Achieving Revenue Integrity in Hospitals and Health Systems

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The Bellevue Hospital launched an initiative to improve days in accounts receivable, reduce denials, and improve charge capture—and enhanced revenue by more than $1 million.

At a Glance

The Bellevue Hospital sought to improve its performance in three areas—days in accounts receivable (A/R), denials, and charge capture—to enhance revenue integrity. Results included the following:

- A 30-percent reduction in days in A/R
- A nearly 200 percent increase in bad debt collections
- A more than $1.6 million reduction in denials write-offs
- An improvement in net revenue of more than $1 million

In today’s economic landscape, revenue integrity—described by Suzanne Lestina, HFMA’s director of revenue cycle MAP, as “the delivery and protocols required to ensure accurate reimbursement and compliance”—is critical to hospitals’ ability to offset rising costs, declining revenue, and decreased access to capital.

Hospitals across the nation are finding that surviving reductions in payment requires more than strategies to contain costs; hospitals also need to focus on optimizing revenue by enhancing revenue integrity. This focus involves implementing the processes, tools, and resources necessary to ensure effective pricing and accurate charging and coding for patient care services and supplies. It also means taking steps to ensure that hospitals are successfully collecting the payment to which they are entitled.

Sixty percent of healthcare executives responding to an annual executive industry survey conducted by Craneware in November 2011 said revenue integrity is essential to their organization’s financial health, while another 5 percent said they were investigating organization models supporting revenue integrity.

The potential for revenue leakage—the gap between the payment a hospital is entitled to receive and what it actually collects—exists throughout hospitals and health systems, primarily due to inaccurate pricing, charging, and coding of patient care services and codable supplies. Identifying and preventing revenue leaks requires a dedicated effort involving assessment of current practices, education of staff on problem areas for the organization, and integration of optimized processes into daily operations.

At The Bellevue Hospital in Bellevue, Ohio, an initiative to improve revenue integrity resulted in the following successes for the not-for-profit hospital:

- A 30-percent reduction in days in accounts receivable (A/R)
How Bellevue Did It

In 2009, The Bellevue Hospital sought to improve its performance in three areas to enhance revenue integrity:

- Days in A/R
- Denials
- Charge capture

The Bellevue Hospital is equidistant from Toledo and Cleveland and, with more than 400 employees, is the largest employer in the city of Bellevue (population: 8,193 people). The hospital faces competition from four other hospitals, all located within a half-hour drive.

To expand its services and better meet the needs of the community it serves, The Bellevue Hospital replaced its original structure, built in 1914, with a new facility in 2005. However, just four years later, the hospital was struggling financially. Challenges facing the hospital included the impact of:

- A weak economy, both nationally and locally
- Reduced payment
- Increased costs for technology and supplies

A number of alarming financial metrics disclosed that the hospital was in trouble. In 2009, The Bellevue Hospital had just 56 days of cash. Its days in A/R were high: 76 days. Meanwhile, denials write-offs were financially crippling the hospital, with nearly 4 percent of net revenue written off in 2009 (nationally, the average is 2 percent annually). Hospital executives realized something had to change for the hospital to survive.

Developing a Plan for Revenue Integrity

The hospital developed a strategic plan focused on improving its revenue cycle operations. Despite what some might consider a contradiction of logic in adding another expense, The Bellevue Hospital created a new leadership position—that of revenue cycle director—to examine the hospital's revenue cycle operations and determine where areas for improvement existed. The director also would be responsible for enacting, facilitating, and managing the hospital's strategic plan for revenue cycle operations.

The new revenue cycle director—one of the authors of this article—was hired in 2010 and quickly established goals and accountabilities for the hospital's revenue cycle team. Benchmarks established by HFMA’s MAP program were used to evaluate the hospital's current performance against industry benchmarks, particularly in the areas of days in A/R, charge capture, and denials write-offs as a percentage of net revenue. The hospital then took a close look at the issues that had led to poor performance in revenue cycle operations.

Days in A/R. On reviewing and assessing all aspects of the A/R process, the hospital discovered that staff were overwhelmed by their workloads, to the point that they no longer knew where to focus their efforts or how to prioritize their work. Morale was at an all-time low. Staff tended to focus their efforts on activities that could generate cash quickly, so they would be able to point to successes and keep revenue coming in. Meanwhile, the hospital’s cash flow problem was steadily growing worse.

It was determined that there was no need to hire additional staff to handle the workload. Rather, the hospital’s existing revenue cycle staff could bring the volume of work under control if they were provided the right opportunities and conditions under which to do so.

The hospital diagramed and refined all A/R business processes, and then established benchmarks for days in A/R and cash on hand. For six months, revenue cycle staff were asked to work
overtime to pare down the number of outstanding accounts so that, ultimately, each staff member would have a manageable number of accounts to work. Responsibilities were restructured to maximize productivity (e.g., by splitting caseloads alphabetically and by insurance carrier to more evenly spread accounts among staff). The hospital also invested in software that helps staff to prioritize their efforts based on the value potential of the accounts. The software also supported data-driven action plans, compliance, and enhanced efficiency.

Staff were encouraged to look at their responsibilities with a fresh mindset and to be open to new approaches that could help them better tackle their work. The hospital motivated and encouraged staff by continually sharing data that reflected improvements in performance, so that staff could take pride in what they had accomplished, and held pizza parties to thank staff for their efforts.

The result: Collections improved significantly, with days in A/R decreasing from 76 in 2009 to 53 in 2010 and 50 in 2011. Days cash on hand rose from 56 in 2009 to 104 in 2010 and 113 in 2011.

**Exhibit**

<table>
<thead>
<tr>
<th>Financial Indicator</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in A/R</td>
<td>76</td>
<td>53</td>
<td>50</td>
</tr>
<tr>
<td>Days Cash On Hand</td>
<td>56</td>
<td>104</td>
<td>113</td>
</tr>
</tbody>
</table>

Denials. Denials write-offs are one of the most frustrating losses for healthcare organizations, because they generally represent a provider’s inability to comply with payer requirements to submit accurate claims.

Not only was The Bellevue Hospital’s performance below the industry standard, but the majority of denials were due to problems with the hospital’s systems or processes. The hospital was in a reactive mode, wherein staff were continually trying to track and respond to denials rather than working to ensure that claims were accurate before they were submitted.

A denials task force was formed to categorize the types of denials The Bellevue Hospital was receiving and get to the bottom of issues that were leading to various types of denials. The task force included the revenue cycle director, the CFO, and all revenue cycle managers in the organization. Using a software program, the task force identified patterns among the denials (e.g., authorization denials and timeliness of claims filing were two of the largest categories of denials the hospital faced) and worked with managers and staff to develop preventive action.

For example, problems with the accuracy of patient information collected by patient registrars as well as issues with insurance verification were causing difficulties throughout the revenue cycle. Educating patient registrars on their importance to the revenue cycle as a whole gave them a perspective that motivated them to be more diligent in capturing the information needed. The redesign of front-end processes also supported improvements.

With workflow levels under control, software that prioritized accounts enabled staff to get a better handle on issues related to timeliness of claims filed, eliminating denials stemming from the timeliness of filing.

Gaining clinical buy-in for initiatives that could enhance revenue cycle performance was critical. Revenue cycle leaders met with clinical managers and clinicians to share how their actions were affecting the revenue cycle department’s ability to file claims and collect payment for care and services provided. The leaders worked with clinicians to develop action plans to improve a number of areas, including coding and authorizations. Comprehensive quality programs related to coding, patient financial services, and patient access also were developed.

The result: Denials write-offs as a percentage of net revenue decreased from nearly 4 percent in 2009 to about 0.35 percent in 2010 and about 0.26 percent in 2011.

**Charge capture.** The chargemaster is the central, and potentially most effective, control point in the revenue cycle. An effective chargemaster is critical for ensuring compliance and optimal payment,
because every revenue transaction goes through the chargemaster before being posted to a patient’s account.

Errors due to absent or incorrect information, such as missing codable supplies or outdated charge codes, are often identified downstream, well past the point of the original transaction. And without the visibility to identify the specific sources of errors and address them at the points at which they occur, payment can be delayed, reduced, or denied altogether.

The Bellevue Hospital quickly determined that its processes for annual chargemaster maintenance and updates were insufficient. Downstream consequences included billing errors that required multiple corrections, poor pricing transparency, and inexact cost-of-care and patient-liability calculations. As a result, the hospital faced compliance risks, a compromised operating margin, and strained staff resources.

The Bellevue Hospital conducted a baseline chargemaster assessment, risk assessment, and opportunity analysis. Results were reviewed with the business-process leads for each department and with members of the management team, both to educate leaders on where money was being left on the table and to develop action plans for improvement.

The hospital selected an automated chargemaster management solution that included workflow and charge analysis functionality and used the results of its assessment to customize the chargemaster to meet the hospital’s needs. The hospital also defined and adopted a new chargemaster management process, with clearly defined maintenance tasks, accountabilities, and performance metrics. Today, charge management processes are reviewed on an ongoing basis.

The result: In combination with other revenue cycle initiatives, operating revenue has increased from –8.5 in 2009 to 2.5 percent in 2010 and 4 percent in 2011.

Lessons Learned

The November 2011 survey of healthcare executives asked leaders to pinpoint the best opportunities to improve their organizations’ financial performance. Respondents targeted three areas: operational efficiencies, charge capture and coding, and denials prevention and management. These areas are the same challenge points faced by The Bellevue Hospital before it took action to improve revenue integrity.

The Bellevue Hospital has experienced a dramatic financial turnaround over the past few years, as shown in the exhibit on page 116. These results demonstrate the value of using industry metrics and best practices to effect change in revenue cycle operations and performance.

The Bellevue Hospital learned five key lessons that could help other hospitals in their efforts to achieve revenue integrity.

Identify benchmarks to assess business process outcomes. The hospital used HFMA MAP Keys—key performance indicators that set standards for revenue cycle excellence in the healthcare industry—to set goals for improvement. These metrics define the essentials of revenue cycle performance in clear, consistent, and unbiased terms.

Let the data define the focus and priorities. The hospital used a software program that helped staff identify which accounts to work first according to their value potential while ensuring that all claims are filed in a timely fashion. Data resulting from assessments of revenue cycle processes and functions also guided the development of action plans for improvement.

Define clear accountabilities and ensure that staff understand their roles. Prior to the revenue cycle improvement initiative, the hospital’s revenue cycle staff did not know whether their performance was satisfactory because they did not know what expectations the hospital had for their performance. There were no performance goals, and no one held them accountable for their work. Today, all staff know the importance of their efforts, their impact on the revenue cycle, the goals they are expected to achieve, and how their performance compares with goals.
Engage clinical areas to increase revenue cycle awareness and maximize their contributions. A central precept of revenue integrity is that all stakeholders must understand their role in supporting the financial performance of the organization.

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The Bellevue Hospital: At a Glance*

Active physicians: 49
Courtesy staff: 33
Employees: 400
Specialties: 33
Total patient revenue: $90 million
Admissions: 2,091
Births: 372
Emergency department visits: 16,334
Surgical procedures: 3,877

* Based on 2011 data.