



# Revenue Cycle Upgrades: Increase Cash Flow and Lower Expenses

## About HFMA Roundtables

With this article, HFMA continues a series of “virtual” discussions to offer thought leadership and practical perspectives on healthcare financial issues by leading industry professionals. This roundtable offers viewpoints and advice about ways to seize opportunities to improve the revenue cycle. This HFMA Roundtable is made possible through the support of Siemens.

**Hospital financial executives have seen the statistics: About 13 percent of lost revenue can be blamed on underpayments, billing errors, denials, and self-pay debt. Rework accounts for up to 80 percent of billing office time.<sup>a</sup> Viewed optimistically, these numbers suggest the revenue cycle is rife with opportunities to improve cash flow and reduce costs. Hospitals that have succeeded in attacking revenue cycle inefficiencies tell of cash influxes of seven figures or more. But such achievements do not come easily.**

**Significant improvements require significant investments—in training, IT, restructuring, and staff time. But where to start? What changes need to be made first—or will provide the best ROI? Hospitals can learn a lot from seeing what other hospitals are doing. But the best answer often lies in a hospital’s own metrics. Like any major redesign initiative, revenue cycle improvement efforts should be based on sound quality management: Look to your data to pinpoint what needs fixing. Then, measure again to see if the fix worked.**

*Presented here are the thoughts of a group of healthcare executives regarding methods for achieving better cash flow and lowering costs in hospitals and health systems.*

ROUNDTABLE PARTICIPANTS



**Loraine Cincotta**, Director of Revenue Cycle, New York Methodist Hospital, Brooklyn, New York.



**Bill Hilton**, Vice President, Patient Financial Services, Carilion Health Systems, a six-hospital system located in western Virginia.



**Linda Reino**, Chief Information Officer, Universal Health Services, Inc., King of Prussia, Pa. UHS comprises 28 medical-surgical hospitals and 47 behavioral health facilities.



**Graham Sykes**, Executive Director, Siemens Revenue Cycle Managed Services, Malvern, Pa.

ROUNDTABLE DISCUSSION

► **How did you determine opportunities to reduce expenses or increase cash flow?**

► **Hilton:** I have a number of reports that I review daily, weekly, and monthly. All of my directors and managers have their own sets of metrics that help them keep a finger on the pulse of what’s going on. Over time, you develop an instinct that tells you when something does not fit. I typically review weekly activity with our major payers, cash posting reports, aged trial balance reports, and noncontractual adjustments. I have a weekly report that shows me six-week trends, so I know if something is escalating from one week to the next. I look at discharged-not-final-billed weekly from an inpatient and outpatient perspective. I review reports on the accuracy of data collection by our patient access areas, as well as the amount of copays and deductibles collected by the registration staff. Each of these reports provides information that assists us in the management of the revenue cycle.

► **Sykes:** There are myriad reports that are utilized to effectively manage the revenue cycle. At a macro level, we monitor cash as a percentage of net revenue, A/R days, and the percentage of total receivables over 90 days. We also monitor liquidity ratios by payer class. These indicators, as well as other indicators such as write-offs attributable to denials, denials by payer, and bad debt, enable us to identify opportunities for improvement.

► **Reino:** UHS enjoys the advantage of being able to do a lot of benchmarking within our own enterprise. We can identify problem areas by comparing one hospital’s metrics against our other hospitals’ metrics.

► **What are you doing on the front end of the revenue cycle to increase cash flow?**

► **Hilton:** One of our goals this year is to reduce our denials through better up-front capture of demographic and financial information. In particular,

we're being more proactive with the preapproval process for our direct admit and emergency department admit patients. In the past, these preapprovals might have been handled by a registration person two or three days after admission. Today, we engage our case managers early in the admission cycle to better monitor all patient admission issues. The case managers get involved on the front end to review medical necessity and identify when a patient's insurer requires notification of an inpatient admission.

We've had to provide significant training to our case managers. The training sessions present case scenarios relating to specific payers so the case managers can learn about the subtle differences between, for example, the Blue Crosses and the Cignas of the world, as well as Medicare and Medicaid admission criteria.

So far, we're exceeding our target on this initiative. We've reduced our inpatient denials by 15 percent this fiscal year. Our target was 10 percent.

► **Reino:** One of the problems in our industry is making sure that we have accurately identified a patient and have not created a duplicate account. We all know the extra work that is created when you have two accounts out there from a guarantor management and collections standpoint, not to mention the patient care impact.

So we are looking at software programs that you can add to your front end to look up all the permutations of a name. For example, if you type in "Bill," the system will also find "William." Right now, we're trying to determine the potential impact of a software program like this and how much we should spend on it.

► **Improving charge capture in clinical and ancillary areas is often recommended for increasing cash flow. What work have you done in this area?**

► **Hilton:** One significant area we are focusing on is our emergency department charges. The ED is typically where you find some undercharging, because people are very busy or don't have that as their principal focus.

We use a point system to determine our ED levels. The ED services that are provided to a patient equal a point value. When compiled, the points will then equal a service level. In the past, certain ED services may have been under-pointed, over-pointed, or left off completely. We are in the process of recasting our

point system to identify levels of care more appropriately. The purpose is to get it right—to make sure that whatever services we are providing are being documented correctly and that the points are being appropriately allocated.

We are piloting it at our tertiary hospital and will move it out to all of our facilities once it is refined.

► **Reino:** The accurate capture of charges is an ongoing process for us. Right now, we are in the process of reviewing our entire pharmacy chargemaster. At the end of the day, the only way to do this is to go item by item down the chargemaster. It's a lot of work. We have four departments involved: information services, finance, procurement, and quality assurance. We are really stepping back and taking a look at how medications are managed in our hospitals. We're not close enough yet to know what the financial impact of this will be. But we do know that we've identified inconsistencies between the pharmacy and hospital chargemasters. Just knowing there are inconsistencies would lead one to believe that there are opportunities there.

► **Cincotta:** New York Methodist Hospital has recently implemented a system for all of our ancillary departments. The system has assisted us in automating the charge capture process and ensuring we capture charges for all services rendered.

Another initiative for FY05 at New York Methodist Hospital is to conduct a procedure-based reconciliation from professional to technical billing. We will identify a specific service line we would like to focus on, identify a sample size, and then cross-reference procedures billed for by the physicians and compare that to hospital billing. This is an excellent way to ensure we are capturing all billable services and have the necessary charge established.

► **What are you doing to increase cash flow on the back end of the revenue cycle?**

► **Cincotta:** One of our main objectives for FY05 is denial management. We are in the process of developing reports off our billing system so we can identify, monitor, and track the root causes of our denials. This will allow us to focus on specific denial issues and payer trends and should result in increased cash flow.

In addition, timely charge entry is an attribute that can increase cash flow. We are developing a charge lag report to monitor the timeliness of charge entry within our organization.

► **Sykes:** Contract management technology can help hospitals capture additional dollars that may have been left on the table due to incorrect billing processes or payer error. Without software, contract management is often a manual, costly, and largely ineffective process for managing payer compliance with the terms of the hospital agreement. Today’s reimbursement formulas are often too complex to be administered and audited by manual processes. These manual processes often neglect opportunities that exist within the outpatient service line, especially within the higher-volume, lower-balance population of encounters.

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► **What about reducing expenses related to the revenue cycle?**

► **Cincotta:** Our denial management initiative will help us identify the root cause of our denials and reduce outsourcing. Consequently, we’ll see a decrease in collection agency fees.

► **Sykes:** One of our organization’s primary objectives is to displace duplicate and manual processes with automated workflows. The challenge is to implement these initiatives without sacrificing quality. We achieve this by maximizing the electronic exchange of infor-

mation and leveraging best-in-class technologies. Enhanced automation tools, such as document imaging and predictive dialer systems, enable us to significantly increase the productivity of our human resources. An increasing number of hospitals are considering outsourcing as a means of increasing cash, reducing expense, and improving profitability. Outsourcing is an alternative to making capital investments in technology and infrastructure.

► **Reino:** We have what we call a Resource Consumption Initiative. One area we’re looking at is surgery. We compare the costs involved in similar surgical cases. For instance, we ask, why do coronary artery bypass graft procedures cost \$1,000 more for physician A than for physician B? Then we start to look at the resource consumption for those cases. If the patient care outcome is the same for both physicians, then we might want to counsel the more costly physician about unnecessary expenses or waste. It’s a painstaking process. You identify a diagnosis or a case and then you have to pull it apart piece by piece. You can’t do that if you don’t have comparative physician data to share.

► **Hilton:** We have targeted the big, ugly word “rework,” with the goal of reducing our overall costs by 10 percent by next year. Our purpose is to identify and eliminate issues that require us to manage a single event more than once. Each area that I oversee has been charged with addressing two or three significant issues relevant to rework.

For instance, our billing area is evaluating why some electronic claims get submitted but don’t make it into the payer’s system. For example, let’s say we sent 1,000 claims to Medicare. The real issue is not whether Medicare received 1,000 claims, but rather, how many of those claims got into their system. Maybe their system only accepted 990. What 10 claims didn’t make it? Identifying the 10 claims out of the 1,000 becomes critical if we are going to be able to improve our overall processes. We are currently engaged with one of our major payers in a Six Sigma project to identify opportunities for improvement, with the goal of reducing rework for both parties.

► **What up-front changes were necessary before you could make a major dent in improving revenue cycle performance?**

► **Hilton:** Two years ago, the typical revenue cycle functions were decentralized. Today, my position is accountable for the patient access areas, the typical health information management operations, as well as coding and transcription, the system chargemasters, and all facility billings plus self-pay collections. As a result of our joint efforts, we have been able to reduce our accounts receivable by more than nine days.

Centralizing the management of these functions has given us control over many of the variables that might have been left off the table in another day. We've been able to implement process changes that have eliminated finger-pointing and barriers, specifically in our coding, dictation, and chargemaster areas.

For example, on our inpatient side, our health information management group is responsible for compiling charts and getting them to the coders. In the past, there were delays in getting the charts compiled so the coders could review and do their work. Today, both areas are under one management stream, which has allowed us to implement new processes for getting completed charts to coders faster, thus reducing our discharged-not-final-billed by 20 percent. One example of how our processes have improved is that our evening and nighttime health information management operations staff prep that day's discharges, giving the coders an instant work queue for the next morning.

► **Cincotta:** From my past experience as a revenue cycle consultant, I have learned that every organization has a different organizational structure. You have to determine what best fits your organization's needs. Our revenue cycle is more decentralized than centralized. We set up standard biweekly revenue cycle meetings that involve admitting, medical records, case management, and patient financial services departments to maintain the flow of communication. This enables us to work as a team to problem-solve and identify solutions to our issues.

We also implemented a front-end and patient financial services training program. We hired an organization to facilitate the training program, which resulted in standardizing education across our organization. The training provided staff with an overview of the revenue cycle and how each person has a direct impact on the revenue cycle. It was an excellent program and let the staff know how valuable they are.

► **Did you need to implement any major information system changes?**

► **Sykes:** It is important to have a robust health information system. It is also imperative to optimize the system to drive proven practice workflows. We have leveraged best-in-class "bolt-on" technology to further enhance revenue cycle workflows. A primary example of this is our predictive dialer system, which has significantly increased our productivity, resulting in enhanced call center performance, patient collections, and customer service. Additional bolt-ons that we leverage include document imaging, contract management, denial management, claims editing, and electronic data interchange solutions.

► **Reino:** To get to where we are today, we had to standardize the chargemaster in all of our hospitals. So our labs, our radiology, our emergency department are all standardized. Now, we're working on the pharmacy chargemaster.

We made a lot of changes to make sure that all of the information in our information system is in sync. Then, we centralized the maintenance of that information at the corporate office. We built a lot of tools and utilities so the business office can add or change a code and know it is replicated across all our hospitals. This also dramatically helps with issue resolution, because standardized processes and system flows are easier to troubleshoot and resolve.

We also implemented a business imaging system two years ago. All of our business offices are now paperless. That was a significant investment, and we believe it has increased productivity and dramatically improved access. It allows multiple people in the

business office to get hold of the patient folder, and gives collection agencies remote sign-on. It's funny—you bring something like this live and, six months later, everyone takes it for granted. They can't remember what it was like to have to go get a paper chart.

► **How are you monitoring and fine-tuning the processes you put in place to increase revenue and/or reduce expenses?**

► **Hilton:** We track our core competencies monthly. Each year we develop both corporate and departmental scorecard metrics. These scorecard benchmarks are broken into four major perspectives: value (or financial performance), customer-patient-physician expectations, internal processes, and learning and growth. The revenue cycle typically has three or four corporate scorecard goals. Each director who reports to me also has two to three major departmental goals.

For example, the patient accounting department may have a goal of reducing the days in accounts receivable in the greater-than-90-day category. Our goal is to reduce the percentage from 20 percent to 18 percent. The director of patient accounting then breaks that down by his manager. So, he tells the

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manager of the Medicare billing team: “Your A/R greater than 90 days can only be x percent in order for us to reach our goal of 18 percent.” We break it down very specifically by manager and reward the managers when they meet their targets.

► **Reino:** We have a variety of ways that we monitor improvements. But it's really initiative-dependent. Sometimes you intuitively know that a major improvement has occurred. For instance, when we put our business office imaging system in place, we didn't need to measure to see that staff no longer needed to spend time pulling charts. Some things you just have to take at face value. You can spend more time collecting data than you really should. ■

Sources

a. Pesce, J., “Stanching Hospitals' Financial Hemorrhage with Information Technology,” *Health Management Technology*, August 2003.



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