



Revenue Cycle Optimization

Consultant People, LP

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Solving the revenue cycle dilemma
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Executive Summary

With the pressures facing healthcare industries today to maintain a position of financial strength, proactive accounts receivable management is becoming more and more necessary. However, with a lack of adequate time and resources it is difficult for Patient Financial Services (PFS) Directors to stay on top of the ever-changing environment of the healthcare field. In fact, many business offices are running on auto pilot with processes operating the same way they did years ago.

An antidote to this stagnation is a Revenue cycle optimization project. This effort focuses on maximizing revenue from existing business. Every layer of the business office operation is evaluated for deficiencies and strategic changes are made. Policies and procedures are reviewed along with job descriptions. Many times an outside consulting company is engaged to assist the facility in performing these operational assessments, analyses and process reviews.

Business Challenge

Managing the revenue cycle is a constant endeavor. Once an optimization review is completed and improvements achieved, it is critical that the process continue daily. A crucial goal of a quality revenue cycle review is the transfer of knowledge and establishment of tools necessary to carry on this maintenance. Understanding the potential causes of revenue loss is an important first step.

There are many reasons why an organization could be losing revenue. Some of the most common causes are:

- Unauthorized Services
- Outdated Charge Masters
- Accounts held from final billing
- Extended days in billing
- Unverified Claim Submissions

Pre-certification and Authorization

If services are not being authorized as required by contract the insurance company may refuse to make payment. This happens when services are scheduled before the pre-certification/authorization was secured. One hospital was able to correct this problem by establishing a set of numbers that began with the letter Z. The scheduling department did not schedule the test until they had a “Z number” from the pre-certification/authorization department.

Charge Master Maintenance

Another hospital had not reviewed their prices for several years. Most carriers will pay either the charges or the fee schedule; whichever amount is less. The hospital was losing revenue because their charge amounts were set lower than the Medicaid fee schedule for some costly services such as MRIs, CT Scans and Angiograms. Once they re-priced their charges, they were able to recognize higher revenue from Medicaid for these services.

Discharged But Not Final Billed

Accounts are held from final billing for a number of reasons. Usually three to five days are allowed for input of charges and coding called “suspense days”. Accounts that are purposely held longer than suspense days are potentially lost revenue since managed care contracts have an established number of days (usually 30, 45 or 60) during which they will accept a claim as timely filing. Missing charges and documentation are issues that cause accounts to be held from final bill. User training will normally resolve these problems but should be ongoing when new employees are hired into the organization.

When the medical coding department is behind in their coding, immediate attention should be given to resolving the backlog. This can be done with temporary personnel or affording overtime when necessary. Health Information Directors should be aware of the number of days allowed for suspense in order to ensure that all claims are coded timely.

Days in Billing

Missing demographic information and needed attachments (emergency room reports, sterilization forms, etc) are common reasons accounts are held in billing. The number of days in billing is calculated from the time the account is final billed until it goes out the door to the carrier, either by mail or electronically. Since suspense days should be enough time for documentation to get to billing, processes should be reviewed and streamlined to resolve these problems.

Claim Submission Verification

It is not enough to mail or transmit claims and assume that the carrier has received them. When claims are submitted electronically, the clearinghouse will return a confirmation report to the provider. Some providers do not realize, however, that there is a second level confirmation report that comes back from each carrier, as well. A physician practice was submitting claims but not checking for their second level report. Because they were receiving their first level report from the clearinghouse, it was thought that everything was fine. But, their claims were not getting from the clearinghouse to the carriers. Because this had been happening for several months, the loss in revenue from untimely denials was significant.

Contract Management

Managed care contracts used to be simple and straight forward, but now they are much more complex as facilities struggle to negotiate rates to meet their costs. Carve-out and stop losses are two payment methodologies that are difficult to manage. When contracts are negotiated it is important to ensure that your financial system is able to identify incorrect payments. Accurate proration rules are a good way to accomplish this. A variance report designed to report cases where the actual posted payment does not equal the expected reimbursement is a way to let the system work for you.

How do you know if you are losing revenue due to the above issues or other issues not mentioned here? Some, such as authorization can be obvious, however, many of these reasons are invisible to the PFS Director unless they are brought to the surface through investigative methods.

A few of the tools that are used to analyze how well processes and

procedures are working are:

- A detailed analysis of accounts receivable aging.
- A review of payment vouchers against managed care contracts.
- A review of third party payer denials.

Once the issues that negatively impact reimbursement have been identified and resolved, how do you know when you might be veering off track?

PFS Directors are realizing the value of a document that reports on a daily basis the performance indicators that are key to the success of their operations. These key performance indicators (KPIs) must be quantifiable and should reflect the organization's goals. An excel spreadsheet can be used to report KPIs and emailed to all interested parties. Attached is an example of a KPI dashboard that gives real time visibility for timely decision making and instant feedback.

When anyone of the KPIs changes significantly, it is an alert to the PFS Director that immediate measures should be taken to investigate and bring it back in line. An example KPI flash report is attached that shows some of the data that is valuable in tracking revenue cycle performance. This example is the summary sheet with monthly totals. Daily sheets can be constructed from this model with daily detail and monthly totals. These can be used to feed this summary sheet.

Summary Sheet Model

Month	Gross Daily Revenue	Month-to-Date Revenue		Discharges			New Accounts Receivable	Daily Cash Posted	Month-to-Date Cash		Late Charges		Claims Billed		Failed Claims			Total Receivables
		Actual	Budgeted	INPT	OP	ER			Actual	Goal	Nbr	Dollar	Nbr	Dollar	INPT	OP	ER	
Jan	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Feb	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Mar	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Apr	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
May	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Jun	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Jul	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Aug	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Sep	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Oct	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Nov	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
Dec	-	-	-	0	0	0	-	-	-	-	0	-	0	-	0	0	0	-
TOTALS	\$0	\$0	\$0	0	0	0	\$0	\$0	\$0	\$0	0	\$0	0	\$0	0	0	0	\$0

Conclusion

If practiced consistently, revenue cycle optimization is an important tool for an organization to stay financially viable. A Revenue Cycle Optimization project, whether done in-house or in conjunction with a consultant, is worthwhile for any hospital in order to assure that billing and collecting for services are being performed in an optimal manner. It can make a big difference in the amount of resources your organization has to provide high quality care.

More Information

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