



Healthcare Revenue Integrity Strategies

Using High Value Revenue Cycle Assessments to Protect and Improve the Bottom Line

Healthcare providers know that every step counts and there is no room for error when securing revenues and reimbursements for their services. However, ensuring revenue integrity can be challenging for these organizations due to numerous industry complexities. Patient clinical and billing information, for example, traditionally are managed in isolation by different departments with very little integration. Thus, it is common for one department's deficiencies to impact other departments adversely, as well as the overall integrity of a hospital's revenue cycle.

Deficiencies and avoidable mistakes in key revenue cycle components undermine the effectiveness of a healthcare provider's revenue cycle. Organizations can fail to realize as much as 3 to 5 percent in net revenue due to a lack of effective internal controls for mitigating financial, regulatory and operational risks.

The hot spots described within this article are areas in which hospitals are commonly at risk for losing revenue. They include **patient access, utilization review, charge capture, and billing and payment accuracy**. Healthcare providers should consider evaluating their processes in these areas against leading practices and, if warranted, also focus on making improvements.

Hot Spots: Patient Access and Utilization Review

Patient satisfaction and optimal reimbursement hinge on the efficiency and effectiveness of the first patient touch points – the patient access areas. A significant percentage of the insurance claim form is generated through information gathered during this stage of the revenue cycle process. It is also where errors occur that often result in avoidable denials. In fact, avoidable denial-related errors made during patient access activities account for up to 60 percent of total denied claims in many hospitals.

Breakdowns in **scheduling, insurance verification, pre-authorization, admissions and utilization review** processes (the patient access areas) can lead to patient dissatisfaction, billing problems, excessive insurance denials and extensive rework. Revenue cycle improvement initiatives should focus on these key processes, as effectively designed controls for ensuring accuracy of information prior to or during patient care will enhance patient self-pay collectability and will significantly reduce resources required for billing and collection, including claims rework, denials management and bad debt management during downstream processes.

Why are these routine processes creating revenue collection headaches for healthcare providers? Here are some factors:

- Typically, patient access staff members are entry-level employees paid relatively low wages and are not adequately educated or trained. In addition, turnover is often high.
- Recent census figures revealed that 46.3 million people in the United States lack health insurance coverage.¹ Rising unemployment and lower earnings due to the weak economy have swelled the ranks of the uninsured.
- Co-payment and other up-front collections are vital to a healthcare provider's bottom line. But when a hospital delays co-payment or coinsurance collection from the time of the initial patient visit, it must invest excessive resources for follow-up correspondence. Also, the likelihood of collecting decreases significantly as time passes.

Common **scheduling** deficiencies include a lack of clear authority or guidance across the organization, staff not collecting or validating patient information appropriately, and failure to review outstanding patient balances. Duplicate patient accounts – often the result of pre-admissions and admissions personnel creating multiple accounts for a single visit – are also a significant issue for many healthcare providers. In fact, it is common for several thousand duplicate accounts to exist at any point in time. Duplicate accounts are a primary reason why authorization information is not correctly associated with a patient's stay. They also can be a significant driver for inaccurate charge capture, which is discussed below.

In the **insurance verification, pre-authorization** and **admissions** processes, typical issues experienced by healthcare providers include failure to: postpone scheduled procedures if insurance verification or authorization is not complete within 12 to 24 hours prior to the procedure; pursue up-front cash collections; qualify uninsured patients for other programs, such as Medicaid; and ensure accurate and complete entry of patient and insurance data into the system. (This area is especially important, since failure to obtain an appropriate Advance Beneficiary Notice from a Medicare patient will preclude an organization from billing the patient for any non-covered services provided.)

Following are just a few common risks within the **utilization review** process:

- Failure to notify payer of patient admission or obtain additional/continued service authorization
- Failure to notify physician when medical necessity conflicts exist
- Use of outdated provider manuals
- Lack of standard checklists or templates, including payer requirements
- No formal monitoring for compliance with payer requirements for notification, authorization and/or subsequent authorization

¹ U.S. Census Bureau | Public Information Office, September 10, 2009.

Beyond traditional system edits included in most patient accounting and management systems, opportunities frequently exist for developing automation to identify when a length-of-stay authorization nears expiration and for performing notification requirements for all new admissions, especially when specific payer contracts contain unique requirements such as weekend reviews. In addition, denials for medically unnecessary services often account for a significant portion of total denial-related bad debt write-offs in many provider organizations and are of particular focus in the Centers for Medicare & Medicaid Services' (CMS) Recovery Audit Contractor program.

Hot Spots: Charge Capture

A healthcare provider's financial success is directly dependent upon accurately charging for services rendered, especially when there is a strong concentration of managed care or commercial payers. According to a 2007 Healthcare Financial Management Association study of data from more than 100 hospitals that encompassed more than 30,000 complete medical records and comprehensive billing and collection records, organizations lose, on average, 1 percent of revenue to errors in the chargemaster and charge capture processes.

Many hospitals have not begun to quantify or understand the impact charge inaccuracies have on their bottom line. They do not monitor charge validation and integrity, which ensures complete and accurate posting of charges. Charge capture deficiencies often occur because these activities are perceived as lower-priority administrative activities and/or individuals other than knowledgeable caregivers are responsible for charge posting and reconciling activities.

Care providers may not understand the associated risks and potential consequences for not capturing charges accurately, completely and in a timely manner. It is typical for charge capture responsibilities to be extremely decentralized across organizations, and for monitoring and feedback to be inadequate. Many healthcare providers lack formal systemwide policies and consistency standards. In addition, there is often little or no coordination between departments or standardized training for those handling charge capture activities.

There are two distinct ways to assess the effectiveness of charge capture processes; both are necessary for ensuring optimal results. The first is chart auditing, which tests for completeness and accuracy in the charging process. Chart auditing identifies lost charges, but rarely identifies and remediates root causes. However, technology has matured and tools, such as charge capture solutions from MedAssets and Apollo Data Technologies, can identify potential missed charges more efficiently and comprehensively than the traditional sample-based chart auditing techniques.

The second method is business process improvement evaluations, which is effective in identifying exactly where financial leakage may occur. It also assists in the reduction of charging errors over time. When performing process-based examinations of charge capture activities, care rendering and administrative processes (e.g., patient arrival at the department, charge sheet utilization, charge entry and reconciliation processes) should be reviewed holistically.

To evaluate and improve the charge capture process effectively, it is important to understand the net revenue impact of charge capture improvements. The impact of payer mix, contracts, carve-outs, add-ons, outliers, implants, high-dollar drugs, cost report accuracy, departmental budgets and productivity measurements must be considered when improving charge accuracy programs. Typical reasons for deficiencies must also be understood, such as:

- Charges for items obtained from automated medication and supply dispensing systems and/or floor stock are not appropriately controlled.
- Charge sheets, charge screens or preference cards are not accurate.
- Interfaces and/or end user computing tools are not baselined and monitored for precision.
- Personnel do not verify the patient account number prior to entering charges.
- Reconciliations to ensure completeness and accuracy are not performed.
- Supplies and procedures do not have a charge description master number.
- Varying system modules or screens are available for charge posting, especially for miscellaneous charges, with varying levels of controls.
- Department-specific procedures describing the process for capturing and entering charges do not exist.
- Personnel backups are not identified or adequately trained.
- Departments are not familiar with, and do not comply with, the charge description master update process, and/or processes are not in place to ensure prices are justifiable, consistent, competitive and profitable.
- Regulatory updates are not implemented within the charge description master in a timely manner.
- Billing department personnel modify/correct charges without consulting caregivers.
- Supply/drug markup formulas are not applied accurately or based on the most recent cost.
- “Clinically clear” and “overflow” patients are accounted for inaccurately.
- Acuity-based charging methodologies are not understood or consistently applied.
- Monitoring of the charge capture process and feedback reporting is inadequate.
- Quality assurance programs are not implemented to monitor ongoing efforts, provide support, perform periodic testing and develop/deliver educational programs.
- Concurrent charge validation programs are not in place to identify missed charges and/or do not focus or prioritize according to net revenue improvement.

Charge capture improvement programs can be complicated and must consider proper utilization of charge information, processes and systems. An effective program should emphasize the importance of administrative non-patient care tasks; risks or organizational impact for not posting charges accurately, completely and in a timely manner; accountability and oversight for assigned responsibilities; and continuous process improvement through consistent monitoring and performance feedback. Departments ideal for charge capture improvement efforts may include pharmacy, surgery, post-anesthesia care, catheterization laboratory, emergency department, electrophysiology lab, interventional radiology, intensive care unit and women’s services.

Hot Spots: Billing and Payment Accuracy

The processes of **billing, collections, denials management and underpayments management** may be routine activities for healthcare providers, but they also represent key areas of opportunity for ensuring revenue optimization. Specifically, processes for ensuring payment accuracy, correctly identifying and resolving denials, and effectively managing underpayments are critical to maintaining a healthy bottom line. This includes not only the effective identification of payment inaccuracies, but also the appealing, trending and upstream reporting to effect improvements in people, processes and technology.

Included below are a few risk areas that can undermine the efficiency of revenue processes. Revenue cycle improvement initiatives should include procedures for each risk when designing their work programs:

- Timely resolution of bill holds and compliance with timely filing deadlines
- Backlog and aggressive resolution of denied claims
- Prioritization of collection efforts to maximize their yield, based on volume, dollar value and probability of collecting, and the utilization of multiple third-party collection agencies versus the utilization of a single partner
- Adequacy and segregation of duties of cash posting activities
- Utilization of contract management systems and tools to ensure precision in the identification of payment variances
- Appropriate classification, monitoring and resolution of all payment variances identified
- Appropriateness of write-off procedures to ensure timeliness of adjustment and accurate classification of contractual allowances, charity or bad debt
- Tracking, trending and reporting of data and reasons for denied claims, payer rejects, and internal system edit results to upstream departments, processes and physicians

Many benefits can be derived from considering these areas. For example, one of the best indicators for determining the effectiveness of a hospital's revenue cycle is denied claims. For some organizations, as much as 25 percent of all claims are "unclean," rejected or denied at some point in the collection process, with at least 5 percent of net revenue being directly affected. A considerable portion of this revenue is lost and never recovered. The vast majority of all denials determined unrecoverable can be prevented with improved controls in upstream processes. Organizations with an effective denials management tracking and classification process should strive for total denials to be less than 3 percent of revenue, with a denial-related bad debt write-off rate of less than 0.5 percent of revenue.

The **denials management** process is generally perceived as simply a back-end financial function in many healthcare organizations. But it should be viewed as an end-to-end revenue cycle process involving business process re-engineering, system enhancements and training initiatives that educate employees on denial issues and provide them with a broader understanding of the end-to-end revenue cycle process. It is important to recognize that refiling a claim is not a solution to the denials management issue. Organizations should quantify, understand and improve the root cause to address identified opportunities effectively.

Equal to denials management is **underpayments management**. Underpayments experienced are many times as high as denials, especially when a contract management system is not used to ensure actual reimbursement equals expected reimbursement. The use of an effective contract management system with complete and accurate payer contract terms entered can be the most important measure in identifying if a denial and/or an underpayment exists for any claim.

Systematically monitoring and resolving payment variances can have a significant impact on a hospital's bottom line and provide the basis for enhancing integration and communication between departments.

High Value Revenue Cycle Improvements for Healthcare Providers

A comprehensive yet targeted assessment to evaluate the effectiveness of a hospital's internal controls surrounding revenue cycle processes can assist in the identification of business process and/or system improvement opportunities that, when implemented, can lead to enhanced profitability and strengthened compliance practices. Enhancing the effectiveness and value realization of revenue cycle improvement activities requires a solid understanding of data indicators and departmental relationships.

The approach should be designed in a way that allows management and other stakeholders to gain a clear understanding of the business. This will help them to identify, source and measure risk at both the entity and process levels. When examining each revenue cycle component or hot spot, the following questions should be addressed:

- What are the key business risks that impact the process?
- How, and how well, are those risks controlled?
- What measures are used to monitor the process, and are they reliable? Should additional measures be considered?
- How efficient is the process in operation?
- How can the process be improved to bring its performance closer to leading standards?

It is also useful to utilize industry-available frameworks and models when approaching revenue cycle improvement initiatives. An example may include the Capability Maturity Model (CMM), which is a framework that describes an improvement path from an ad hoc, immature process to a mature, disciplined process focused on continuous improvement. The CMM defines the state of a process using a common language and consists of a continuum of five process maturity levels, enabling process owners to rate the state or maturity of a given process to pursue improved performance.

Scoping Considerations

The following areas should be considered when planning revenue cycle improvements to ensure realization of the desired value:

- *Review of Process Design and Observation.* The design of critical processes should be reviewed at a very detailed level, especially when evaluating the process for the first time. Performing observations is an absolute must; it is certain you will find differences between stated and actual practice. Be sure to plan observations during peak or busy times, when errors and the use of shortcuts are more likely to occur.
- *Application Controls.* When assessing revenue cycle operations effectiveness, application controls utilization should be reviewed. Reviewing system functionality and system literature will lend invaluable benefits to improving control processes.
- *Data Analysis, Sampling and Benchmarking.* Make strong attempts to perform targeted assessments, which should require a review of revenue reports, preliminary testing via sampling or diagnostic assessments to identify revenue cycle components with a likelihood of control concerns. Be sure to benchmark against other organizations or published leading standards and look for key indicators of need.
- *Regulatory Compliance.* Do not ignore compliance issues, such as privacy and the security of patient information. Compliance must never be separated from revenue cycle improvement.
- *System Implementations.* For large-scale revenue cycle system or electronic health record implementations, consider planning checkpoint assessments throughout and after the implementation for revenue cycle optimization. Focus on project planning, management and communication, as well as:
 - Involvement/acceptance by physicians and/or key employees and the use of formal workflow approval checkpoints
 - Specificity of operational workflows, data conversions and “sunsetting” old systems/data
 - Issue tracking
 - Sufficient/objective project risk management oversight and project manager or project management office competence
 - Vendor implementation methodology and requirements definition
 - Security and compliance
 - Change management and testing practices
 - Configuration of application controls
 - Go-live readiness and post-go-live support plans
 - Training and backfill personnel
 - Deviations between planned and actual post-go-live practices, including paper to paperless transition plans
 - Productivity expectations, value realization and benefit measurement

Focus on Revenue Enhancement

A healthcare provider's revenue cycle is very complex and involves many processes and players across a broad spectrum of activities – from patient scheduling and registration to charging for services to billing and collections. A provider is at risk every day of losing revenue at many points in the cycle, especially in routine areas of operations where inefficiency and a lack of communication between departments are common.

By identifying potential points of failure in the revenue cycle and focusing on high value concepts, a healthcare provider can make critical improvements that not only can help eliminate financial leakage but also improve patient satisfaction and compliance practices. However, understanding how one department's deficiencies can affect another's and the impact improvements may have on net revenue are critical to realizing desired value.

This article highlights a few hot spots to center improvement activities around, but there are many other revenue cycle activities that should not be ignored. With comprehensive and sustainable revenue cycle improvements, operating income for many hospitals could be improved by 25 to 50 percent. Given the significant industry reform being contemplated, hospitals should assume future payment increases will be minimal, or even negative. Therefore, they should focus more attention on optimizing the revenue to which they are entitled.

About Protiviti

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About Protiviti's Healthcare and Life Sciences Practice

Protiviti's professionals assist healthcare providers with strengthening compliance programs and improving technology, finance and revenue cycle efficiency and effectiveness, resulting in improved operational performance and lower costs.

Protiviti's team of industry experts understands the challenges faced by healthcare providers. Our professionals help providers achieve growth and profitability through effective risk management in the following areas:

- Revenue Cycle
- Finance
- Cost Reduction
- Supply Chain
- Internal Audit
- Regulatory Compliance
- Technology
- Clinical System Implementations

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