Rethinking Revenue Cycle Management: Moving Toward Enterprise-Wide Operations

Maintaining the status quo in revenue cycle management is not a viable option for organizations that aim to remain profitable long-term. Looking across the enterprise, health systems can find improvement opportunities and implement best practices that enable better performance. There is great value in embracing a longitudinal view, whether by centralizing business operations or standardizing processes among independent units.

Consolidation Takes Many Forms

Integrated revenue cycle processes look different depending on an organization’s goals and priorities. Some facilities may focus on combining business operations for similar settings, such as across multiple hospitals or all physician practices. Still, others may choose to blend one aspect of the revenue cycle throughout diverse settings—for example, by designing standard approaches to denials management and collections in both physician practices and hospitals. The most comprehensive method involves the creation of shared governance, establishment of standard processes and consistent policies, and merging of patient access and registration, coding operations, and receivables management across various settings.

The Advantages of a Unified Revenue Cycle

When done well, centralization and standardization can elevate efficiency by eliminating duplication and waste. They can also enhance accuracy because patient information either is collected once or, if collected by various departments, is done in the same way every time.

This consistency limits errors and reduces the likelihood of missing information. Centralized business units also can take advantage of economies of scale—buying office supplies, technology software licenses, and other materials in bulk rather than for each individual location.

In addition to the operational benefits, patient satisfaction increases as organizations unify business processes. Patients appreciate smooth registration, easy-to-understand patient statements, and accessible customer service—all services that a more enterprise-focused business can deliver.

Although many revenue cycle operations can profit from integration, centralization and standardization especially can take business performance to the next level in these five key areas.

Patient access. This multifaceted function is often a patient’s first exposure to a healthcare facility. By streamlining the elements that make up this department, organizations can create a more efficient, accurate, and patient-friendly experience. Here are some specific aspects to address:

Eligibility verification. Taking a unified approach, an organization is able to consistently assess coverage across diverse settings, fostering greater coordination while preventing denials due to lack of coverage.

“We consolidated eligibility verification for elective procedures,” explains Dave Charles, director of patient financial services for Christiana Care Health System in Newark, Del. “We use an electronic solution that automatically checks patient insurance. For those cases that pop out of the system—due to a mismatch, lack of insurance, or another concern—our centralized admitting department takes a closer look and works to resolve the discrepancy. This ensures we bill the correct payer initially and avoid denials on the back end.”

Preauthorization. Streamlining preauthorization is also beneficial for limiting back-end rework. “Our admitting
department reviews every invasive procedure that occurs throughout our facility, whether it’s outpatient or inpatient, to secure the appropriate preauthorizations, and works with the physician practice and payer to confirm the person is cleared for the procedure,” Charles says.

Not only can centralizing preauthorization help avoid denials, it can also assist with the appeals process should a denial still occur. “If we determine that a patient does not require a preauthorization for a particular procedure, but the payer disagrees, we can easily put our hands on the information used to make the decision and any dialogue that occurred because all of the work is done out of one department,” says Todd Craghead, corporate vice president of revenue cycle for Intermountain Healthcare in Salt Lake City. “This lets us respond to denials faster and increases our likelihood of reversing negative decisions.”

Obtaining preauthorization can be especially challenging for emergent procedures because the patient’s care is evolving, and an organization needs to rapidly double-check that the case will meet authorization requirements and get payer approval to proceed with care. “We may be a little unusual in the way we handle concurrent preauthorization,” says Christiana Care’s Charles. “We created online portals for each of our major payers. Every day, they access the portal and review a list of their patients who are receiving care and require a concurrent review. The payer can access the patient’s medical record in real time and see exactly the care that the individual is receiving. This eliminates the need for us to notify the payer, and it also gives them the information they require to grant permission. Ultimately, this heads off some communication mix-ups and misunderstandings, allowing us to receive approvals more swiftly and avoid denials.”

**Eligibility counseling.** In addition to proactively verifying coverage, organizations may want to consider standardizing eligibility counseling—working with uninsured or underinsured patients to convert them to an insurance plan. “Using enhanced workflow technology and a more standardized workforce, we developed a consistent approach that includes defined scripts to guide staff on how to engage patients around this topic,” Craghead says. “By correlating efforts between our medical group and hospitals, we are better able to identify patients who could be eligible for Medicaid or some other insurance program. As a result, our uninsured conversion rate went from 7 percent to 9 percent over the course of the past year, which for us is a significant improvement. Not only does this help our hospital in terms of receiving money for services rendered, it also benefits the patients as it reduces their financial burden.”

**Patient payment.** As patients assume more financial responsibility for their health care, the need to reliably collect patient payments increases. Without a consistent method, an organization may miss opportunities and inadvertently leave funds on the table. Garnering payment is best done up front, as it is much easier to collect funds at the point of care rather than chasing people down on the back end. “We have standardized scripts that govern how and when during the pre-registration process to solicit patient payment,” Craghead says. “We introduced workflow technology that has helped guide staff in their efforts to discuss the patients’ financial obligation during the preregistration process. We also leverage technology to assist in creating estimates of the patient liability, which help us better collect on patient balances. We started getting serious about this in 2011 and that year saw a 24 percent increase in our pre-service collection rate, which amounts to several million dollars for a system like ours. Each year since then, the improvement hasn’t been as large in part due to the emergence of high-deductible health plans. We have had to tweak our processes to accommodate those high patient payments and figure out the best ways to capture funds without putting the patient in a difficult position.”

**Documentation review.** In addition to streamlining the front end of the revenue cycle, organizations can smooth cash flow, enhance revenue, and limit denials by employing a robust process for reviewing documentation and charge capture prior to claims submission. Taking an enterprise perspective assists a health system in uncovering global issues and implementing best practices system-wide.

“We have more than 100 revenue integrity specialists on staff,” Craghead says. “These are clinicians and nurses who are very helpful in connecting the dots between clinical documentation and what ultimately becomes the charge. Aligned in key clinical areas—imaging, surgery, wound care, lab, and so on—these specialists meet regularly with clinicians to talk about what kind of documentation supports compliant charging. This strategy has garnered a wide variety of quality-based improvements across our system and also has limited the amount of lost or insufficient charges we experience. For example, we have improved the way we document drug waste. Previously, documentation that supported charging for drugs that are wasted during a
procedure was often insufficient. The revenue integrity team worked to develop guidelines on how to improve documentation in a way that supported our ability to charge for this waste in a compliant manner.”

Leveraging technology can be especially beneficial when trying to ensure robust documentation. “We employ an automated solution that reviews our outpatient services and compares them to the diagnosis to see if they meet medical necessity,” says Christiana Care’s Charles. “We have a centralized medical audit team that handles the edits but also is responsible for educating physicians about what is missing from the documentation and how the provider can elevate information specificity to better support medical necessity. This medical audit group works closely with our clinical documentation improvement (CDI) team to make sure we are documenting appropriately and sufficiently. Each of these groups interacts with the patient medical record, so they can coordinate efforts and send a consistent message to physicians about what is required.”

Performance improvement. As organizations rely on integrated systems that span the enterprise, it becomes easier to make use of internal comparisons to set targets, benchmark performance, and identify strengths and weaknesses across care venues.

“We report out key metrics to all of our financial and clinical leaders every morning, showing our performance with a variety of measures, including outpatient revenue, late charges, clean claim rates, and so on,” says Carol McDonald, vice president of patient billing for Albany Medical Center in Albany, N.Y. “This report also includes alerts that highlight if anything doesn’t look right. We can quickly determine whether this is a one-time issue or a larger problem, allowing us to temper our interventions accordingly. Moreover, by having consistency with all our processes, we know the numbers paint an accurate picture of what is actually happening. For instance, since all units input charges in the same way and within a defined time frame, we know that our revenue number is accurate. It used to be that because departments submitted charges at different times, a daily drop in revenue could signal a large-scale problem or merely that someone just didn’t get their charges in on time. We do the reporting from our financial system through our morning dashboard. We also developed an interface reconciliation report that has preloaded normative volumes. When the charges don’t process as required or the volumes are higher or lower than our normative averages, an alert triggers. Then it is the department or process owner who is on the hook for sending out the update, the all-clear, or just sending the charges they may have forgotten to send in the prescribed time frame. This was developed with the business office, integration teams, and our clinical department liaison.”

In addition to responding to problems and identifying improvement opportunities, consolidated data reporting also lets organizations monitor the impact of any changes and easily make adjustments. “For all the metrics we collect, we look at them on the hospital level, roll them up by region, and then aggregate them in total,” says Intermountain’s Craghead. “We also review metrics over time to uncover performance shifts, implement response strategies, and check whether any new initiatives are working. If we examine patient cash as compared to patient responsibility and spot a concerning trend, we can apply best practices to influence cash collection, including prioritizing accounts or offering payment plans. We can then note the interventions’ impact, tracking performance after we on-board new processes and procedures to gauge whether they are working or could benefit from further tweaking.”

Staffing. As health systems bring in new technology and make changes to their operational processes, staffing requirements ebb and flow. At the same time, new regulations—such as the Affordable Care Act and ICD-10—substantially expand the need for rapidly deployable trained staff to tackle challenges such as dual coding and increased census. By taking a more enterprise-wide approach to the business office, organizations can smooth some of the challenges associated with staff utilization in today’s shifting landscape.

“We have found that by standardizing processes we can be more flexible and easily send staff where we need them,” says Albany’s McDonald. “If someone is ill or out on vacation, we can backfill and quickly place a person with the depth and breadth of knowledge where they are needed so that work performance is seamless. We use consistent technology throughout the organization and we are applying Lean methodology to business unit workspaces so that if an employee comes to a department to cover for another, the staff person knows exactly where things are located and how the department’s processes work. For instance, a staff person covering registration would know where to look for copay receipts, labels, and any other supplies. They would be familiar with the technology system, and the scripts the person would use to communicate with patients would also be the same regardless of location.”

Staff can even move between the hospital and physician practice sides of the operation as
organizations bring the two entities closer together in terms of process and flow. “As our hospital revenue cycle has become more efficient, we have been able to deploy staff to help with registration and billing follow-up on the medical group side,” says Intermountain’s Craghead. “Our ability to do this has infinitely improved by having a single and completely integrated system as well as a centralized reporting structure. Because we reorganized and both the hospital and medical group business office staff report to me—either directly or indirectly—I can send individuals anywhere we need them. We’ve done that with our coding and transcription staff as well.”

**Remaining agile.** An integrated revenue cycle management philosophy can support greater flexibility for organizations that are adapting to external market pressures. Whereas siloed entities might be constrained in their ability to quickly respond to new dynamics and realize global change, having a more longitudinal view can break down barriers and expedite change management.

“If we are looking at a change, we can gauge how it would impact both sides and what has to be done in each area to accomplish the change,” says Christiana Care’s Charles. “Basically, we can see the bigger picture and we’re not dealing with autonomous departments trying to work through all the details.”

Being more cohesive also helps health systems implement new processes more quickly. “By standardizing, you don’t have to worry about one-off issues because there aren’t 20 different ways of doing things—there is one,” says Albany’s McDonald. “This lets you adapt to changes and new scenarios more swiftly, fostering smoother implementation and training because you develop the best ways to on-board, educate and apply those across your entire system.”

Since hospitals and physician practices are being asked to do things they have not done before—emphasize value over volume, put the patient at the center of the financial experience, and shift financial processes up front, for example—many new initiatives may require multiple iterations before an organization can settle on the right way of doing things. Integrated business operations allow systems to tweak processes more easily and therefore remain nimble. “For instance, if you think about the health insurance exchange marketplace and all those people who are moving from uninsured to insured status, organizations must continually refine what they are doing to influence the outcomes and get patients the coverage they need,” says Intermountain’s Craghead. “By having a central business office, we can test different changes and modify our scripting about eligibility counseling to better direct the patient to an appropriate insurance product. We can then assess those changes and note if they are working or warrant further refinement.”

**Consolidation Is Worth the Effort**

Regardless of how your organization chooses to pursue an enterprise-wide revenue cycle management strategy, the benefits of this endeavor are clear. As providers continue to navigate the greatest amount of change the industry has ever seen, they will need to embrace the concepts of streamlining business operations, implementing best practices, and shifting from a siloed mentality to a comprehensive program. By pursuing centralization and standardization, organizations can be more flexible and adapt to the changes in a way that improves patient care and sustains financial viability.

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