



# Improving Cash Flow with Better Charge Capture and Denial Management



This project is a collaborative effort by MedAssets and the Healthcare Financial Management Association.

It might seem impossible that a patient would undergo hip-replacement surgery without anesthesia, but it's been known to happen. Likewise, there have been cases of surgery to implant a pacemaker without the actual pacemaker. Or at least that's the impression you might have upon noticing such items glaringly missing on the bills sent by the healthcare provider.

The situation is almost humorous, if it were not so serious. Hospitals across the country lose multiple millions of dollars every year due to mismanagement of the billing process. The reasons range from inaccurate charging, such as undercharging for a service or procedure or missing a charge altogether, to sending out claims that are for various reasons deemed inaccurate by the insurance carrier and therefore denied.

"Denials management is uppermost in everybody's mind," says Kim Newland, director of patient financial

services for Lexington Clinic, Lexington, Ky., a multi-specialty clinic with 21 branches in nine Kentucky counties. "It's been a huge, huge topic of discussion with just about everybody for the past five years now."

These service and item omissions and claims denials generally stem from an unhealthy mixture of unwieldy process, improperly trained employees, and inadequate technology. Fixing the billing problem, therefore, means determining the underlying causes and then directing resources toward those areas.

Whether the solution involves instituting new procedures, improving staff training, or implementing new software systems, the benefits should be obvious. Accurate charge capture and claims denial management processes mean not only improving cash flow, but also protecting revenue that the provider is entitled to—and that all adds up to a healthier bottom line.

## Who Knew?

No matter the size of the organization, billing inconsistencies affect all healthcare facilities to some degree—even those that are on top of the problem. On average, providers lose 5 percent of gross revenues, and that can translate into millions of dollars for a single organization.

“There’s no hospital in this country that is accurately charging for all the services it provides. There’s none,” says Joe Pajor, executive director of patient access and business services at Stamford Health System, Stamford, Conn.

Getting paid for all the services and supplies that a hospital provides would seem like an elemental strategy in order for any hospital to function, but many CFOs are not even aware of the scope of the billing mismanagement issue.

While those in finance positions may know that their hospitals cannot stamp “paid in full” on every claim, Pajor believes the industry in general is not being proactive in implementing measures that will ensure accurate charging and reduce the amount of denied claims.

“And I think that’s because a lot of CFOs still say there’s not that much money there,” says Pajor, noting that some CFOs brush aside the issue, arguing that so many services these days are paid on a fixed rate case basis anyway.

That may be true, but Pajor still believes that many CFOs are missing the point, if not the dollar sign.

And, he should know. Pajor says that by better managing Stamford’s billing processes, the hospital was able to recover approximately \$750,000 in net revenue that otherwise would have been lost. He says total net revenues for Stamford are about \$240 million.

“So, it’s significant,” he says. “In this day and age, you start looking at the nickels and dimes, they add up. They add up over time.”

One study by America’s Health Insurance Plans found that 14 percent of claims submitted to payers are denied and one out of every seven claims had to be resubmitted, appealed, or written off by providers. That represents millions of dollars in lost revenue that some CFOs aren’t even looking for.

Aside from the direct impact from the loss of revenue, there’s an additional impact on resources because of the expense associated with reprocessing denied claims.

Even for hospitals where billing problems have not had such a major impact on the bottom line, accurate charge capture and managing denied claims are priorities. “We do see implants occasionally that are missed; we see high-cost drugs that could be missed, even services like OR time and recovery charges,” says Tony Lantzy, assistant vice president, finance chagemaster, for Carolinas HealthCare System, which includes six owned and an additional eight leased and managed healthcare facilities, based in Charlotte, N.C.

However, because so many of these services are paid based on diagnosis-related group and not based on the actual charge, the impact on the health system’s bottom line has not been so significant, Lantzy says. Nevertheless, he realizes the importance of accuracy.

“We want to accurately reflect our cost to the insurance companies,” he says. “We’re not doing ourselves any favors by not reporting our costs.”

With profit margins squeezed so tightly in the health-care industry, it’s hard not to think that any loss of revenue would not affect the bottom line, adds Dave Cavell, business office director of Chelsea Community Hospital, Chelsea, Mich., which has 124 licensed beds and specializes in pain management.

At Chelsea, Cavell figures that denied claims for unauthorized services comprise less than .02 percent of claims and the same is true for rejected claims. Denied claims affect Chelsea and all hospitals, he says, but some providers feel the burden much more deeply.

“Our bottom lines are small,” Cavell points out. “If we were in the 11 percent to 17 percent earnings [ratio] like most Fortune 500 companies, you would not notice much of an impact. But when you’re looking at 1 percent or 2 percent above, and then you have denied claims, it definitely impacts the bottom line.”

## Errors Here, Errors There, Errors Everywhere

With reams of regulatory rules, disparate software systems, and frequently high employee turnover, opportunities for mistakes to occur in the billing process are many.

For many providers, technology issues coupled with poorly trained or even misguided staff can wreak havoc on accurately charging for services or pile up those denied claims.

A community-based teaching hospital with 302 licensed beds, Stamford Health System has had its share of billing issues, according to Pajor. “We saw spinal tap results from the lab, but we never saw a spinal tap test in the charge for the emergency department,” he offers as one example of an error. “We also have found things in the APC world and the CPT world that we weren’t charging for because no one knew we could.”

Pajor says he has heard about incidences of hospitals missing OR charges for one full day because of computer glitches—errors that took weeks or even months to discover. “So, one day of OR revenue never made it on to the books.”

At Stamford, there was a time when the hospital had a full house and patients receiving medically necessary care were being held up in the recovery room past the midnight census. When the bills were sent, some of the patients in the recovery rooms were not charged for any recovery time—only room and board. Upon investigating, it was discovered that a nurse felt she would be overcharging patients if she charged both for the recovery time and room and board. She thought she



was preventing the meter from still running during the delay, so to speak, and didn’t realize that she would keep the hospital from receiving even the payment it was due—for time patients truly spent recovering.

“She didn’t understand that’s not how it works,” Pajor explains. “But she was trying to be fair.”

Often, costly errors can result from technical issues. System interfaces sometimes fail or are improperly linked so charges aren’t transferred to the billing system—and because most department staffers don’t see the bills, they have no idea that their charges never made it to the bill.

That’s why vigilance over these areas is so important, says Lantzy with Carolinas HealthCare System.

“There’s no way you can be ready for those things to happen, unless you’re constantly monitoring your systems and reconciling your charges,” he says. “Those problems can occur and go unnoticed.”

Often a breakdown occurs when staff haven’t been properly trained and educated. Employees are not necessarily lax. But the healthcare process is so

heavily regulated that retaining all the rules and regulations is a difficult process, and one minor mishap can result in lost revenue.

Medical necessity, for example, is a common reason for denials. But to be able to understand what constitutes medical necessity, employees of every department—whether it’s cardiology, radiology, rehabilitation, or respiratory therapy—need to have an understanding of the source documents that govern the scope of service for that department.

Another area that incurs problems that can add up to multiple dollar losses by the sheer volume of errors is registration. At some hospitals, denials related to errors at the time of registration account for as much as 60 percent of total denied claims. Often, the source is a simple mistake that could have been easily avoided, such as accepting an expired insurance card, transposing a digit, or missing a code.

“We found that registration was a significant problem,” says Kim Newland of Lexington Clinic. “Errors in this area were responsible for the denial of 18 percent of our submitted claims.”

The main difficulty, Newland explains, was that registration staff were not seeing the need to verify insurance coverage every time a patient registered. Nor were the employees making sure that claimant group numbers were updated. “They just didn’t understand how their job impacted a claim,” she says.

## Education or Automation?

The importance of an educated and well-trained staff cannot be overstated. Employee errors are one of the main reasons for missed charges and even overcharging. So fixing problems at the front end—through improved training—may go a long way toward solving the problem. But can it go all the way?

The problems at Lexington Clinic, for instance, only began with the registration staff. Addressing this area was relatively simple. “Our registration department

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now reports to the business office,” Newland says, explaining how employees learn how their actions tie to financial performance and that they are expected to be accountable for their work.

Yet as recently as 1998, fully 35 percent of claims submitted to payers by Lexington Clinic were denied, according to Newland. It soon became clear that something more than improved employee training was necessary for the health system to find a solution that would really have an impact. For Lexington, that solution was automation.

“We’ve managed our denials very well in the past few years, but it wasn’t always that way,” Newland says.

At the worst point in the health system’s billing problems, the actual denied claims were measured in feet and inches. “We had two 6-foot banquet tables with nothing but paper on top of them,” says Newland, explaining that every time a denial came in, a copy would be made and placed on the table. It was not exactly the best way to manage the problem, she admits.

“You just can’t figure out what you’ve got, what needs to be done. You can’t prioritize, you can’t track trends,” she says.

In 1999, the clinic began investing in several software enhancements, beginning with a claims scrubber. The software performs customized edits of the claims data and format so they will be submitted to the carrier as error-free as possible. For example, if a clinic service or supply item has been coded wrong, a code is missing, or medical necessity is not appropriately documented, the software can catch that error before it is billed. The software also will perform carrier-specific edits. For instance, an identification number for a carrier's HMO coverage may require digits plus alpha characters, Newland explains, while the same carrier's PPO coverage requires all digits. The system will flag any inconsistencies and make necessary corrections, if possible. Claims that have errors that cannot be fixed by the system are indicated in real time and reviewed by a Lexington employee.

Currently, about 300 claims a day contain an error requiring an employee to review. That's out of about 8,000 claims that are processed daily. Originally, about 19 percent of claims processed through the claims scrubber were stopped for someone to review, Newland says. Now, only about 4 percent of claims require that review.

Part of the reason for the improvement is because as the system highlighted the errors, employees could see what they were doing wrong. "It actually helped train the staff on how to do things right to begin with," Newland says.

In the first quarter of implementing the scrubber software, denied claims decreased by 8 percent, according to Newland, and an additional 14 percent the next quarter. All in all, the software reduced the denial rate to 13 percent, compared with the 35 percent experienced prior to implementation.

An added benefit was improved employee retention. Newland says enhancing the computer systems made employees' tasks more manageable and made it easier for them to be successful in their jobs.

"And," she continues, "our overall turnover rate in our business office is probably about 11 percent, and in this community, for purposes of comparison, it's closer to about 30 percent."

In the midst of figuring out why so many claims were being denied, Newland says the organization discovered something else that proved to be of benefit to the bottom line. The use of custom reporting and denial management reduced Lexington's denial rate even further—from the 13 percent accomplished by the claims scrubber to between 3.5 and 4 percent. And of this 3.5 percent to 4 percent, about half are due to errors by the insurance carrier.

For example, because the automated system made categorizing denials easier, Lexington was able to question one carrier's denial of thousands of claims relating to venous punctures. Upon investigation, the carrier discovered a mistake with *its* process, and that Lexington should have received reimbursement for those procedures.

"And that happens with other types of claims, as well," Newland adds.

Armed with such information—that carrier processing errors are adding to administrative costs—Lexington has approached contract negotiation a little differently. It used to be, Newland says, that the CFO just routinely signed carrier contracts without a whole lot of scrutiny—not an uncommon practice. Now, however, a committee comprised of the CFO, COO, Newland, and specialty and primary care physicians reviews the contract to determine if the rate of pay is acceptable and if the provider will be able to administer the rules of the carrier.

Lexington also devised a payer report card, focusing on such areas as accounts receivable days for a particular carrier and the carrier's denial rate—data taken from computer trending reports.

"And, we use that information to negotiate better terms," she says.

## Bang for the Buck

What solution will have the most impact, of course, depends on the particular issue at the individual healthcare facility. If inaccurate billing or denied claims are the result of employee negligence or a process that is too cumbersome, then providers who focus their resources in those areas will be well served. Of course, the larger the organization, the more likely it is that the issues are interrelated.

While knowledgeable, well-trained employees are fundamental for any organization to function successfully, some in the industry say that the sheer volume of services, supplies, and procedures that a health system provides calls for an automated system of checks and balances that can help to ensure accurate and prompt payment.

So, while training employees better is one solution, it's probably not a permanent one, says Stamford's Joe Pajor.

"Because you train them, and then they leave," he points out. "And then somebody else comes on board, and you start the process all over again."

And even if all employees are properly trained, there are so many rules and changes to rules and codes and changes to codes, "There's just no way," Pajor continues, "any one person, any department, any one doctor can say, 'I'll make sure we're charging for everything we could.'"

About one year ago, Stamford began using a concurrent charge capture review software system that Pajor says has fleshed out the hospital's problems. The system reviews the claims before they're sent out to improve the chances that the claim won't come back denied—and that it's not missing anything. So, for instance, a claim for a pacemaker procedure will include an item for a pacemaker.

Automation also helps with tracking and trending information, which can pinpoint problems more clearly and

lead to solutions more quickly. For example, sophisticated computer systems can not only sort denied claims by reason, but then route the claims to the appropriate department for review. That process also automatically generates a denials aging report, which can be helpful when reviewing accounts receivables.

At Lexington Clinic, a coding denial goes back to the coding department, registration receives claims denied because of their errors and claims denied because of medical necessity or precertification issues, and waivers go back to the physician's office.

The latter was something physicians weren't too keen about at first, says Newland. But once they realized how their office's errors could affect their payment and that the business office couldn't address these issues, the number of denied claims routed back to the physicians was reduced from an average of 100 to 150 per department per week down to less than a dozen per department.

Lexington actually hired a data analyst to create trending reports. The provider also hired a computer programmer who wrote a program that tackled the issue of dealing with claims that were technically not denied, but for which the carrier gave no response. Lexington also used data derived from the computer system to manage a third type of claims problem—those that were only partially paid.

All in all, in addition to having better-trained staff—and getting rid of those claims-covered banquet tables—automation has helped Lexington's bottom line. Despite Medicare's payment cuts and increased patient out-of-pocket pays, Newland says, "We have increased our net collection percentage by 6 percent."

According to Tony Lantzy, Carolinas HealthCare System decided to implement an automated charge capture audit system when a manual audit of a few departments within the health system turned up some missing charges. During the manual audit, the patient's

## Get Top Billing

How much do missed charges affect gross and net revenue? Consider the chart below. Revenue potential is great for healthcare organizations that bill correctly and can supply proper patient documentation.\*

State	Unbilled Gross IP	Unbilled Gross OP	Unbilled Gross Total	Unbilled Net IP	Unbilled Net OP	Unbilled Net Total
AR	\$5,803,265	\$1,236,950	\$7,040,215	\$369,376	\$361,537	\$730,913
AZ	\$5,284,982	\$482,678	\$5,767,660	\$187,422	\$66,028	\$253,450
CO	\$5,362,948	\$2,308,932	\$7,671,880	\$370,872	\$92,403	\$463,275
GA	\$767,146	\$1,343,590	\$2,110,736	\$42,240	\$305,782	\$348,022
LA	\$7,481,664	\$3,390,762	\$10,872,426	\$312,555	\$981,608	\$1,294,163
NC	\$12,832,203	\$7,070,765	\$19,902,968	\$900,437	\$1,994,989	\$2,895,426
TX	\$11,194,170	\$6,301,474	\$17,495,644	\$472,995	\$462,437	\$935,432
VA	\$14,085,891	\$5,812,870	\$19,898,762	\$988,976	\$1,858,453	\$2,847,430

\* Figures listed are potential revenue. Patient charts must be reviewed to ensure what is billed is correct.

Source: Rebecca Hayworth, vice president, charge capture products, MedAssets Net Revenue Systems.

chart was pulled and the documentation in the chart was compared with the charge capture sheet and then with what actually was listed on the claim.

“That’s how we determined that there was a need for some type of safety net that could basically secure the revenue for us,” Lantzy explains.

Lantzy says the value of the automated audit tool has been great. “It’s been really helpful to us, both in catching those charges that are missed and then also in using that as an education tool for the department. They can actually see the charges they’re missing and correct the situation on the front end.”

The automated system sends daily reports to the various departments on everything billed the night before that contains a charge capture issue, he explains. Therefore, the department responsible for correcting those errors can review the claims before they’re sent

out. “So the departments are doing a better job. As they recognize they have an issue, they’re correcting it and getting better at what they do,” he says.

The solution was implemented this past February at the four largest of CHS’s 14 facilities. Lantzy says plans call for the software system to be implemented at some of the provider’s other facilities, as well.

Stamford Health System’s Pajor believes that technology has the greatest potential for improvement for any provider. A capable system, he says, can even reduce the negative impact of a staff that is less knowledgeable than it should be or a process that is inherently flawed.

“My pitch is: Invest in the software that says this is what you should be charging for. As you make discoveries, you update the software and you get an edit in place every day,” he says. “I would strongly say that’s the only way to go.”



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