to pay applicable insurance copayments and deductibles. These signs will prepare patients and/or families for what is expected upon registration. Posted signs will also facilitate the staff's collection efforts.

Reduce credit balance accounts. A review of Example Hospital's credit balance report as of March 31, 2010, found that credit accounts total

Factors contributing to instances of high "no-show" rates among scheduled patients likely include the limited number of days between when a patient is added to the schedule and when the patient is preregistered. The lack of timely reminder notices communicated by mail and telephone may also have an impact on the rate.

Hospitals should communicate automated, prerecorded outbound call messages to all scheduled patients one to two days before their scheduled visit. Use of an automated mailer to remind patients of their scheduled appointment date, time, location, and patient responsibility amount due is also recommended. By using both methods,

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hospitals can effectively reduce current no-show rates. Further reductions toward best-practice levels can be achieved by maintaining preregistration of scheduled patients at least four days before their service date.

Identify and manage unbilled A/R. Based upon a review of Example Hospital’s legacy system and billing software reports, the current amount of A/R discharged not final billed (DNFB) is \$14,503,295 for the legacy system and \$884,893 for the billing software as of March 31, 2010. It is important to note that the legacy system amount represents only a portion of the unbilled accounts in this system. The exhibit below right shows that Example Hospital’s total DNFB days in A/R are higher than both the national average and best practice.

Hospitals should initiate a focused effort to identify and address the reasons for billing delays. As shown in the exhibit, A/R days attributable to unbilled claims are currently at 7.4 days, which is 2.1 days greater than best practice. Achievement and maintenance at the best-practice level would reduce associated average daily A/R by \$4,386,812 based upon average daily revenue as of March 31, 2010.

Because the largest portion of DNFB is typically tied to uncoded charts, healthcare finance leaders should conduct an analysis in the HIM department to determine why delays occur in releasing accounts for claim submission. Based on the results, they should determine the steps needed to significantly decrease claims held for coding and monitor unbilled accounts daily to ensure the timely release of claims in HIM. Likewise, patient finance should review the unbilled claims in the billing system on a daily basis. Additionally, the total unbilled A/R should

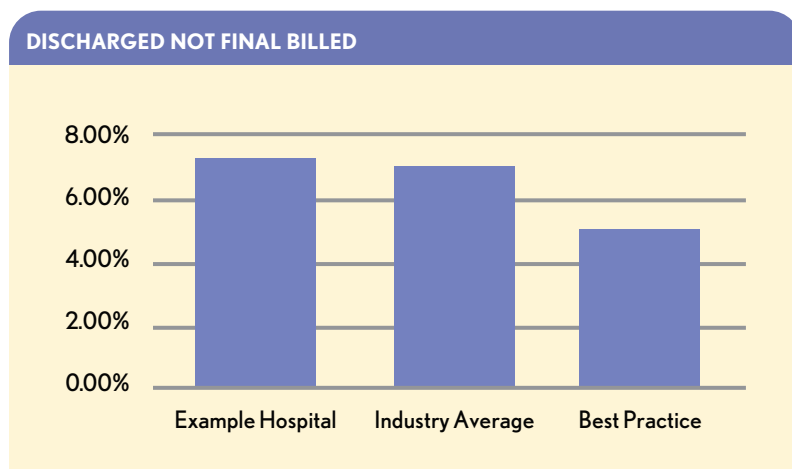
be tracked and monitored weekly by revenue cycle leaders to achieve best-practice levels.

The Roles of Clinical Coding, Clinical Documentation, and IT

As hospitals prepare for healthcare reform, clinical coding, clinical documentation improvement (CDI), and IT will play increasingly significant roles.

Clinical coding and ICD-10 initiatives. Changes in clinical coding will accompany all healthcare reform initiatives. The best plan of action for dealing with this challenge includes establishing a solid coding program, implementing remote coding practices with or without an electronic health record (EHR), evaluating computer-assisted coding, implementing a clinical documentation improvement (CDI) program, and preparing for ICD-10. Additional possible initiatives include Recovery Audit Contractor response, EHR and meaningful use, and HIPAA/HITECH compliance.

The challenges to improving clinical coding include a lack of experienced and qualified coders, continuing coding changes, paper HIM processes, changing technology, competition, and



demand for remote work opportunities. Telecommuting offers many advantages. Remote coders are happier and therefore retained longer with less turnover. They are offered flexible hours and fewer interruptions, which leads to greater productivity and a reduced DNFB. The challenges, however, are often formidable and also encompass matters of culture change, privacy, security, communications, and management.

Healthcare finance leaders should evaluate the benefits, survey for interest and support, form an implementation project team, implement an EHR, and compare outside services.

If the staff and procedures have been on autopilot too long, the organization is probably leaving money on the table.

CDI. An effective CDI program involves the elements of staffing, strategic and operational metrics, concurrent focus, physician queries, medical staff education, ongoing monitoring, and preparation for ICD-10. ICD-10-CM is the U.S. clinical modification of the World Health Organization's ICD-10, involving the diagnosis portion and no procedure codes. The ICD-10-PCS was developed under contract by the Centers for Medicare & Medicaid Services specifically to replace the ICD-9-CM procedural coding system and contains only the procedure code portion.

ICD-9-CM is 30 years old, and its 18,000 diagnosis and procedure codes are insufficient to allow for new codes. It also does not allow the United States to compare with other countries at the same level. The U.S. compliance date is Oct. 1, 2013. The United Kingdom, France, Australia, Germany, and Canada have already moved to ICD-10. (See a list of the potential impacts and risks of implementing ICD-10 at www.hfma.org/hfm.)

The expected impact of the transition to ICD-10 on the revenue cycle continuum includes the following:

- > ICD-10 assessment and preparedness
- > Education of anyone using codes
- > Training of coders
- > Software upgrades and replacements
- > Hardware upgrades to support software changes
- > Reduced coder productivity
- > High coder turnover
- > Initial increase in edits and claim denial
- > Ongoing coding compliance monitoring

IT. Hospitals rank nearly at the bottom of the list for IT spending across U.S. industries, just above physicians. Knowing the return on IT investments is critical to long-term success, both in terms of optimizing current systems and in ensuring the effectiveness of new IT purchases. Many common legacy system modules and common uses of bolt-on systems exist. The disadvantages of software patchwork can be numerous and result in gross inefficiencies in the IT area. It is very important that each hospital perform a mini-IT performance self-assessment as part of its overall revenue cycle review.

Asking the following questions will facilitate the IT self-assessment process:

- > What functionalities are being used in each IT module?
- > Can any training opportunities, small configuration changes, or incremental process changes be enacted to immediately improve the IT system?
- > Can the existing legacy system vendor assist in identifying and resolving system issues?
- > What integration issues are facing the hospital?
- > Is the existing bolt-on system being leveraged to its maximum capability?
- > Will upgrading the legacy system reduce or eliminate the need for bolt-on technologies?

Successful integration and implementation can result in major benefits to the hospital, such as:

- > Reduced costs through reduction in redundant procedures, staff labor (clinical and administrative), and greater billing accuracy
- > Improved patient health and safety through quicker access to more accurate information

Once all components of the revenue cycle have been thoroughly assessed, the next critical step in the process is to develop a detailed work plan.

and improved communication among providers

- > Increased provider productivity as more patients are assessed and treated
- > Increased workplace satisfaction by tightening the bonds between hospitals and physicians

IT decisions are business investments that should support strategic priorities and deliver a sustainable advantage to the organization. They should be viewed from the perspective of value rather than as a cost center, and should be evaluated in terms of how well they help the organization meet critical business objectives.

Developing a Work Plan

Once all components of the revenue cycle have been thoroughly assessed, the next critical step in the process is to develop a detailed work plan. The major purpose of the work plan is to ensure that all recommendations are fully addressed and implemented. Key elements include time required, sequencing among other tasks, task leaders assigned, and deadlines for completion. The work plan should establish accountability for all team members. (See a sample work plan at www.hfma.org/hfm.)

Of course, a complete facility work plan will include hundreds of specific tasks across all revenue cycle departments. Additionally, related Gantt charts should be used to plan, record, and document the schedule, and to track results against the schedule.

Eliminating Hope from Your Strategy

Like any good approach to upcoming change, a truly action-oriented, holistic outlook is one that will serve the organization best. Delaying a

comprehensive revenue cycle assessment is rarely the prudent course of action, regardless of what other projects are under way or pending. Maintaining the status quo can be costly. As healthcare operating margins shrink, hospitals need to find efficient and innovative ways to capture and collect all revenues due them. If the staff and procedures have been on autopilot too long, the organization is probably leaving money on the table.

Analyzing the hospital's current revenue cycle operations and focusing on ways to improve revenue capture and collection are even more critical in this era of healthcare reform. Don't make hope a strategy. Act now. ●

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