

# Securing Revenue with Improved Data Use



Denials. Underpayments. Rejects. Unbilled inventory. These are some of the most common areas where hospitals fail to realize revenue for services they have delivered.

And while most hospitals routinely target these functions for improvement efforts, all too often they remain a significant threat to the bottom line.

For many organizations, financial success depends on a strong commitment to revenue integrity. Revenue integrity is about performing each process in the revenue cycle correctly the first time to eliminate redundant work processes and rework as a means to drive inefficiency out of the revenue cycle. Such a focus includes collecting accurate demographic and insurance information, coding accurately and completely, maintaining complete and accurate system master files, and managing denials, among others.

To fully support revenue integrity, hospitals need to adopt a holistic view of the revenue cycle that incorporates the leadership necessary to transcend boundaries around traditional functions and roles in order to establish:

- Organizationwide understanding of the importance of revenue integrity to the hospital’s mission
- Effective communication across all aspects of the revenue cycle
- Processes that ensure appropriate collection of data, transformation of data into information, and actions based on the information—actions that prevent revenue loss before it occurs
- Technology support for these processes, including automating routine actions

- Reporting of information about revenue integrity for senior management guidance and for middle management actions
- Continual review and analysis of causes of revenue loss to improve processes systemically

Developing such a focus often begins with timely use of key data. The more efficient an organization is at capturing proper performance information and transforming it into actionable strategy, the better positioned it will be to adapt swiftly to changes and prevent potential problems from escalating.

As shown through the following real-life examples, providers often maintain revenue integrity by leveraging people, process, and technology for improved data use.

## ■ Quality of the Patient Bill

At the heart of a hospital’s revenue is the quality with which it develops the patient bill.

Every element in the patient bill has to be right to head off rejects, denials, underpayments, and unbilled charges. That means the hospital must accurately capture patient demographics, insurance information, and preauthorization status. In addition, documentation of any conditions present on admission must occur so appropriate charges can be developed.

Many of the best hospitals have a quality assurance process in place to test the integrity of their data within 24 hours of the data being entered. This process may involve having each department review all of its charges for the day before to make sure nothing has been missed and/or doing an

## Fundamentals of Revenue Integrity

Holistic View Supported by Leadership, Process, Technology										
Common Element: Timely Capture and Use of Key Data										
Front End Scheduling, Preregistration, Patient Access				Middle Charging, Coding, Utilization Management				Back End Billing & Collections, A/R Management, Cash Posting		
Bill Estimation & POS Collections	Insurance Verification	Medical Necessity	Financial Counseling	Charge Capture	Coding and Documentation	Case Mgmt, Utilization Review	Claims Mgmt & Billing	Expected Reimbursement, Contract Mgmt	Denials & Remit Mgmt	Collections, A/R Mgmt

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automated audit of charges from a systemic standpoint. The latter audit method involves using technology to flag instances where certain diagnoses or procedures are missing their typical accompaniments—for example, an operating room procedure with no recovery room time.

The most progressive practice in this area is concurrent charge capture auditing, according to Patrick McDermott, senior vice president, revenue services, Resurrection Health Care, Chicago. “With this type of process, a chargemaster internal auditor is reconciling the charge slips, the medical record, and the UB-04 forms to make sure that no charges, procedures, or supplies have slipped through the cracks.”

Such a time-intensive auditing approach isn’t something hospitals can afford to do for every bill, so the first task is to define some parameters that will deliver the biggest punch in terms of both compliance and net revenue.

For example, McDermott notes that a provider might focus on bills that are just beneath the level indicated in stop-loss clauses. “If the clause is \$60,000 for a managed care payer, you might look at every bill that is between \$57,000 and \$59,999 to determine if supplies or pharmacy or surgical implant devices were left off; by identifying missing charges, the account may reach the \$60,000 threshold. Or you may find charges that are duplicative or inappropriate and therefore not compliant.”

For the most part, this review process is manual, but there are software programs available that can help hospitals identify typical sources of error.

“You will still need a very careful, detailed manual review,” McDermott says. “But the software can help you prioritize efforts and scope things out based on your particular managed care contracts, identifying claims that routinely have mistaken billings on them.”

At the University of Pittsburgh Medical Center, data capture efforts are designed to drill down and identify actionable error as close as possible to its source. Thanks to a series of innovative electronic components that integrate preregistration and back-office collection processes, the organization is able to identify errors even as soon as the day they happen, based on patient registration, notes Donald C. Riefner, UPMC’s chief revenue officer of hospital services.

## Centralization: Integrity from the Top Down

Ardent Health Care has 10 hospitals, two regional business offices, and one department of revenue integrity. When Valerie Woodbury became director of that department, IT had implemented a high-quality information system capable of extensive reporting. The problem was, she says, the organization wasn’t using that system to its fullest potential.

“We decided that our contract management system—which houses all of our claim information, our chargemaster, our detailed charges, our payments, and our discounts—needed to be brought into synch with our patient accounting system,” Woodruff says.

Today, many of Ardent’s systems—including its data warehouse—are web-based, so individuals in each facility can readily access the information they need and headquarters can pull data from every facility separately or in the aggregate. “Such functionality allows us to compare and analyze certain service lines, to compare markets, and to identify best practices. It also means that if we find a problem that affects one facility, we can correct it at every facility.”

“With thousands of registrations a day, there’s too much data to sift through manually,” Riefner says. “So we developed an automated system that allows us to scrape information off of our patient accounting system. We use denials as a feedback mechanism to create edits in our bill scrubber to hold the bill before it goes to the payer.”

As an example, Riefner describes how his organization can take registration information in batch mode and compare it with that of payer systems through their web sites. “Then, on an exception basis, we can bring back claims that are not correct for whatever reason—a misspelled name, the wrong insurance—and create automated work lists for corrective action.”

For Valerie Woodbury, director, revenue integrity, Ardent Health Services, patient bill quality is very much about checks and balances. “When we get an amended set of rates from managed care, for example, we have one staff member

load the data and another audit the data, and then a manager approves everything before it goes into production. We also audit each one of our 10 hospitals every six months.”

## ■ Payer Rejects

As with most facets of maintaining revenue integrity, reducing payer rejects depends on identifying—and interrupting—patterns of error. Swedish Covenant Hospital in Chicago uses a list of internal codes to identify reasons payers are rejecting a claim, such as failure to meet medical necessity requirements, the patient’s benefits are maxed out, or the submission is a duplicate claim. “This allows us to improve collections and cash flow,” notes Lawrence K. Connell, FHFMA, the hospital’s director of patient financial services.

The codes also assist in developing denial prevention strategies.

“Fixing the root cause of a denial may require some additional work on our part,” Connell says, citing the examples of a payer wanting an explanation of benefits form from another company or asking for additional records. “We don’t like leaving money on the table, so we want to make sure every time that we fully understand why we’re not getting paid.”

Again, applying lessons learned to the front end of the revenue cycle is easier with automation. Hospitals can use registration quality improvement software to create a rules engine that brings typical mistakes and omissions—perhaps as much as 10 percent of total claims—back to the registrar on a worklist in real time, according to Resurrection’s McDermott.

“The payers represent a moving target that’s always ahead of your training, and updating a rules engine allows registration staff to stay on top of the situation on a daily basis. It also fosters greater accountability within the department,” he says.

## ■ Underpaid Claims

When it comes to underpayment, two areas present the most significant threats to revenue:

- The payer hasn’t paid the hospital according to the contract, most likely because the payer’s system can’t adjudicate the rules effectively.
- The payer is accessing inappropriate discounts (the “silent PPO”).

Stopping these revenue leaks requires a hospital to act aggressively, with both primary and secondary claims, because the time to appeal can be as little as 90 days. An essential tool toward this end is a good contract management system, one that models the contract rules to run claims against. Such technologies allow hospitals to calculate their expected reimbursement up front and spot discrepancies quickly.

Certainly, it doesn’t pay to chase every dollar. But, as Woodbury notes, “If you have a trend where every claim on a fee schedule is being underpaid by \$50 and there are a thousand of those, then that’s definitely worth going after.”

She says the system used at Ardent gives staff the ability to find these types of trends. Typically, staff will develop a spread sheet for each issue that lists the multiple claims affected. “We have regular meetings with most of our large payers where we will address specific mistakes that are resulting in underpayment. Once the payer has acknowledged a problem, it’s very easy to have the payer fix the whole group. We don’t have to submit an individual appeal letter on each claim.”

Connell, with Swedish Covenant Hospital, believes that a major cause of underpayments is that some payers do not load contracts correctly on their computer systems. “Sometimes it’s a matter of misinterpretation at either the pricing or the claims level,” he says. “We need to be sure that if a contract is changed or updated, then the terms are fully understood and properly loaded. The simpler and more straightforward the contract language, the less room there is for error.”

As with rejected claims, Swedish Covenant uses predetermined, internal codes designating reason for underpayment. Doing so helps pinpoint troublesome patterns. “We recently renewed a managed care contract and were able to identify those coded underpayments and make them a part of the negotiated settlement,” notes Connell.

While many payers use some type of underpayment module within their registration and billing system to generate exception reports that collectors can work, McDermott suggests turning over that recovery work to a dedicated group of underpayment representatives. “You can divide

up the labor by contract and enable each person to become an expert in the payment clauses for a specific payer.”

McDermott also recommends getting that same team to act as an advisory panel for the managed care contracting department. In this way, he says, providers can avoid the disconnect that often occurs between back-end patient financial services and the contractors. Such gaps are common at many hospitals since these areas typically report to separate vice presidents.

Ardent uses five-person underpayment teams that are segregated from regular follow-up staff. One team is assigned to each of its two major markets. “The kind of work they’re doing requires a little more analysis,” says Woodbury. “It’s harder money to get because you’ve already been paid once.” However, she credits the teams for collecting \$10 million resulting from underpayments in each of the past two years, compared with previous annual averages of \$2 million.

## ■ Denials

Sometimes a whole claim is denied, while other times it’s a single line item. Maybe the hospital kept the patient for four days when the insurer only approved three; maybe a procedure was determined to be not medically necessary.

The better a hospital’s data-mining abilities, the greater its chances will be for identifying and correcting patterns of denials that reflect systemic problems. Electronic remits certainly ease this whole process. But no matter the amount of automation, hospitals need a process for identifying a denial as soon as the remittance is received and getting that information to the people who can do something about it.

Too often, says Connell, the departments that generate the charges hear about their denials from finance when it is three, four, or six months later—far too late to act on the matter. At Swedish Covenant, all claims denials are shared with the appropriate departments every day. “We expect staff from these departments to get back to us within a week or so with an update,” Connell says. “The reason for denial may not be something we can fix after the fact, but it’s always something we can learn from. Everybody is interested in maximizing cash collections and no one likes to have a claim from their cost center denied.”

## First Things First

Revenue integrity efforts hold so much potential for data mining that it can be hard to know where to start. April Langford, vice president, revenue cycle operations, University of Pittsburgh Medical Center, recommends focusing on denials analysis, self-pay cleanup, bill editing, and insurance verification—four areas, she says, where her organization focuses first when bringing its own hospitals online. As she explains:

**Analyzing denials:** “Denials are your main feedback mechanism, so you need to look here to figure out where you need help.”

**Verifying insurance:** “The sooner you can get this right, the easier it is to get the rest of the process in order – you really need to build an intuitive tool for this purpose as quickly as possible.”

**Cleaning out self-pay:** “We found so many things that really should have been billed to insurance when we first started to explore outstanding self-pay accounts, that we now make this review a top priority.”

**Developing bill edits:** “You need to make sure the claims you send to the payer are correct, and this means putting them through your bill scrubber.”

Swedish Covenant also goes through all of its denials at the end of the month, sorting them by denial codes. “So it’s easy to see how many claims were denied for preventable reasons, such as lack of authorization, and to determine the dollars that were actually left on the table as a result,” says Connell. This information is shared with registration staff every week, including ancillary departments that have direct registration.

But what about denials that don’t show up in remittances? As McDermott notes, there is a whole category of hidden denials that are getting buried in contractual allowances.

As an example, he describes a managed care payer calling when the patient is being discharged and saying, “We’re not going to pay this as an inpatient, we’re going to pay it as an observation.”

Given that the average difference between the two kinds of payment is around \$4,500, says McDermott, these hidden denials could add up to a significant fraction of a percent of net revenue being lost. "It's important for the departments involved—patient financial services, utilization review, registration, and medical records—to try to catalog these denials every year," he says.

## ■ Unbilled Inventory

Unbilled inventory represents another potential revenue leak, either occurring in the coding or charging process. As UPMC's Riefner explains, one potential problem area is when a patient has been discharged but the bill doesn't drop because of missing or inappropriate information caught by the claims editor. A hospital certainly doesn't want to send in a claim to Medicare that's just going to be rejected. However, if the organization fails to monitor this inventory to make sure every item is being resolved appropriately, it may end up penalizing itself for finding something early but not doing anything about it.

At UPMC, bill holds are categorized by code, which allows staff to aggregate and prioritize them; each code is associated

with a specific person who is responsible for addressing that problem. "We have an unbilled reporting tool that sends out automatic alerts to those people, and then we do a weekly scorecard across all our hospitals," he says.

In addition to fixing the individual claim, says Riefner, staff basically go through a root cause analysis for each category of hold. For example, a review of excessive bill holds for claims requiring authorization led to the implementation of a Web-based reservation process allowing physicians to schedule same-day surgery and inpatient admissions, and the automation of the authorization validation process for outpatient radiology services. These initiatives standardized data collection, improved accuracy, and significantly reduced the number of claims being held for pending authorization.

## ■ Biggest Challenges

Perhaps one of the biggest challenges involved in using data to support revenue integrity efforts is simply identifying the right data to use. Data on charge capture, data on denials and rejects, data on underpaid claims and unbilled inventory... It can all add up, says Riefner, to data overload.

## University of Pittsburgh Medical Center Bill Hold Report

The CFO examines total claims/charges that are beyond normal hold for each hospital. Such weekly trending of "claim scrubber" bill holds exceeding expectation helps the organization track its performance and intervene quickly when necessary.

Date	Hospital A		Hospital B		Hospital C		Grand Total	
	Total # Accts.	\$	Total # Accts.	\$	Total # Accts.	\$	Total # Accts.	\$
27-Jun-07	34	\$585,433	22	\$150,860	8	\$81,922	<b>64</b>	<b>\$818,215</b>
25-Jun-08	28	\$88,432	35	\$220,174	15	\$25,127	<b>78</b>	<b>\$333,732</b>
02-Jul-08	31	\$147,164	22	\$122,967	10	\$66,623	<b>63</b>	<b>\$336,754</b>
09-Jul-08	30	\$458,292	31	\$217,495	40	\$61,369	<b>101</b>	<b>\$737,155</b>
16-Jul-08	30	\$647,261	29	\$209,162	17	\$64,077	<b>76</b>	<b>\$320,500</b>
23-Jul-08	35	\$153,187	5	\$67,034	11	\$15,954	<b>51</b>	<b>\$236,175</b>
30-Jul-08	41	\$156,690	9	\$128,846	11	\$12,175	<b>61</b>	<b>\$297,710</b>
FY08 Average	79	\$888,991	29	\$224,989	49	\$81,690	<b>499</b>	<b>\$5,882,056</b>
FY09 Average	33	\$312,519	19	\$149,101	18	\$44,040	<b>70</b>	<b>\$385,659</b>
Wk-to-Wk Var:	6	\$3,503	4	\$61,812	0	(\$3,779)	<b>10</b>	<b>\$61,535</b>
Wk-to-Wk %	17%	2%	80%	92%	0%	-24%	<b>20%</b>	<b>26%</b>
FY End %	46%	77%	-74%	-42%	-27%	-52%	<b>-22%</b>	<b>-11%</b>

Source: University of Pittsburgh Medical Center (abridged by HFMA for publication purposes). Used with permission.

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## Supporting a Culture of Revenue Integrity

**D.T. Nguyen, interim president, revenue management segment, MedAssets, Inc., describes ways to garner buy-in among revenue cycle stakeholders for the organization's revenue improvement efforts.**

### Q How do you get the whole organization behind achieving revenue integrity?

A It's essential that all the stakeholders understand the critical success factors of revenue collection and most importantly, are educated and accountable for the execution of their role in the task. Best practice organizations have a standing revenue cycle committee, chaired by a vice president, director of revenue cycle, or director of revenue integrity. This committee includes major stakeholders in the revenue cycle and is charged with the process of reviewing monthly trends, key metrics, and new initiatives as well as implementing improvements for identified revenue breakdowns. Key stakeholders include leaders in patient access, case management, chargemaster, medical records, patient financial services, and managed care.

Organizations should establish goals at every level, making them meaningful to the individual as well as relevant to the revenue integrity objectives. Once these goals are established, success requires that each team member has the tools necessary to guide their workflow as well as measure and report the results of their actions.

Any individual's desire to achieve these goals is reinforced with an understanding of the impact of their work on the overall financial success of the organization, and progress can be rewarded on that basis.

Establishing closed feedback loops that return every missed charge and rejected or denied claims enables staff to learn from and avoid future mistakes. Too often, today's billing and collection processes are marked by ongoing rework, where one team or system routinely corrects the output of another. With an overall organizational imperative to get it right the first time, a hospital's cost and collection dynamics are sure to improve. Solutions and technology infrastructure that include workflow feedback loops and reporting capabilities can be cost-effectively achieved. Moreover, additional training opportunities, including web-based offerings, can educate staff further by encouraging them to take responsibility for their success.

It is the combination of leadership, rigor, and disciplined processes with automated business rules, workflow, and reporting that enables organizations to sustain revenue integrity for improved financial performance.

Source: MedAssets.

Five or six years ago, UPMC had very little data. "We used whatever we had as the basis for starting our improvement initiative," he says. "But now, there's so much data flowing through the system that it can be hard to identify the right indicators or measurements that are going to drive the right behavior."

This problem can manifest itself in several ways. In some cases, people are looking at data that's so high-level they can only determine good or bad, not cause and effect. In others, notes Riefner, "People outside the revenue cycle pull out data that they don't really understand and decide that there is an issue, when, in fact, the data are not relevant to the efficiency of the process or any kind of improvement opportunity."



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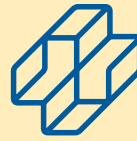
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UPMC manages to avoid many of these difficulties by having a dedicated technology support team, he says.

Woodbury believes the biggest challenge for hospitals is getting the right tools in place, so they can track actual payment against what the hospital is expecting to receive based on its contract and then be able to act when these amounts aren't the same.

"If you can't track your variances, then you have no follow-up opportunity," she says, noting that Ardent takes a conservative approach to these efforts. "We post the remittance advice discount, compare it with what we expected, and appeal if there's a variance; then, when we get the money in, we correct the discount."

Of course, technology can only take a hospital so far. Staff members have to know how to use the technology to drive workflow. The organization must be able to mine the data, identify larger patterns, understand their significance, and devise solutions appropriate for the particular patient and



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payer mix. Real-time intervention also is key for allowing a hospital to continually course-correct without constantly turning the whole operation upside down.

Are such efforts at revenue integrity a burden—or an opportunity? It's both, says Riefner. "If you're not monitoring change, then you're going to miss something. But the sheer amount of change means you can always improve something."



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