



**hfma**

healthcare financial management association

# Real-World Applications of Revenue Cycle Process Mapping

Process mapping is an improvement strategy that's ideally suited to the revenue cycle. As a multifaceted operation involving many intersects, the revenue cycle can be particularly prone to process challenges such as duplication, non-value-added steps, role or authority ambiguity, and bottlenecks.

By developing an “is” map that creates an accurate and detailed picture of business workflow, and comparing it with a “should” map that tells where the organization wants to go, hospitals are better able to:

- Identify productivity opportunities
- Identify best practices
- Conduct a root cause analysis of perceived challenges
- Create business workflow consistency
- Identify ownership and accountability
- Provide a means for consistent training

Process mapping can be applied to almost any process in the revenue cycle. For examples of ways some hospitals are using this improvement strategy, consider the following case studies.

## The Many Uses of Process Mapping: Case Examples

### Case #1: Erlanger Health System

*What:* Recreate the entire revenue cycle in one map, from scheduling through billing, to optimize use of the Tennessee-based system's new information system. The goal: Improve reimbursement.

*How:* The vendor facilitated “is” mapping by a group that included the CFO, controller, and managers and front-line staff from the business office, medical records/health information management, utilization review, registration, and scheduling, as well as three clinical areas—outsource lab, outpatient surgery, and cardiac catheterization—where the organization saw the greatest opportunity. “It took about two and a half days and the front-line people did the talking,” says Erlanger's HIM director, Rita Bowen. A month later, the vendor came back with a “should” map reflecting best practice business flow for the group to discuss. “The new process, which will probably take a full year to implement, gives more ownership to HIM to control

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## Web Verification Process at Hudson Headwaters Health Network

1. The database report will be generated automatically and sent to the designated locations within each health center.
  2. The report is used for the following insurances:
    - Blue Shield of Northeastern New York
    - Medicaid
    - MVP
    - Excelsius Blue Cross
    - Empire Plan
    - CDPHP (to verify all but identification number)
  3. Following are the steps to follow when you receive the report:
    - a. The report is in Excel. Double click on the report to open the file.
    - b. Go to the drop down box at the top of the report—column “E” and click on the initials for your location. That will filter the report so that only your patients with the above insurances will show on the report.
    - c. Now sort the spreadsheet by provider:
      1. Move all the way to the left of the report and click on the column that has the number in it. Click on that number and the entire row should be highlighted.
      2. Drag the cursor down the number column to highlight all of the rows.
      3. With the rows highlighted, go to the toolbar at the top of the spreadsheet. Click “Data” then “Sort” and in the first drop down box click on “Column D.” Then click “OK.” This will sort the report by provider number, and you will have the patients in visit order by provider.
    - d. Anytime you see red in the column under “member ID,” go all the way to the right of the report. Click on the link to the web page, and print two copies of the web page.
    - e. Print the report. It will print on legal size paper and fit all columns across, or on letter it will break the columns.
    - f. Should you see a shaded area, it means that the ID number on the web site is different than the ID number in Medical Manager. **GO AHEAD AND MAKE THE CHANGE IN MEDICAL MANAGER TO MATCH THE ID NUMBER ON THE REPORT.** The only time you would not do this is for CDPHP—their ID numbers are not accurate on the web site and you will need to use the insurance card presented by the patient.
  - g. Check the Primary Care Physician column. If you see a provider listed who is not a network provider, then you need to let the patient know at the time of the confirmation call that he or she needs to change the primary care physician.
  - h. For any patients where you see “patient not found on web site” or “web site information not found,” you will need to go to the web site to verify the information.
  - i. The Medicaid responses will not have a PCP—that is correct. However, you need to be looking for whether the insurance is active.
  - j. Review the Additional Information column. It will display information regarding referrals, copays, etc.
4. When you have completed working the report, compare it with the appointment worksheet that contains the insurance information. Indicate on that report the patients who may have invalid insurance or who may need to change their PCP. *That information must get to the person who will be checking in patients the following day so it is clear who has been verified and who we need to get a card from.*
  5. Initial and date the bottom of the worked report and send that to the billing department in the batch *along with one copy of the web page for each change that was made* (any that were printed due to the “red” or shaded column).
  6. The other copy of the web page goes into the chart in place of the ID card. *You do not need to ask for the ID card or make a copy if the insurance has been verified and there were no changes, or if the change was printed from the web page.*
  7. Insurances not yet included in this report will need to be checked via the web sites individually.
- WHEN YOU NEED TO GET A CARD/COPY AND SEND A CARD COPY TO BILLING:
1. All new patients.
  2. If there is a change that was not able to be verified through the web verification process.

Source: Hudson Headwaters Health Network. Used with permission.

the accuracy of data before the health data are released to PFS.” HIM is now doing its own detailed map of use of its ambulatory revenue management system, “so that we can justify where we may need to use contract help.”

*Key Issues:* The “is” map revealed some limitations in the integration of technology. “For example, our technology for medical necessity validation is in one system, but some areas were doing scheduling on their own without access to that system,” says Bowen. There were also too many non-value-added steps, where instead of data going downstream, they were first looping back to the original department.

#### **Case #2: Hudson Headwaters Health Network**

*What:* Set up and document a web verification process to enhance and standardize the way receptionists at the New York-based network’s 12 community health centers verify coverage status and demographics for commercially insured patients. The goal: Reduce demographics-related claims denials.

*How:* The Denials Workgroup was an offshoot of a Patient Business Services Committee, which includes the CFO, COO, director of administrative services, director of patient business services, billing managers, and several lead receptionists. One of the workgroup’s first tasks was to create a reception-related denials tracking report in order to get a handle on the denial rate. After that, the group set a corporate target for 2003 to reduce the denial rate from 6.3 percent to below 5 percent and developed the new verification process, which featured the use of insurers’ web sites. Over time, the process was refined to address problems that arose and put in outline form for receptionists to follow. (See page 2 for the process document.)

*Key Issues:* For CFO Eric Burton, one of the biggest lessons learned involved the need to ensure appropriate feedback from front-line staff in developing or refining tools. “It turned out that the receptionists didn’t even know how to decode the information on the sites,” he says. “So we had to step back and create a training tool with process keys that spell out where the ID number is, where the date of birth is, etc. The tool was created by an IS staff person and that was really the turning point in making this process work.” (See page 4 for the training tool.) In addition to reducing claims denials, the new process freed up time for the receptionists by automating a big part of the job; they had been spending a major part of their day trying to verify information for the next day’s appointments.

#### **Case #3: Mercy Medical Center-Sioux City**

*What:* Create close to 100 process maps for patient access and PFS for use with new information system. Goal: Identify process issues and concerns in relation to use of the new information system.

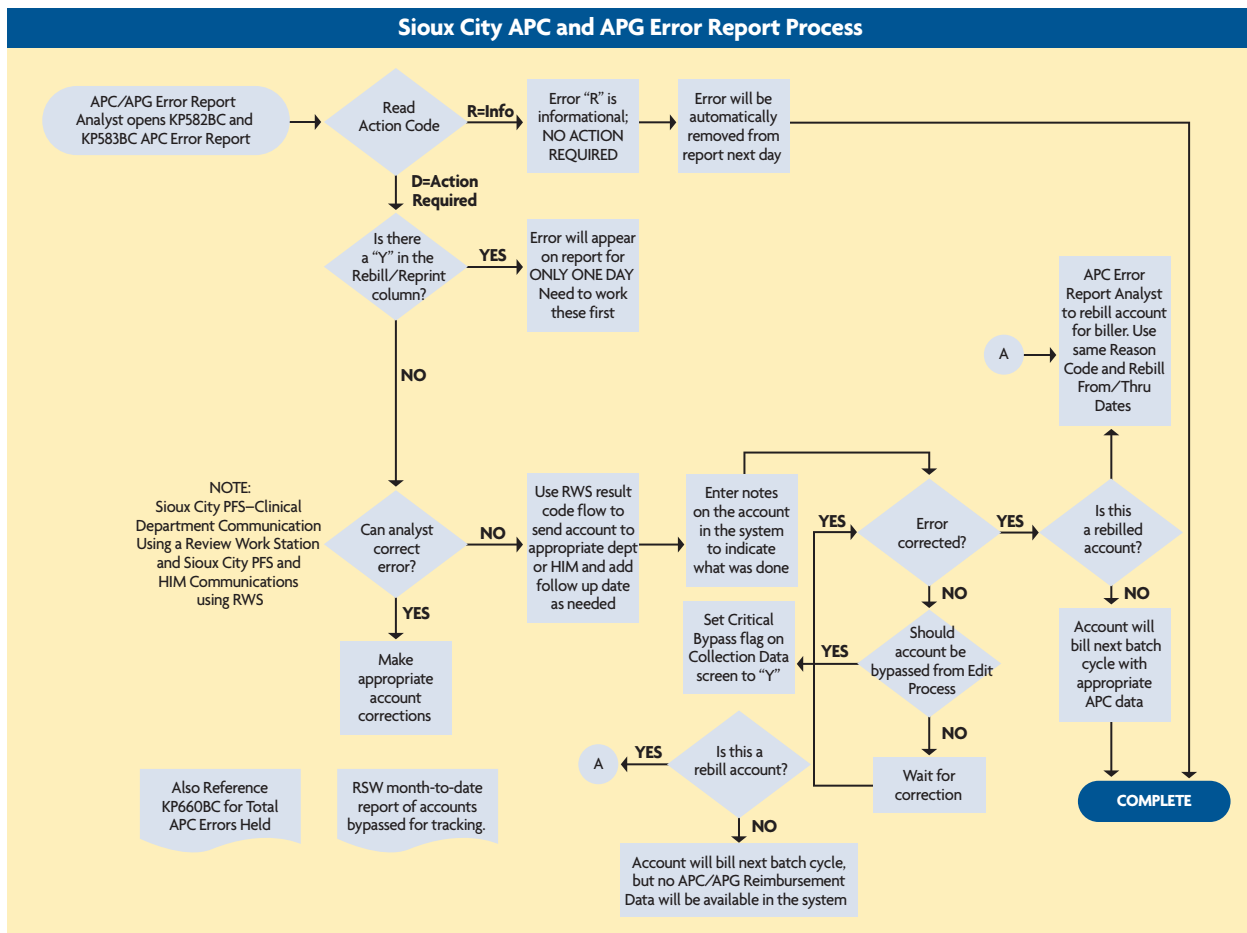
*How:* Each process was tackled by a small group that included both managers and superusers or key staff acknowledged as leaders within a department, according to Johnny S. Tureaud, director of Patient Financial Services. “Previously, we had relied on policies and procedures—general statements about what we wanted to do and outlines of how to do it. But this doesn’t take into account any variations that may occur. Process mapping allowed us to really take a critical look at what we were doing and identify gaps or holes that we could then begin to address. Then we could build in policies and procedures to support the process flow.” More than 40 processes were mapped

## Hudson Headwaters Health Network Receptionist Training Tool

8	<b>Member Information</b>		
	<b>Member Name</b> Jane Doe	<b>Gender</b> Female	<b>Birthdate</b> 11/21/1958
7			
<b>Plans</b>			
4	<b>Plan Name</b> Direct HMO	<b>Status</b> Active Inactive	<b>Effective/Cancel Dates</b> 01/01/2005– 01/01/2003–01/01/2005
1	<b>Plan/Benefit Summary: Direct HMO</b>		
6	<b>Group Number – Name</b> 376645-Moses-Ludington Nursing Home Co., Inc.	<b>Contract Type</b>	<b>Member ID</b> 8092299700
			<b>Prefix</b> YLN
			<b>Relationship</b> Self
2	<b>Current PCP</b>		
	<b>Provider ID</b> 74K99	<b>Physician Name</b> Richard McKeever	
3	<b>Medical Liability</b>		
5	<b>Medical Benefits</b>	<b>In Network</b>	<b>Out of Network</b>
	<b>Mental Health</b> \$25 Copayment	\$25 Copayment	Call phone number on back of member's ID card to inquire
	<b>Hospital Benefits</b> – Inpatient – Outpatient	\$500 Copayment For information regarding this benefit, use the Click to Talk feature to contact us.	For information regarding this benefit, use the Click to Talk feature to contact us.
	– ER	\$50 Copayment waived if admitted	\$50 Copayment waived if admitted
<b>Wellness</b>			
	<b>Physical Examination</b>	1 visits/year	
	<b>Mammography</b>	ages 35-39 - one ages 40 and over - one annually with or without the recommendation of a physician any age, as required, for covered persons having a prior history of breast cancer or whose first-degree relative (parent, sibling, child) has a prior history of breast cancer.	
	<b>Well Child Care</b>	exam at birth in hospital – 1 visit birth to the 1st birthday – 6 visits ages 1 to 4 - 6 visits ages 2 to 17 - 6 visits ages 8 to 19 - 2 visits	
	<b>Well Women Care</b>	Unlimited times annually for routine OB/GYN exams and any necessary follow-up care. For HMO and POS, PCP referral not required.	
<b>Benefit Limits</b>			
	<b>Spinal Manipulation</b>	<b>Contracted</b> Unlimited based on medical necessity	
	<b>Speech Therapy</b>	30 visits combined with Occupational Therapy	
	<b>Occupation Therapy</b>	30 visits combined with Speech Therapy	
	<b>Outpatient Physical Therapy</b>	30 visits	
	<b>Inpatient Physical Therapy</b>	30 days	
	<b>Mental Health</b>	Call phone number on back of member's ID card to inquire	
	<b>Substance Abuse</b>	Call phone number on back of member's ID card to inquire	
	<b>Home Health</b>	200 visits	
	<b>Hospice</b>	210 visits/days	
	<b>Skilled Nursing Facility</b>	60 days	
	<b>Waiting Period</b>	No Waiting Periods	
	<b>Student Coverage</b>	College students are covered to age 25	
	<b>Dependent Coverage</b>	Dependents are covered to age 19	

- 1 Insurance ID Number and Prefix
- 2 Relation Code or Member Suffix
- 3 Primary Care Physician Name
- 4 Effective Date/Termination Date of Coverage
- 5 Copay
- 6 Group Number
- 7 Date of Birth
- 8 Patient Name

Source: Hudson Headwaters Health Network. Used with permission.



Source: Mercy Medical Center-Sioux City. Used with permission.

in 18 areas just for PFS, right down to how to post a denial. This work was completed prior to implementation of the new information system and the maps were used for training.

*Key Issues:* Tureaud aptly describes process flow as an evolving animal. “You design it and then once you apply it to the real world, you find that you need to make little tweaks and updates.” An example is how Mercy’s process of correcting errors in Medicare and Medicaid claims originally required the analyst to examine each claim for errors and determine

where they should be sent to be corrected. “Once we identified the lab as a major source of these kinds of errors, we developed a report that identifies and automatically sends to the lab accounts that have a lab-related error.”

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