**Hospital revenue cycle best practices:**

Operational assessments are the key to getting immediate results in your revenue cycle. But for many managers who are too close to their operations, a third-party assessment provides the most objective outcome. A good consulting partner must not only be objective, he or she must also be patient and a good listener. Both sides must have the commitment to allocate time for the project completion and the dedication to involve all levels of staff. This level of full staff participation requires the establishment of realistic deadlines.

If possible, prior to engaging a consulting partner, start with the end in sight. Target your key end results and thus set project objectives. Define clear goals and objectives, and conduct a brainstorming session with staff, listing issues that need to be addressed before conducting the assessment. Setting targets must be a balance between the current status of performance and best practice standards. Set the focus on best practices by selecting your team with an eye to the best individuals to identify key issues and barriers.

By keeping the end in focus and identifying the potential outcomes if key issues are resolved, the following will improve:

\* Quality of data collection;

\* Net revenue;

\* Productivity and performance;

\* Cash collections; and

\* Re-work.

Although management over the process points in the revenue cycle is on all branches of the hospital organization chart (finance, nursing, clinical services, etc.), patient accounts is the key stakeholder. Management of revenue cycle areas therefore requires the PFS manager to track the outcomes of other managers' areas of responsibility. Accordingly, they must look through all the processes to make sure that everything is really working the way it should, with no exceptions.

The Hospital Revenue Cycle

Phase 1: Front-End Processes

Every successful outcome measured in the revenue cycle actually begins with the right steps taken in the front-end processes. The first contact point in the revenue cycle is the scheduling event. Revenue best practices have therefore focused on ensuring quality and completeness during the scheduling process. Several best practice strategies for scheduling include:

1. Training staff with scripting for more efficient dialogue to capture all required data, including correct procedure codes, full demographic data, and all required financial and payer data;

2. Making the right investment in education and systems, such as improving staff education on clinical procedures scheduled to assure their knowledge of protocols/scheduling intervals for treatment regimens (by diagnosis/procedures); and

3. Investing in an expanded telephone system to route calls and assure excellent provider access for scheduling.

Best Practices: Pre-Reg/Registration

The next step in the revenue cycle is the pre-registration process. To assure the maximum benefit of the pre-registration event, set standards that assure completing the data set as quickly as possible after the scheduling/admission notification. Many registrars mistake the "three-day" standard as meaning that they have all patients pre-registered at least three days prior to the date of service. Best practices require, however, that all pre-registrations be completed within three days of scheduling/admission notification. Establish a minimum data set that encompasses all the data elements required to establish a "clean claim" and ensure the payment of the claim. Establish training for staff around these quality standards. Training about the complete preregistration process must include scripting about deductible and co-payment collection.

Best Practices: Eligibility Verification

Every step in the registration cycle is directed to completing an accurate, billable patient record. The final step, eligibility verification, also verifies the quality of the data gathered. If the patient's data is not complete and accurate, there is rework (even re-interviewing the patient) to get a complete data set for insurance benefits "locked in" for billing purposes. Every step must assure the quality of data collection: One cannot assume that the data is correct from one visit to the next.

Best performers have discovered that developing a central insurance verification unit is the most effective. A centralized team can take advantage of the best technology, such as optimizing eligibility software. Using the most robust eligibility software possible will assure more productivity and higher data integrity. Particularly valuable is the feature that takes the direct data from the registration and matches it electronically to the payer without the registrar intervention; so there is a one-to-one match with every data element without the risk that additional human error is possible.

With this technology, as soon as the data for the insurance is entered into the system, in the background, the product goes out electronically and connects with the payer database. It brings back the data to plant in the notes field of the registration screen. Even before the rest of the patient interview is complete, the registrar can see the outcome and, in some cases, say, "Your co-insurance and deductible will require a payment. How would you like to handle that?" If the data is incorrect or eligibility denied, the script would be, "Do you have another card? That one did not go through." Hold the software company accountable for the operation of their software, including timely data exchange. Accurate mapping of the data retrieved and interfaced to the hospital information system (HIS) is essential.

Even though the patient may be eligible for benefits, the service he or she is requesting may require a separate authorization. Strengthen the authorization process by collaboration with the clinical department providing the service.

Unfortunately, fewer payers allow a "clerical" authorization wherein a simple call of notification of the patient's scheduled service is deemed "authorized." More often, the payer wants to exchange detailed questions and answers about the plan of treatment and the ordered services. This will delve into the timing and depth of services and patients' medical history. In some cases they want to drill down into treatment alternatives. Obviously the person from the provider side working with the payer must have a clinical background. Few hospitals employ an admissions nurse performing these duties unless the case management team is expanded to accommodate these duties.

Frequent calls to the payer are required to maintain the appeal data base in case of a denial of payment after billing. Detailed records of these contacts must be maintained and easily retrieved for each account. These records must contain dates and times of contact, the insurance representatives' names, phone numbers, and detailed conversations and agreements.

Best Practices: Financial Counseling

Eligibility vendor tools at the point of service enable the provider team to complete their financial counseling early in the patient contact cycle. As a result, best practices show increased collections of co-payments and deductibles before admission or at the point of service. The primary resource for locking in payment of patient balances after insurance payment (or dealing with the uninsured patient balance) is the financial counseling team. These are the bankers. They are the one component of the revenue cycle that really sets the financial tone of the hospital-patient relationship. They must have training on the payment options, insurance process, and common patient disputes.

Positioning of financial counseling representatives at the emergency room point of service is critical. Although their contact with the patient starts in ER, they must have shared responsibility throughout the facility to support financial counseling all the way through the patient stay. One key training piece is development of a strategy around when to approach patients in-house (in the ER, on the patient unit/ inpatient floor, or at discharge).

The financial office must provide registration with effective scripting and set an expectation of payment from each patient contacted. The collections scripting must start with pre-registration and registration. Point of service collections is a function requiring staff who are in these positions that are willing to ask for money: We must set the expectation that payment is not an option.

Establishing a position for bedside registration is a new trend to expedite the complete record. In the extreme best-practice model, the claim would be completed by a coder in ER. The addition of skilled, certified team members with an RN or coding background can also assist in accurate patient transfers that require "bed-level" status changes. They can provide invaluable QA review for errors of each service type so that every claim is correct before discharge. Although achieving this standard is a rare best practice, it will maximize the benefits of a good revenue cycle process.

Patient satisfaction is built around choice. Accordingly, when discussing the patient's payment for his or her stay, multiple payment options should be offered to the patient. More choices make the patient more confident regarding control of his or her budget. These options start with the full or partial payment at the point of service. Another option is up to three equal payments within 90 days (also known as 90 days same as cash).

Patient choice expands when payment option products are provided by vendors. These outside companies have the access to long-term funding and technology that assure payment. These products assure that patients are billed timely, that shortfalls are tracked, and that all debt payment regulations are observed. There are many products with banking support that offer up to ten years in payment deferment. Most common best practice products access credit reporting tools to assist in proper matching of the patient with the best payment option.

Key performance indicators are based on standards common in the health care industry. The front-end process should focus on:

\* Registration QA percentage;

\* Admissions patient satisfaction percentage;

\* Pre-collection denial percentage;

\* Point-of-service collections percentage;

\* Timely filing denial percentage (this shared with PFS); and

\* Medical necessity denial percentage.

Phase 2: Middle Processes

Best Practices: Utilization Review

Payers require constant concurrent monitoring of their patients during their stay. Even with the completion of the patient demographic and verification of benefits. Additional clinical intervention must go beyond the clerical-level staff requests for treatment authorization. A nurse would best be designated for authorization follow-up, similar to an admissions nurse.

It is also a best practice to have the medical director provide back up and support. Medical directors need to be a part of the revenue cycle team. The medical director is there to also help get what is needed from the physicians to process claims correctly.

The best practice is to maintain the focus for concurrent review. Concurrent review includes constant monitoring of each hand-off to successful closure. Consequently, call backs to the insurance companies are imperative. Utilization review staff must invest resources for a nurse to be designated for authorization follow-up.

Many best-practice hospitals use the services of a "hospitalist" to support the utilization management nurse with concurrent review. Health information management (HIM) is a major player in assuring complete documentation of the clinical data set, assuring that the data supports the level of service provided. One hospital was able to set up a room in the dinning room of the physicians' lunch room. This provided HIM easy access to physicians for follow-up on charts. They were able to sign their charts while eating lunch.

Communications technology can greatly assist in further cutting administrative costs for the clinical team. Providing the administrative support for timely discharge orders and quickly linking with the insurance company translates to financial success. Auto-dialer technology and assist-call technology can really speed up the process and even cut down on "hold" time experienced with calls to the insurance company.

Best Practices: Charge Capture

Another concurrent process with the care event is the charge capture. The effective flow of this process in the revenue cycle starts with a good foundation in the charge description master (CDM) management.

Improvement of charge capture requires a full audit of all process points:

1. Review all order entry methods.

2. Reconcile all system to system interface points.

3. Inventory and verify the various charge capture forms.

4. Audit and test order entry to final charge.

5. Re-educate clinical staff.

Finally, examine and test the charge capture responsibility points on each shift, each day. Ask who is responsible per department for accurate charge capture (many clinical staff refer to this function as "billing," which can be confused with claims billing performed in the business office). Examine who backs up for weekends and holidays. Hospitals do not close; therefore, charge capture should not stop on Friday night.

Often late charges occur when the charges are backlogged from Friday to Monday. Strict standards for timely charge submission should be enforced. Example: If the suspense hold is four days, do not let charges go through later than that. A common myth is that setting out the suspense days to provide a larger charge submission window cuts down on late charges. One hospital set its bill hold at 15 days and is still having problems with late charges. Run a report that shows the number of days from service date to charge submission date. Set the plan around the specific problem departments that constitute the majority of late changes.

Concurrent charge capture reviews are necessary, examining the final charge detail against the medical chart. This must be performed by professionals with a nursing background. Five percent is the average lost charge rate. The process must examine the entire charging perspective, looking for overcharges as well as undercharges. Standards should require balancing department revenue daily--there should be no exceptions.

Full charge master reviews are very important. CDM reviews must be ongoing, with complete reviews on a monthly basis. Create a revenue integrity unit to conduct a full CDM review utilizing "Bolt-on Technology and Knowledge/Scrubber" system tools. These are designed to scan concurrently for any compliance gaps or revenue gaps in the charges and their companion codes (CPT and diagnosis) in the claim development process.

Observe a daily practice of balancing the revenue for each clinical department using a charge audit and reconciliation process. Many best practices include assigning the charge audit and reconciliation process to "department charge police" who balance department revenue daily.

Additionally, keep an aggressive annual charge master review process going annually. Conduct an industry peer group (regional) provider pricing comparison. Using a credible vendor product that provides objective data about all your peer pricing will keep you clear of the anti-trust price fixing regulations that come up if you try to gather your own pricing comparisons with peers. A third-party vendor is deemed "objective" and can provide CMS data with examples from actual peer providers.

In addition to an annual "check-up" for the CDM, review all order entry methods (system/voucher) to identify gaps or duplication. Re-educate clinical staff on the proper charge process.

Establish an HIM task force (led by a department director) for chart review to verify the complete cycle of charging and coding review. The HIM manager and the medical director need to be a part of the revenue cycle team.

Establishing a "management of information committee" can provide a good review group for the data and promote education outreach for the findings of the reviews. The health information management leadership, the billing manager, and the compliance manager should be in the task force. To expedite a good revenue cycle process, HIM must use a robust encoder with quarterly updates for CCI and LMRP edits and assure that concurrent review is system-driven rather than manual. Selection of the right HIM tools requires a robust encoder with quarterly updates for keeping up with the correct coding initiatives (CCI) and the local medical review policies (LMRP).

Before HIM can code, they must have a complete chart. Tracking the physician's documentation backlogs is critical as a strategy to keep charts completed on time. Easy access to computers for chart review in our electronic health record (EHR) era is also important. The staff in HIM/medical records must understand that they play a huge role in the generation of cash into the hospitals to complete the revenue cycle.

Set up the performance indicators for every step of the revenue cycle leading to claims submission and make sure they are actively communicated to all stakeholders. Ultimately, cash is the KPI for the revenue cycle. KPI also stands for "keep processes improving."

Unfortunately the revenue cycle is somewhat a downhill process and its results (good and bad) end up in Patient Financial Services much as all products end up in the inspection department of a factory prior to shipping. Good quality equals a smaller "rework" team.

Phase 3: Back-End Processes

Best practices in claims processing focus on lowering the "touch rate" of claims resulting from re-working data to get a clean claim. If we have met all the requirements of the clean claim standards for submission to a payer, we would not be touching these accounts prior to sending them into the payer.

Any best practice operation must have the right tools including a robust billing scrubber updated with correct payer edits. Optimizing software regularly rather than doing QA on every claim can shift the biller focus to working claims that hit the exceptions edits. The ability to work claims "by exception" is the most effective staffing model. Most standards are set at an 80 percent clean claim transmission rate (without manual intervention), thus only "touching" the 20 percent or less that fail edits. Average bill submission from discharge to out the door is just over 10 days. Billing managers need to have the most qualified billers working with the best payers to make sure that those claims are flowing unobstructed.

Tracking the source of claims errors provides strong data back to the source of the error. Often the key departments in the revenue cycle: registration, clinical, HIM, and charge capture, are the source of most claim errors. Ongoing education facilitated by the billing manager should include routine orientation for registration personnel. Billing must provide the information to the front-end staff about the problems triggered in the front-end process.

One barrier to reaching best practice status for the billing team is the tendency for billers to remain silent about their problem claims. Although most underestimate the cost of each "fix" they make to claims, some staff are more concerned about their production goals than about long-term billing effectiveness. Billers should not have a delete function in their control. This will prevent any biller from deleting claims to meet production work goals.

Following are key performance indicators for the back-end process:

\* Noncovered charge denial percentage;

\* ePremis billing acceptance rate percentage;

\* HIS bill filter > 4 days percentage;

\* ePremis bill hold filter percentage;

\* HIS bill hold filter percentage over 4 days;

\* HIS bill hold filter APC edits percentage;

\* GUS bill hold filter service date edits percentage; and

\* Late charges percentage gross revenue.

Claims Collections and Transactions/Cash Control

Although monthly payer meetings to review issues are essential, provider representatives usually have limited knowledge or impact on claims processing. Thus, it may be necessary to insist on escalating issues if progress is not made. It would also be helpful to have support from hospital senior management or their presence at the meeting. Preparation for these meetings requires a full understanding of correct reimbursement rates, claims issues, and payer payment statistics.

Variance units are geared to debit/credit analysis of the claim payment versus the contract negotiated by the hospital managed care contracts. It is interesting that many payers that have signed such contracts are often not able to process the claims according to the contract profile. If contracts are so carefully crafted, how is this possible?

The key to identifying all denial levels is to invest in line item posting rather than just posting at the summary level (claim payment posting). A good, robust denial system management technology is essential.

Using an auto posting software module for EDI/ ERAs assists in capturing all the detail in the remittance file. Create adjustment codes by denial type, by payer, by service for full drill down on the source of denials. Payers are increasingly denying individual line items on claims. These multiple small payment cuts can be overlooked by providers. The most popular line item denial for payers is medical necessity. Thus, the billing manager needs to engage the medical director for appeal support for larger claims and patterns of denials by service type.

Patients need to be updated on issues with their third-party payers and on their individual claims. Tracking issues by payer rather than just by claim is very effective. Establish reports that track payers' payment performance as a report card. Payer report card trends data answers the provider question: "Why am I not getting paid?"

It is effective to meet with employers and keep them updated on problems with their insurance payers (avoiding discussing any individual claim, but citing general issues and statistics). The benefit administrator at the employer is the purchaser and can put pressure on the payer. The benefit administrator is a key partner.

Systems Check

Conduct periodic reviews to all system files to assure complete claims. Review all master files and profiles:

\* Doctor master;

\* Room and bed master;

\* Payer master;

\* Contract master; and

\* Insurance master.

Once these essential areas of the revenue cycle are reviewed and modifications made to meet best practice standards, the monitoring can begin. Reviewing any revenue cycle for best practices must focus on the key performance indicators. In Part 2 (in the November issue), I provide definitions, the formula, and the desired trend for key performance indicators of the revenue cycle.

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