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Final Pieces of the HIPAA Privacy Puzzle

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Revenue Cycle Redesign: Honing the Details
Revenue-Cycle Redesign: Honing the Details

The healthcare revenue cycle is not about just billing and collections anymore; hospitals require new revenue-cycle processes that focus on the entire patient-flow process.

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Revenue-cycle management is the hot topic for hospital managers today—the subject of countless seminars and articles, and the current watchword for consultants across the healthcare industry. Yet hospitals that have made the necessary operational and organizational changes to implement effective new revenue-cycle processes remain in the minority. This situation must soon change, as the need to remain competitive forces other hospitals to follow suit.

But how should a hospital go about determining what changes will result in effective program improvement and revenue-cycle redesign? Four basic steps are necessary:

• Identify the key problematic issues in the revenue cycle;
• Identify the systemic causes of the problems;
• Evaluate the specific problem indicators; and
• Outline best practices that can eliminate the problems.

When evaluating revenue-cycle processes, process components should be described within the context of a flow rather than as a series of unrelated events. Only by highlighting the essential links among the components can one gain an accurate perspective on the overall revenue cycle.

Throughout the following discussion, examples highlighting best practices in addressing revenue-cycle issues will be drawn from the experiences of Genesis Health System (GHS), a multihospital integrated delivery system serving eastern Iowa and western Illinois.

The Revenue Cycle and the Patient-Flow Process

The issue. The revenue cycle correlates strongly with the patient-flow process, which runs from scheduling and registration through treatment, discharge, and collection. In the past, hospitals tended to focus their efforts at the end of this process, on billing and collection. Yet most revenue-cycle problems originate early on, at the time when the hospital is collecting and verifying patient information needed to ensure submission of a clean claim and receipt of full payment. Rather than address problems retrospectively, hospitals should focus their efforts on front-end processes that help ensure the problems do not arise in the first place.

Avoiding problems or addressing them in a timely manner requires effective alignment of revenue-cycle components. Lack of alignment between clinical and financial functions is a leading cause of revenue-cycle problems for many hospitals. In many organizations, for example, preregistration and registration staffs report to a clinical manager. As a result, questions asked of patients during the initial scheduling call and at registration typically focus on the clinical preparation for the visit, and
Genesis Health System

Genesis Health System (GHS) is an integrated delivery system composed of three hospitals, a home health program, nursing homes, and Genesis HealthPlan, an insurance product jointly owned by GHS and a network of more than 400 physicians in the Quad City area.

The 502-bed Genesis Medical Center, Davenport, Iowa, includes a state-of-the-art birth center that delivers 200 babies per month, a cardiology services area that performs almost 3,000 heart catheterizations and about 550 open heart surgeries annually, a cancer program with a broad research component, a 45-bed inpatient psychiatric unit, a neurosciences center, and a 42-bed comprehensive inpatient rehabilitation program.

Illini Hospital, a full-service acute care medical center located in Silvis, Illinois, is part of a larger entity called Illini Health Services, an integrated network that also includes an urgent care clinic, an occupational health facility, home health services, a restorative care center, a skilled care facility, an 85-unit assisted-living community, and a physician network.

DeWitt Community Hospital, DeWitt, Iowa, is a 24-bed critical access hospital that provides a full range of services in medicine, surgery, coronary care, and pediatrics. DeWitt also provides intermediate care, outpatient surgery, emergency care, laboratory, X-ray, and ambulance services.

insufficient emphasis may be given to obtaining comprehensive information about patient and insurance demographics and responsibility for primary and secondary payment options.

In short, proper organizational alignment and focus of patient-access, clinical, and patient financial services (PFS) functions will positively affect revenue-cycle results.

Problems also emerge if the organization’s approach and perspectives on managing the revenue cycle are fragmented, as occurs when some areas of the organization operate as “silos.” Without open channels and clearly defined processes for rapid sharing of essential information, the billing process can become bogged down, resulting in delayed payment.

This issue is a particular concern for multihospital systems, such as GHS, in which a number of separate—and in some instances, independent—entities often are faced with the challenge of combining different philosophies, processes, and technologies. Extreme variation in policies, procedures, processes, and technology among related entities within a healthcare system can lead to inconsistent reporting and suboptimal management of results.

**Key problem indicators.** Primary contributors to revenue-cycle problems in the patient-flow process are inadequate data capture during preregistration and registration processes and inadequate sharing of patient data among departments. These inadequacies are evidenced through high claim denial rates, elevated days in accounts receivable, and declining patient satisfaction with the registration, billing, and collection processes. To identify potential problems, the accuracy and completeness of patient demographic information collected by patient access areas should be monitored, tracked, and reported on an ongoing basis. Particular emphasis should be placed on accurate keying of insurance group and policy numbers, assignment of insurance plan, completion of the Medicare Secondary Payer Questionnaire, and identification of cases that may involve a third-party liability (e.g., workman’s compensation, auto accidents, and slips and falls).

**Best practice—integrating the revenue-cycle process across multiple departments/health system entities.** In GHS’s case, the unique characteristics of the health system’s individual facilities made cross-institutional assessment and planning particularly challenging. To address this issue, GHS is establishing a new corporate entity, Shared Business Services (SBS), with systemwide responsibility for both PFS and patient-access processes such as preregistration, registration, and insurance verification.

Through economies of scale and process, coupled with technological standardization created by a consolidation of these PFS and patient access functions, GHS is able to reallocate 12.25 full-time equivalents (FTEs) from traditional PFS functions of billing, follow-up, and customer service to underserved functions such as claim denial management, managed care payment audit and recovery, training/education, and uniform maintenance of
key tables that drive PFS processes (e.g., charge description master, insurance master, and employer master). It was determined that without SBS, reinforcing the underserved functions in each facility individually would have required GHS to add a total of 17 FTEs across the system.

**Best practice—creation of integrated revenue-cycle teams.** GHS has established multicampus, cross-functional revenue-cycle teams charged with addressing recurrent breakdowns that are detected in the revenue cycle. The teams include individuals outside of SBS and are composed of representatives from clinical, PFS, patient access, utilization review, medical records, managed care, billing and collections departments. The teams focus on data sharing and the integration of continuing quality improvement, best practices, and common goals.

**Uncollectible Account Analysis, Genesis Medical Center**

In September 2002, Genesis Medical Center’s executive team was presented with an analysis of the organization’s circumstances with respect to uncollectible accounts. The analysis included the following points:

- Definitions of charity care and bad debt differ: Charity care is the difference between the established service rates and the amounts charged to individuals with little or no resources. Bad debt is the difference between billed rates and amounts expected to be recovered from self-pay patients.
- At Genesis Medical Center, charity care increased by 40 percent in the last three fiscal years (FYs). The rate of growth slowed, however, to 8.9 percent from FY01 to FY02.
- Conversely, bad debt, which increased by 30.6 percent in the past three FYs, grew by 22.5 percent from FY01 to FY02.
- The number of accounts for unemployed patients referred to collections rose by 15 percent from FY01 to FY02.
- The average account balance referred to collections grew by 10.2 percent from FY01 to FY02.
- Not surprisingly, emergency department charges constitute the largest portion of bad debt, at 36.4 percent. Outpatient services, including outpatient surgery, account for about 16 percent of bad debt.

The executive team called for development of a detailed improvement plan to address these points. The plan included the following steps:

- Focus on key patient-interaction points, including preregistration, registration, discharge, third-party follow-up, and collections.
- Tighten credit policies and educate staff in access areas about these policies.
- Before scheduling elective services, review the patient’s account history for outstanding balances. Require payment in full before scheduling new services.
- Initiate financial counseling before the visit.
- Secure a deposit from the patient on the day of service.
- Initiate a point-of-service collection program in the outpatient, urgent care, and emergency areas.
- Explore use of bank-loan programs to support the tighter credit policy.
- Consider providing a financial counselor in the emergency department.
- Expand the public-benefits advocacy program to include patients receiving emergency and outpatient services.
- Discontinue courtesy discharge practice and ensure all patients visit a cashier or financial counselor before leaving.

**Identifying Entities Responsible for Payment**

**The issue.** Identifying the appropriate individuals or entities that should be held responsible for payment is of paramount importance. As the level of uninsured Americans increases and those covered by health insurance bear more of the costs of care through defined-benefit programs and benefit redesigns, an increasing portion of a healthcare provider’s payments will be due from individual patients. Thorough financial counseling before service delivery and enforcement of provider payment and credit policies are critically important to receiving appropriate payment from these individuals. Moreover, patient satisfaction increases when patients understand what they are being charged for and what their insurance will not cover.
Nonetheless, health care may be the only industry in which services often are delivered before costs or payment are discussed. This issue poses a particular challenge for a not-for-profit organization, whose mission is to serve the community uniformly regardless of ability to pay. A reticence to discuss cost and collection issues with patients, coupled with a lack of business rigor, focus, and coordination of revenue-cycle processes, often results in these providers subsidizing care for individuals and entities that actually are able to pay. Thus, having a clear process for evaluating the ability and responsibility for payment and setting proper expectations for payment before providing services, where possible, are critical first steps in the revenue cycle.

**Key problem indicators.** If the hospital has a high number of accounts for which payment is not received within 30 to 60 days after treatment, then appropriate diligence may be lacking in this area. Key indicators of problems in this area are a high rate of bad-debt write-offs and escalating self-pay days in accounts receivable.

**Best practice—setting patient expectations about payment.** At GHS, the initial contact with patients at the time of scheduling or preregistration is seen as an opportunity to educate them on the expected cost of providing the service and, based on their coverage, the potential cost they may be responsible for paying. GHS has recently strengthened its policies and procedures to support performing this type of financial counseling. Likewise, GHS is developing the training and tools necessary for pricing and proration to adhere to and be successful with these policies and procedures. One such area of development is customer service and collection training for patient-access staff.
**Best practice—collections.** At GHS, self-pay accounts receivable (A/R) are kept in-house for the first 45 days before they are turned over to a third-party collector, recognizing that some patients who are willing and able to pay just need some time. Upon analyzing its past collections, GHS has found that, within this time frame, it can collect more in outstanding A/R at a lower cost than third-party collectors can collect. This approach allows third-party collectors to focus their efforts on accounts requiring a third-party influence.

**Acknowledging the Value of PFS and Patient-Access Staff**

**The issue.** A failure to properly value admitting, scheduling, and registration staff—through appropriate pay levels and clear work guidelines—can exacerbate problems in the critical areas of PFS and patient-access staff satisfaction and retention. Historically, PFS and patient-access staff positions have been regarded as entry-level positions. When PFS and patient-access staff receive low pay, minimal training, insufficient tools, and unclear standards or expectations, they almost certainly will lack the initiative to diligently obtain all the information required to support the revenue cycle. Moreover, dissatisfaction with such work conditions contributes to high staff turnover, further undermining revenue-cycle performance.

**Key problem indicators.** Staff turnover in patient access/registration areas in excess of 20 percent annually may indicate a problem requiring corrective action.

**Best practice—investment in staff training.** GHS recognizes that training is essential to develop and retain qualified PFS and patient-access staff. One of the purposes of SBS is to provide consistent training of these staff across all health system facilities to allow exchanges of resources, effective implementation of new systems and uniform reporting. Charged with defining clear job specifications and requisite qualifications, SBS is able to identify specific training requirements.
which include knowledge of Medicare and Medicaid regulations, local medical review policies, regulatory compliance requirements, insurance benefits, proration and financing options, clinical terminology, and the health system.

**Managing Contracts/Claims Denials**

**The issue.** Among the most significant issues, with extremely high financial stakes for healthcare providers, is contract/denial management. Insurers and providers are in a constant tug-of-war, with insurers generally taking a longer time to issue payment than providers would prefer to see. This issue challenges even the highest-performing hospitals, because managed care contracts tend to be complex and difficult to interpret and administer. Many hospitals and health systems compound the difficulties by dividing responsibility for negotiating and administering contracts between two departments, and then giving the department responsible for contract administration insufficient staff, time, and tools to compare actual payments with amounts stipulated in the contract.

**Key problem indicators.** Problem indicators that point to a lack of data integrity and accuracy at the time of registration include high rates of claims denials, lost payments, and costly claims revisions. High claims denial rates often occur because registration staff have not obtained and validated current information on the patient, guarantor, insurance coverage, and methods of private payment for copayment. Many organizations also fail to provide patients with detailed estimates of costs or to require deposits in advance of treatment.

**Best practice—establishment of a formal claims denial management program.** At GHS, analysis of a nonstatistical sample of 3,600 claims disclosed that 64 percent of all claims denials among Medicare and two major private insurers were due to problems with coordination of benefits, noncovered charges, and medical necessity issues or duplicate claims. Notably, all of these problems originated at some point before the accounts reached the PFS department. Most of the claims reviewed were found to be recoverable, in that a corrected claim could be resubmitted for payment either to the insurer or the patient. However, considerable rework and resources were consumed in researching and recovering these claims.

GHS determined that a consistent process for monitoring and following up on systemic denials and underpayments on managed care contracts was required to address this problem. In the past, managed care contracts were negotiated and administered at the corporate level, and PFS staff was not afforded access to contracts. No tools or framework existed for systematic monitoring of the managed care payments. Once a payment was received, it was posted to the patient’s account and, in most instances, balances were recorded as contractual adjustments. As a result, days in A/R and bad-debt write-offs appeared within norms, while contractual adjustments were increasing at an alarming rate.

GHS’s solution was to reallocate 5.75 FTEs from current PFS and patient-access areas to focus on a formal systemwide claim denial management program. The program’s goal is to keep partial- and full-claim denial rates to 5 percent or less. This goal is to be accomplished by systematically identifying points in the revenue cycle where there are recurrent inconsistencies.
in data collection and/or entry. The group is then charged with working cross-functionally to improve processes, implement training, and apply information technologies more effectively to eliminate the causes of these inconsistencies. Although the program has only recently been implemented, the business case for the program projected that GHS could expect a 1 to 2 percent increase in cash collections and that the initial resource requirements would decrease as the claim denial rates are reduced over time.

An important function of GHS’s denial management program is to investigate claims “variances.” Recent industry research indicates, on average, providers can expect 10 to 12 percent of managed care claims to show up as variances during a retrospective review. Moreover, typically two out of three variances are true underpayments, late payments or medical appeals that the provider should partially or fully recover.

Based on these findings, GHS anticipates an additional 1 to 2 percent increase in cash collections through an 18-month retrospective review of payments from its managed care payers. Also, with an equal focus on prospectively addressing the issues identified during the retrospective review with payers, GHS expects to maintain this level of improvement in cash collections.

**Ensuring Adequate Medical Necessity Screening**

**The issue.** A substantial percentage of healthcare services provided nationally are performed on Medicare patients, many involving high acuity of care. Billions of dollars are lost annually through lack of understanding of or adherence to correct medical-necessity screening processes.

**Key problem indicators.** A high rate of outpatient denials due to lack of medical necessity points to a lack of sufficient tools and uniformity in screening for medical necessity, and inconsistent processes for obtaining signed advanced beneficiary notices (ABNs).

**Best practice: adopting effective medical necessity screening tools.** The most effective way
to avoid medical-necessity denials is to deploy screening software tools at the initial patient access points. Using such tools during scheduling or the preregistration process allows a provider to quickly identify scheduled services that may not be covered by Medicare. The provider can then work with the physician on the diagnosis/scheduled service or identify the need to obtain an ABN from the patient prior to service delivery.

To date, one GHS hospital has such a medical-necessity screening tool in place, and all hospitals have an online ABN available as part of the registration process. The hospital with the medical-necessity screening tool has shown a significantly lower claim denial rate due to lack of medical necessity than the other two hospitals. The other hospitals therefore are preparing to implement the same medical-necessity screening tool.

**Conclusion**

As a relatively new system, GHS initially lacked a common, systemwide vision for the revenue cycle. However, through extensive use of multicampus, cross-functional teams to develop and review new approaches to revenue-cycle management, GHS has demonstrated a strong commitment to creating and supporting its revenue-cycle vision. GHS’s vision includes the following components:

- Seamless flow of information within the system, with minimal points of contact and duplicative requests for information;
- Patient satisfaction ratings of 75th percentile or better;
- Increased information accuracy;
- Decreased manual effort to bill and collect; and
- Easy access for referring physician offices and staff to necessary patient demographic information and data.

Top-performing organizations like GHS manage the revenue cycle as an end-to-end process, rather than a series of functions or departments. The costs of inadequate revenue-cycle management—whether in terms of denied claims, staff turnover, bad debt, or medical-necessity denials—are easily identified. Successful management of the revenue cycle demands the attention and engagement of departments outside of patient accounting. This approach sets the foundation for the use of quality improvement and cross-functional teams to support a systems approach to revenue-cycle management. Focus on the revenue cycle should become an operational priority for hospitals of all sizes, both for-profit and not-for-profit.

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