

High-Value Revenue Cycle Assessments

Key steps that will protect and improve your organization's bottom line

By Don Billingsley and Richard Williams

Deficiencies in key revenue cycle components can undermine the bottom line. Hospitals typically will fail to attain as much as five percent of their net revenue because of ineffective internal controls that mitigate financial, regulatory and operational risks. Areas commonly at risk for losing revenue include patient access, utilization review, charge capture, billing and collections. Assessments in these key areas can identify risks and deficiencies that, if alleviated, can lead to decreased risk and increased revenue.

.....
 Don Billingsley is an Associate Director in Protiviti's Dallas office, and leads Protiviti's national Healthcare Provider Revenue Cycle practice. Previously, he worked as a revenue cycle consultant at Arthur Andersen, and a care manager and compliance auditor for a large healthcare management organization. You can reach Don at (214) 476-2933 and Don.Billingsley@protiviti.com.



.....
 Richard Williams is a founding member of Protiviti and Global Healthcare Provider Practice Lead, providing operational, financial, and regulatory consulting and internal audit services to the healthcare industry. You can reach Richard at (214) 395-1662 and Richard.Williams@protiviti.com.



Patient satisfaction and optimal reimbursement hinge on the efficiency and effectiveness of the first patient touch points. According to the American Association of Healthcare Administrative Management, approximately 50 percent of an average insurance claim form is generated using information gathered within the patient access area of the revenue cycle process. Patient access-related errors can result in a significant number of avoidable denied claims.

Malfunctions in scheduling, insurance verification, pre-authorization, admissions and utilization review processes can lead to patient dissatisfaction, billing problems, excessive insurance denials and the extensive reworking of claims. Revenue cycle assessments should focus on these key processes. Effective controls, designed to ensure the accuracy of information gathered prior to or during patient care, can enhance collectability and reduce the overall resources required for billing and collections, including claims rework, denials management and bad debt management during downstream processes.

Scheduling, admissions and utilization procedures

Common scheduling deficiencies include:

- A lack of clear authority or guidance across the organization
- Staff not collecting or validating patient information appropriately
- Failure to review outstanding patient balances

Duplicate patient accounts are often the result of pre-admissions and admissions personnel inadvertently creating multiple accounts for a single visit, leading to inaccurate authorization information associated with a patient's stay. This can also be a significant driver for inaccurate charge capture, discussed below.



In the insurance verification, pre-authorization and admissions processes, typical issues incurred include failure to:

- Postpone scheduled procedures if insurance verification or authorization is not complete within 12 to 24 hours before the procedure
- Pursue up-front cash collections
- Qualify uninsured patients for other programs, such as Medicaid
- Ensure accurate and complete entry of patient and insurance data into the patient accounting system

In addition, failure to obtain an appropriate Advance Beneficiary Notice from a Medicare patient precludes billing the patient for any noncovered services that are provided.

In the utilization review process, common deficiencies and risks include:

- Failure to notify the payer of the patient admission or to obtain additional/continued service authorization
- Failure to notify the physician when medical necessity conflicts exist
- Use of outdated provider manuals
- Lack of standard checklists or templates, including payer requirements
- Lack of formal monitoring for compliance with payer requirements for notification, authorization and/or subsequent authorization

Beyond the 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. Automation can also be used to perform 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. These have become particular points of focus in the Centers for Medicare and Medicaid Services' (CMS) Recovery Audit Contractor program.

Charge capture

Financial success is directly dependent on accurately charging for services rendered, especially when a strong concentration of managed care or commercial payers exists. An HFMA study consisting of data from over 100 hospitals and 30,000 complete medical records including comprehensive billing and collection records, reveal that on average, organizations lose one percent of revenue due to errors in the chargemaster and charge capture processes.

Charge capture deficiencies often occur because charge validation and charge monitoring activities are perceived as lower-priority administrative activities and/or individuals other than knowledgeable caregivers are responsible for charge posting and reconciling activities.

There are two ways to assess the effectiveness of charge capture processes: chart auditing and business process improvement evaluations. Both are necessary to ensure optimal results.

Chart auditing tests completeness and accuracy in the charging process by identifying lost charges, but rarely identifies and remediates root causes. However, technology has matured, and tools such as several charge capture solutions can identify potential missed charges more efficiently and comprehensively than the traditional sample-based chart auditing techniques.

Business process improvement evaluations are used to identify exactly where financial leakage may occur, also assisting 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.

Charge capture improvements

To improve the charging 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-cost drugs, cost report accuracy, departmental budgets and productivity measurements must be considered when improving charge accuracy programs.

Charge capture improvement programs can be complicated and must consider proper utilization of charge information, processes and systems. An effective program should emphasize the following:

1. The importance of administrative nonpatient care tasks
2. Risks or organizational impact of not posting charges accurately, completely and in a timely manner
3. Accountability and oversight for assigned responsibilities
4. Continuous process improvement through consistent monitoring and performance feedback

Departments that are good candidates 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.

Billing and collections breakdowns

The processes of billing, collections, denials management and underpayments management may be routine activities for healthcare providers; however, they also represent key areas of opportunity for ensuring revenue optimization.

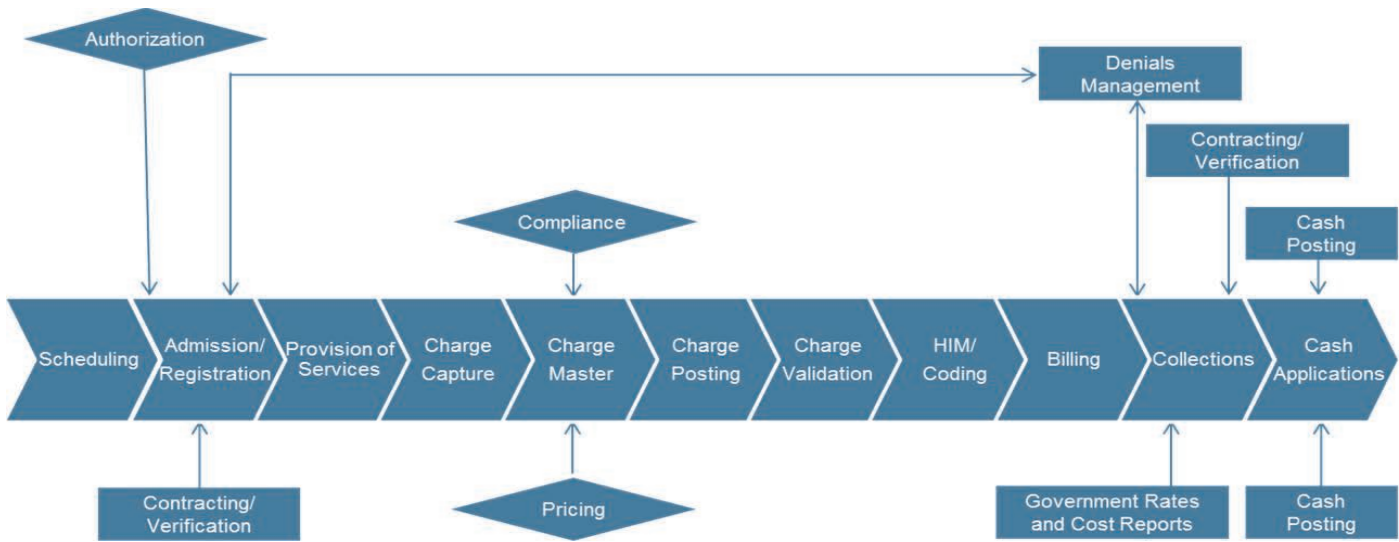
Having processes for ensuring payment accuracy, correctly identifying and resolving denials and effectively managing underpayments is critical to maintaining a healthy bottom line. This includes not only the effective identification of payment inaccuracies, but also the appealing, trending and upstream reporting to effect improvements in people, processes and technology.

Reduce denied claims and underpayments

One of the best indicators for determining the effectiveness of a revenue cycle is assessing 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 five percent of net revenue being directly affected. A considerable portion of this revenue is lost and never recovered.

Common reasons for charge capture deficiencies

- Charges for items obtained from automated medication and supply dispensing systems and/or floor stock are not appropriately controlled.
- Interfaces and/or end-user computing tools are not baselined and monitored for precision.
- Reconciliations to ensure completeness and accuracy of the charge capture process are not performed.
- Supplies and procedures are not assigned a charge description master number.
- There are varying system modules or screens available for charge posting, especially for miscellaneous charges, with varying levels of controls, and they may not be fully accurate or updated.
- 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, profitable or compliant with regulatory updates.
- Billing department personnel modify or correct charges without consulting caregivers.
- "Clinically clear" and "overflow" patients are accounted for inaccurately.
- Monitoring of the charge capture process, feedback reporting and department education are inadequate.
- Concurrent charge validation programs are not in place to identify missed charges and/or they do not focus on or prioritize charges according to net revenue improvement.



The vast majority of all denials determined to be unrecoverable can be prevented with improved upstream controls. Denials at organizations with an effective denials management tracking and classification process should be less than three percent of revenue, with a denial-related bad debt write-off rate of less than 0.5 percent of net revenue.

The denials management process is generally perceived as a back-end financial function. However, it should be viewed as an end-to-end revenue cycle process involving business process re-engineering with system enhancements and feedback loops. It is vital to include training initiatives for departments, to increase awareness of experienced issues. Merely re-filing a claim is not a solution to the denials management issue. Organizations should quantify, understand and improve the root causes of denials to address identified opportunities effectively.

Equally important is underpayments management. Underpayments are sometimes experienced at a higher rate than denials, especially when a contract management system is not in place to ensure that actual reimbursement equals expected reimbursement. An effective contract management system in which the complete and accurate payer contract terms have been entered can be the most important measure used to identify whether a denial or an underpayment exists for any claim.

Targeting the assessments

A targeted comprehensive assessment that evaluates the effectiveness of internal controls surrounding revenue

cycle processes can assist in identifying business process improvement opportunities. This can lead to enhanced profitability and strengthened compliance practices. Enhancing the effectiveness and value of revenue cycle activities requires a solid understanding of data indicators and departmental relationships.

The approach should be designed to allow management and other stakeholders to gain an informed understanding of the business, and to identify, source and measure risk at the entity and process levels. When examining each revenue cycle component, the following questions need to be considered:

- 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?
- How can the process be improved to bring its performance closer to leading standards?

Industry-available frameworks and models can be useful when considering improvement initiatives. The six elements of infrastructure illustrated here represent a useful framework for categorizing operational practices and potential issues, as well as understanding where problems may occur and drawing conclusions to form the basis for recommendations.

Scope considerations

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 in-person observations is an absolute must; differences between the stated and actual practice are nearly always found. Schedule observations for busy times, when errors and shortcuts are more likely to be seen.

Application controls – When assessing the effectiveness of revenue cycle operations, application controls should be reviewed. Reviewing system functionality and system literature are invaluable benefits to improving control processes.

Data analysis, sampling and benchmarking – Perform targeted assessments. Be sure to include a review of revenue reports, as well as preliminary testing via sampling or diagnostic assessments in order to identify revenue cycle components that have a likelihood of control concerns. Incorporate benchmarking against similar organizations and

published leading standards, looking for key indicators of need.

Regulatory compliance – Do not ignore compliance issues, such as privacy and security of patient information. Compliance must never be separated from the revenue cycle improvement process.

One of the best indicators for determining the effectiveness of a revenue cycle is assessing denied claims.

System implementations – For large-scale revenue cycle system or electronic health record implementations, plan internal controls assessments throughout and after the implementation for revenue cycle optimization. Focus on project planning, management and communication, in addition to:

Take action on these risk areas to improve the efficiency of revenue processes

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

1. Involvement in and acceptance of the process by physicians and other key employees
2. Use of formal workflow approval controls
3. Specificity of operational workflows, data conversions and “sunsetting” of old systems and/or data
4. Issue tracking
5. Sufficient and objective project risk management oversight and project manager or project management office competence
6. Vendor implementation methodology and requirements definition
7. Security and compliance
8. Change management and testing practices
9. Configuration of application controls
10. Training and backfill personnel
11. Go-live readiness and post-go-live support plans
12. Deviations between planned and actual post-go-live practices, including paper-to-paperless transition plans
13. Productivity expectations, value realization and benefits measurement

The six elements of infrastructure



There is a risk if element is deficient:



Process does not carry out established policies or achieve intended result

People lack the knowledge and experience to perform process

Reports do not provide information for effective management

Methodologies do not adequately analyze data and information

Information is not available for analysis and reporting

Value for patients and compliance

By identifying potential points of failure in the revenue cycle and focusing on high-value concepts, a healthcare provider can make critical improvements that can help eliminate financial leakage and also improve patient satisfaction and compliance practices. Understanding how one department’s deficiencies can affect another’s and the impact of improvements on net revenue are critical to realizing desired value.

You can center improvement activities around a few key areas highlighted here, but don’t ignore the many other revenue cycle activities. By instituting comprehensive and sustainable revenue cycle improvements, your hospital can upgrade its operating income substantially. Given the anticipated and significant industry reform, hospitals should presume future payment increases will be minimal, or even expect reductions. Therefore, providers should focus attention now on optimizing the revenue to which they are entitled. **NP**

