Rural Hospital Performance Improvement (RHPI) Project

Best Practice Concepts in Revenue Cycle Management

August 8, 2014

National Rural Health Resource Center

RHPI — RURAL HOSPITAL PERFORMANCE IMPROVEMENT

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PREFACE

This guide is developed to provide rural hospital executive and management teams with generally accepted best practice concepts in revenue cycle management so that they may consider opportunities for performance improvement within their own hospitals and individual departments. It's also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding of the revenue cycle best practices so that they may develop educational trainings to further assist rural hospitals with performance improvement.

The information presented in this guide is intended to provide the reader with guidance in health care revenue cycle matters. The materials do not constitute, and should not be treated as professional advice regarding the use of any particular revenue cycle technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The National Rural Health Resource Center (The Center), the Rural Hospital Performance Improvement (RHPI) Project, Eide Bailly LLP, and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation, and should independently determine the correctness of any particular insert subject matter planning technique before recommending the technique to a client or implementing it on the client's behalf.
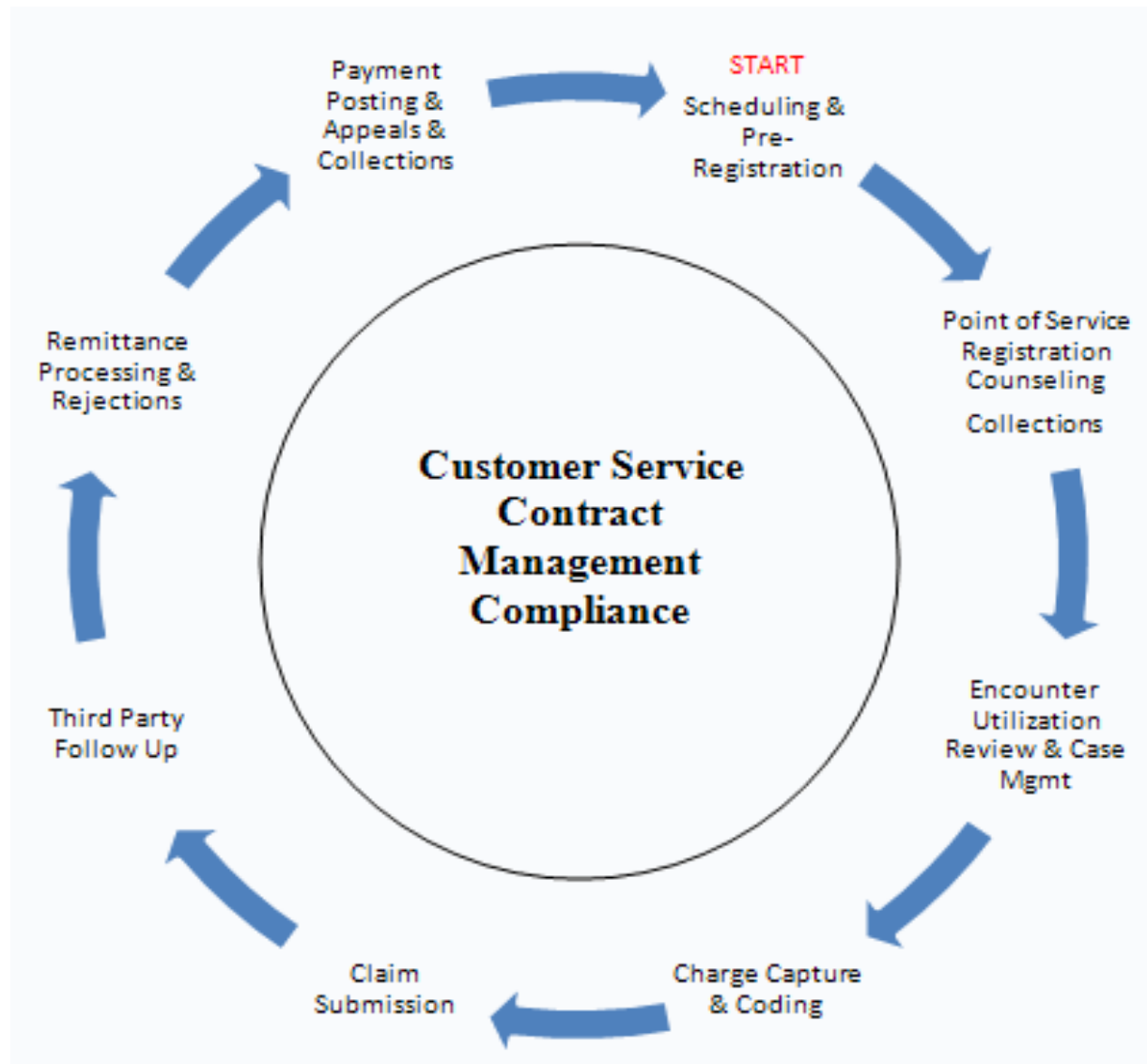
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INTRODUCTION

The revenue cycle is the financial process related to a patient's clinical encounter. The basics within the revenue cycle are reinforced with payer contract management, customer service and compliance. The individual patient encounter starts when the patient is scheduled for a service. This event triggers the collection of patient demographic and payer data. This data is then utilized to verify the patient's identity and assign an appropriate payer source. Through the financial clearance process financial conversations are initiated and expectations set prior to service. Registration is the next step and if a face to face encounter occurs at the point of service where cash is collected, compliance documents are reviewed and signed and the patient's clinical chart is initiated. Once registered that patient begins their clinical encounter where clinicians document the services that were rendered and the supplies that were utilized. This documentation is then used to support appropriate charge capture and code assignment for billing. Revenue Integrity Programs are recommended to ensure that appropriate clinical documentation, updated charge description masters and pricing theories are utilized to maximize appropriate reimbursement. After the patient is discharged all of the data from above converge into to the billing system where either a claim form is sent to the patients insurance or a statement is generated for those without coverage. The revenue cycle is not complete until the account has exhausted all payer sources and is closed as either correctly paid in full or uncollectible. The Healthcare Financial Management Association (HFMA) defines revenue cycle as "*All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue"*. "Revenue cycle represents the entire life of a patient account from creation to payment."[1]

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[1] Oregon Health and Science University http://www.ohsu.edu/xd/about/services/patient-business-services/revenue-cycle/

Figure 1: Revenue Cycle

Figure 1 below provides an overview of the revenue cycle from the start (scheduling and pre-registration) to the end (billing and collections).[2]

START
Scheduling & Pre-Registration

Point of Service Registration Counseling Collections

Encounter Utilization Review & Case Mgmt

Charge Capture & Coding

Claim Submission

Third Party Follow Up

Remittance Processing & Rejections

Payment Posting & Appeals & Collections

Customer Service Contract Management Compliance

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[2] Figure 1 image obtained from Oregon Health and Science University website at http://www.ohsu.edu/xd/about/services/patient-business-services/revenue-cycle/

"Revenue cycle processes flow into and affect one another. When processes are executed correctly, the cycle performs predictably. Problems and errors that occur early in the cycle can have significant negative effects at the end that typically impact efficiency, productivity, and performance. The further an error travels through the revenue cycle, the more costly revenue recovery becomes."[3] Therefore, it's important to have a general understanding of the steps in the revenue cycle, and how to target processes that improve performance. **Figure 2** demonstrates the processes that follow the patient encounter.[4] **Figure 3** illustrates how the 'front-end' impacts the 'back-end' of the revenue cycle.[5] Both graphics exemplify that if hospitals are to be more efficient in managing the revenue cycle in the back-end, they should target performance improvements efforts at the front-end.

Figure 2: Revenue Cycle Processes Following the Patient Encounter

Patient Access	Case Mgmt	Service Documen-tation	Billing	A/R Mgmt	Customer Service
• Scheduling • Pre-Registration • Financial Counseling • Registration	• Utilization • Discharge Planning	• Charge Master • HIM • Charge Capture • Late Charges • Coding • Audits/Compliance	• Claims Editor • Bill Reconciliation • Contractual Adjustments • Patient Statements	• Cash/EOB Posting • Third Party Collections • Account Write offs • Bad Debt	• Customer Inquiries • Issues Resolution • Service Recovery

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[3] Oregon Health and Science University http://www.ohsu.edu/xd/about/services/patient-business-services/revenue-cycle/
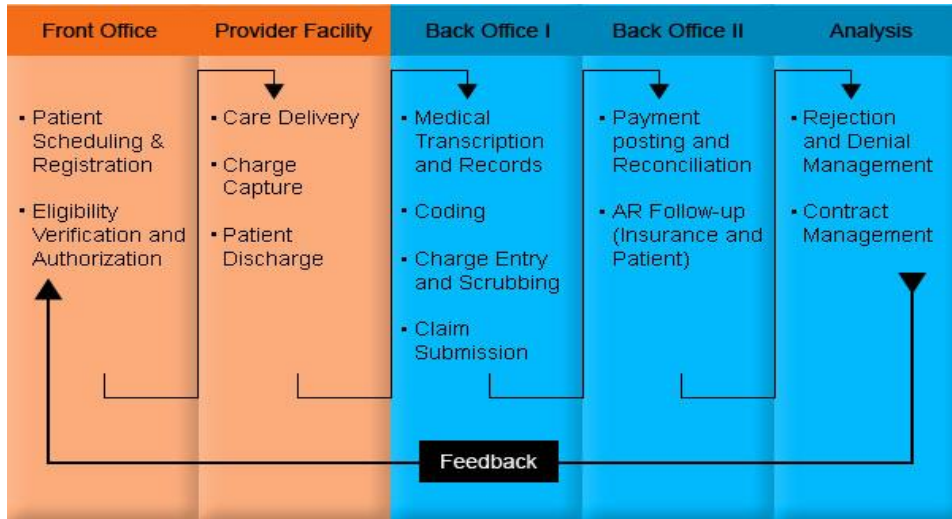
[4] Figure 2 image obtained from Eide Bailly LLP presentation; *Account Management: Move from Denial Management to Denial Avoidance with Process Improvement*

[5] Figure 3 image obtained from Somega Healthcare website at http://somegablogs.blogspot.com/

Figure 3: Front-End and Back-end of Revenue Cycle

In today's economic environment, it's critical that hospital administrators utilize best practices to effectively manage the revenue cycle to optimize efficiency and maximize reimbursement. Revenue cycle management (RCM) has a key role in addressing shifting industry practices in response to three major trends: real-time processing, consumer-driven health care, and changes in regulations and reimbursement structures.[6] According to HFMA, "A basic role of RCM is to measure how well a hospital maximizes the amount of patient revenue billed and how quickly it collects that revenue."[7] While RCM primarily focuses on processing claims, payment and revenue generation, it also includes patient services since care management directly impacts the reimbursement. "Revenue cycle performance is affected by those across the organization, with success dependent on support from health, department managers, information management, physicians, nurses, and IT, to name only a few. As such, key actions will be needed from both the hospital's executive team and revenue cycle leadership to attain the widespread support vital for achieving high performance."[8]

With decreasing reimbursements and as more patients are paying increasingly higher deductibles, it's important to improve performance by focusing on best practices in all areas of the revenue cycle. Best practice adoption is key to long term success for any hospital. Hospitals that are more successful develop processes

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[6] HIMSS Financial Systems Revenue Cycle Task Force; Revenue Cycle Management: A Life Cycle Approach for Performance Measurement and System Justification. 2009 -2010
[7] Healthcare Financial Management Association (HFMA) http://www.hfma.org/Content.aspx?id=3097
[8] Healthcare Financial Management Association; Strategies for a High-Performance Revenue Cycle; A Report from the Patient Friendly Billing® Project. November 2009

to adapt and implement best practices to ensure that they are capturing reimbursement dollars and controlling expenditures. Best practices can be adopted by all hospitals and everyone can do it with reasonable success. Long-term success is typically due to two key factors: location and competition; and, development and implementation of best practices. Location and competition are difficult to change. However, best practices can be adopted and implemented by all rural hospitals of any size to improve processes, and thus, performance.

PATIENT CENTERED REVENUE CYCLE

Best Practice Hospitals:

- ✓ Put the patient at the heart of the revenue cycle process
- ✓ Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management
- ✓ Provide both verbal and written explanation to patients

Creating a positive patient experience within the revenue cycle process is absolutely critical as it directly impacts the hospital financially, but more importantly, it helps to build a customer sensitive environment. An environment that emphasizes the patient care needs. Patients perceive the billing process as difficult and frustrating. The last experience that the patient usually has with hospital is with the billing. In general, this last experience isn't as positive as we would prefer it to be. Customer service is paramount for the future success of health service providers. Utilize your revenue cycle team (RCT) to help build patient loyalty. It's important to think holistically about your patient to include other family members. The more information that we can provide upfront to help both the patient and the family helps to keep the patient in the center of the care and services. As the health insurance marketplace continues to move forward, hospitals should expect more and more patients to be exploring their options, and asking more questions; many patients will be very confused. Hospitals should train staff to:

- Answer "Marketplace" questions
- Articulate coverage options
- Discuss payment options
- Know when and who to escalate to, if necessary

SCHEDULING AND PRE-REGISTRATION

Best Practice Hospitals:

- ✓ Have centralized scheduling to receive patient
- ✓ Schedule patients for services
- ✓ Draft scripts for staff to follow to support customer service
- ✓ Complete prior-authorization to meet medical necessity
- ✓ Educate patients about what their insurance covers to include the amount of copayments, deductibles, and coinsurance for which they would be responsible for paying at the time of service
- ✓ Provide patients with cost estimates at pre-registration
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Assist uninsured patients by scheduling a meeting with financial counselors to complete financial assistance applications
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures
- ✓ Enter all tests into the online scheduling system
- ✓ Integrate IT systems for scheduling and pre-registration functions
- ✓ Develop process to ensure physician order is available at the time of scheduling
- ✓ Provide verbal and written explanation of the hospital policy to the patient
- ✓ Provide reminder calls to patients and include discussion regarding patient balances and point of service (POS) collection policies, confirm third party coverage, and restate proper clinical preparation for the service

To improve revenue cycle performance right from the start, successful hospitals develop a pre-registration process to make patients aware of their portion of the bill prior to the procedure, and collect co-payments, deductibles and balances at time of service. According to HFMA, high performing hospitals target performance improvement around those revenue cycle areas most affecting the consumer's experience such areas as front-end processes, POS collections, and charity care. It's important to identify charity care patients upfront during the pre-registration process. HFMA claims that "trends suggest that hospitals spend considerable effort to capture revenues that they will never be able to collect". They also utilize a centralized scheduling process. Having access to all schedules allows the patient a one-stop option within a single contact center. It minimizes the possibility for error and/or missing data (orders, insurance information etc.). Data deficiencies can

cause back logs when attempting to financially clear and/or confirm a patient visit. During the scheduling process the patient's medical needs should first be addressed by gaining a full understanding of the service being scheduled. Basic demographic data is needed to create the appointment such as: patient's name, date of birth, address, phone number, and insurance provider name and identification number. Centralized or not, high performers have established well defined policies and procedures for scheduling. Staff that schedule appointments should have a firm understanding of the facilities policies and procedures; for example: how far out to schedule certain types of procedures (are there clinical implications that require a 48 hour prep, or do certain payers require prior authorization that could take up to 72 hours); how much time is needed in advance of a service for financial clearance; what data elements are required versus those that can be obtained at a later time; and so on.

If the patient is calling, staff should ask if there is insurance that they would like the hospital to bill. In successful hospitals, staff obtain the information while the patient is on the phone. If they do not have their card handy, it's important to be very specific on next steps and on the facilities expectation from the patient. If the scheduler does take the insurance information directly, it's important to inform the patient that they will be receiving at least an additional call(s) regarding their upcoming service. Possible calls could be from a:

- Financial team member to discuss their coverage and obligations to possibly include co-payments, deductibles, previous balances, and prompt pay and self-pay discounts
- Clinical team member to discuss how to prepare for the service, if applicable
- Scheduling team member to confirm the appointment and to provide a courtesy reminder

Verbal, along with written explanations, are imperative to ensure that the patient understands the financial process and obligations. To improve performance in scheduling and registration, hospitals should:

- Create a brochure explaining the financial process
- Give patients a link to the hospital's web site for further details. The website should be a one-stop destination for facility information, health information, forms, and secure messaging with the facility
- Give a direct phone number in case they have further questions
- Repeat the same scripting at every visit to keep the message consistent

Prior-authorization for procedures should be completed during the pre-registration process to meet medical necessity requirements.

After the appointment slot is chosen, staff initiates discussions with the patient regarding the financial obligations. Staff should be trained on how to ask for detailed insurance information and payment options. In addition, they provide scripts for their staff to support this process. This is a key opportunity to provide excellent customer service. It's important to let the patient know it will take a couple of moments to complete the process. It also ensures that the patient understands the payment options for the scheduled service.

Pre-collection is important for rural hospitals because of the growing uninsured population and large number of patients with high co-payments and deductibles. Best practice hospitals collect co-payments and deductibles at time of scheduling and POS. Patient satisfaction could be improved because patients have a better understanding of the charges and total bill before having the service, which reduces anxiety and confusion by the patients. Successful administrators and managers develop processes to schedule patients and build awareness of hospital policy for co-payments and deductible at time of service, based on estimates, if necessary. These facilities also include scripts for staff to follow (Refer to **Appendix A** for sample scripts) and develop processes for staff to collect co-payments and deductible at the time of service. This increases the ability to identify charity care patients early in the front-end. It also reduces staff time in trying to collect payment from those that should have been placed in a charity care program at the start.

It's essential that the hospital's financial policies are up to date and communicated clearly with all team members, as well as the clinical team in case a patient asks while in the room with the nurse, technician or doctor. Since the financial conversations will be with the patient and/or responsible party, the hospital's financial counseling staff should:

- Use the data received from the payer to discuss out of pocket amounts
- Base the discussion upon the hospital's financial policies. The financial policies should define the patient's payment options to include acceptance of credit cards. The policies should also outline options for the staff to exercise if the patient cannot pay their out of pocket costs in a timely manner.
- Understand and be able to execute a formal payment arrangement, help with loans, and identify areas where a patient may qualify for other coverage and/or financial assistance

In addition, staff should:

- Ask the patient if they are interested in learning more about payment options
- Ask the patient if they are interested in learning more about financial assistance options
- Attempt to resolve prior balances
- Provide the patient with written information regarding financial assistance, summary of obligations, and include a phone number for questions

To improve visibility in upfront performance, the revenue cycle team should show support for POS cash collections, and monitor back-end activity for denials and write-offs. The RCT should also consider creating a percentage of net revenue targets and track them against POS cash collections by registrar, financial counselor, department, and site. Lastly, the RCT should determine and track the actual versus expected POS collection based on the patients plan and required co-pay and deductibles. **Figure 4** shows the key performance indicators (KPI) that should be considered for monitoring performance during the pre-encounter phase[9]. It also summarizes the best practice recommendations that improve pre-registration and scheduling processes.

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[9] Figure 4 image obtained from Eide Bailly LLP presentation; *Financial Clearance and Pre-Registration: Steps for Success*

Figure 4: Scheduling and Patient Access Key Performance Indicators

Key Performance Indicators for Scheduling	Best Practice Standards
Pre-registration rate for scheduled patients	>98%
Percent tests scheduled in system	100%
Medical necessity checking at time of scheduling	100%
Legible order with all required elements at time of scheduling	>95%
Reminder calls for scheduled services	100%
Number of calls per test scheduled[1]	individual
Average speed of answer	<30 sec.
Percent inbound call abandonment rate	<2 %
Percent of patients rescheduled, cancelled, no show[2]	individual
Percent of patients postponed for lack of pre-certification[3]	individual
Next available appointment for diagnostic tests	<24 hours
Call abandonment rate	<2%

Key Performance Indicators for Patient Access	Best Practice Standards
Percentage of claims on hold for registration errors[1]	<1/16 Day of Revenue
Number of statements in returned mail weekly[2]	<5%
Percentage of patients waiting greater than 10 minutes for a registrar	<10.0%
Average face to face registration duration (minutes)	10.0
Average Registration Throughput	35 IP, 40 OP
ABN's/MSPQ's obtained when required	100%
Data entry quality compared to established department standards	98%
Master Patient Index (MPI) duplication rate as percent of total registrations	<1.0%

PATIENT REGISTRATION AND ADMISSIONS

Best Practice Hospitals:

- ✓ Complete patient insurance verification
- ✓ Pre-determine if services will meet medical necessity
- ✓ Utilize electronic tools such as to support clinical decisions for evaluating patient placement
- ✓ Provide ongoing education on medical necessity to staff and physicians
- ✓ Make the Advanced Beneficiary Notice of Non-coverage (ABN) a requirement
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures

Financial clearance should begin as soon after the patient is scheduled as possible, at least 48 hours prior to an appointment. Benefit verification is based upon the service to be offered to include coverage percentages and out of pocket obligations. Out of pocket obligations could include co-payment, co-insurance, deductibles and non-covered services. Facilities that utilize electronic verification process are the most successful in confirming insurance benefits. For phone verification, it's important to document the name of the representative, their badge number, the date and exact time of the call. The data obtained should be accessible to the clinical and Business Office (BO) staff for when they need it. Successful facilities train staff to not only to request coverage data but also request quotes of anticipated reimbursement for the planned procedure.

It's crucial that staff pre-determine if services will meet medical necessity by utilizing electronic tools (ex. McKesson's InterQual® Criteria) to support clinical decisions for evaluating patient placement in either observation or inpatient services. Therefore, the hospital is more likely to ensure that the patient receives the right level of care, and thus, medical necessity is met.

Best practice facilities also utilize presumptive methods to determine which patients may qualify for charity care, which predicts the ability of the patient's ability to pay. Pre-collection processes assist hospitals with identifying charity care determinations at the beginning, which reduces staff time trying to collect payments at the end.

EMERGENCY ROOM ADMISSIONS

Best Practice Hospitals:

- ✓ Assess how the emergency department reaches the Evaluation & Management (E/M) levels
- ✓ Determine the actual distribution of E/M levels following correction
- ✓ Pull out procedure charges and bill separately
- ✓ Monitor the ER admission rate for inpatient and observation services
- ✓ Manage an ER re-direct program to collect co-payments, deductibles, and any previous balances from non-emergent patients following the EMTALA screening and/or attempt to move the patient to the more appropriate level of care by either redirecting them to a walk-in clinic or scheduling them in the clinic the next day
- ✓ Have clearly defined policies and procedures

Some patients are admitted directly through the emergency room (ER). Best practice hospitals monitor the admission rates for inpatient and observation services to evaluate if they are placing patients in the right level of care. Patient placement has a direct impact on reimbursement. The CDC cites a national baseline average of 12.5% of all emergency department visits are admitted to their inpatient units.[10] For these patients a financial counselor should visit the patient's room before they are discharged. It is helpful when the clinical and financial teams work together to assist the patient with understanding their financial obligations and options for payment.

High performing hospitals develop and implement an ER re-direct program that stops services that are being provided to non-emergent patients following the Emergency Medical Treatment & Labor Act (EMTALA) screening. Patients that are deemed non-emergent following the EMTALA screening are re-directed back to registration to collect co-payments, deductibles, and any previous balances. Preferably, staff makes the patients aware of the additional costs associated with the ER visit and provides them with other primary care options such as walk-in clinics. High performers assist with scheduling the patient in the hospital's clinic. Alternatively, if the patient decides to continue to seek care through the ER, then registration collects co-payments, deductibles, and any previous balances at that point, prior to completing the ER visit with the physician.

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[10] Ivantage, 2013 National Rural Emergency Department Study, Establishing Rural Relevant Benchmarks

In addition, high performing hospitals assess how the ER reaches the Evaluation & Management (E/M) levels. This action allows the facility to report levels more accurately that better reflects the actual services rendered. The hospital may then bill procedure charges separately. Typically, processes are not in place in the ER to capture revenues, which commonly result in significant charge capture issues and negatively impact revenues. In addition, the E/M levels for Current Procedure Terminology (CPT) codes (particularly 99281 – 99285) are frequently reported incorrectly, and may include other services. Thus, the assigned levels and overall distribution don't reflective of actual services provided. Most likely, E/M is 'overstated' and other billable service are missed. Medicare claims that they expect the E/M distribution should be more of a bell curve, in general (see **Figure 5** below).[11]

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[11] Figure 5 image obtained from Eide Bailly LLP presentation; *CAH Financial Management*

Figure 5: Evaluation and Management (E/M) Levels
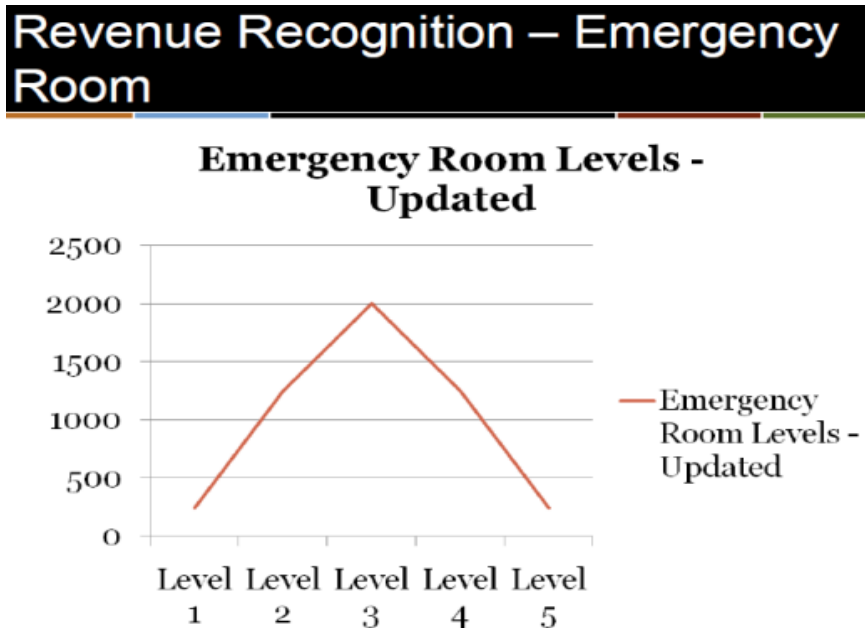
Successful facilities conduct a process review to determine how they reach each level. This allows the facility to report levels that more accurately reflect the services rendered. High performing facilities also determine the actual distribution of E/M levels following correction of assigning levels, and further assess to conclude if the levels and the explanations for differences are feasible. For example, does the ER have more than normal non-emergent patients? They also pull out procedure charges and bill separately, especially in critical access hospitals (CAHs). This process improvement typically results in increased potentially gross revenue by correctly assigning E/M levels and charging for other billable services.

CHARGE CAPTURE AND CODING

Best Practice Hospitals:

- ✓ Use concurrent coding to improve medical necessity documentation
- ✓ Hold weekly nursing and Health Information Management (HIM) team meetings to discuss medical necessity documentation and charge capture opportunities
- ✓ Hold ancillary department managers responsible for reviewing the prior day's charges in order to identify errors
- ✓ Train ancillary staff on appropriate charging and reconciliation

- ✓ Hold weekly interdisciplinary team meetings to engage managers and build department accountability
- ✓ Hold weekly interdisciplinary team meetings to determine issues that put the facility at risk, which may include:
  - o Conducted chart audits
  - o Review system reports such as one day stays and cumulative totals for each ER level
- ✓ Develop processes that clarify what a separately reportable charge for outpatient services is
- ✓ Develop a process for regularly reviewing pharmacy charges by auditing the medical records versus charges and claims for injections versus drugs
- ✓ Establish a formal process that involves the business office and department managers to review existing charge codes and to establish new charge codes
- ✓ Develop pricing strategies based on market based data
- ✓ Perform an annual review to update pricing
- ✓ Hold quarterly meetings with department managers and BO to conduct a review and update chargemaster
- ✓ Review third party contracts
- ✓ Have clearly defined policies and procedures

To improve charge capture, staff should clearly communicate suspense times to the departments and state it in their policies and procedures. Suspense times are strict timelines placed on clinical departments to enter compliant, audited and correct charges for services rendered. It is important to remember that each day that charges are not entered and fall out of "suspense" can cause negative effects on your days in accounts receivable outstanding as well as cash flow. Systematic reviews of the chargemaster are essential to ensure that hospitals are capturing all revenue correctly and that they are not leaving dollars on the table. However, it's important to note that adjustments to the chargemaster create downstream effects to the cost reports. In addition, no matter how up to date the chargemaster is, it not effective until there are processes in place to ensure that the charge is captured. Therefore, high performers have processes in place that tie charges to a compliant cost report.

Charges for rural services, particularly in CAHs, are frequently below that of PPS and larger urban facilities for the exact same services (i.e. same procedure or same E/M level). This is commonly due to lack of appropriate pricing strategy. Best practice facilities develop a pricing strategy based on market data through commercial sources and/or Medicare Provider Analysis and Review (MEDPAR)

[claims data](#) (MEDPAR files contain data from claims data with CPT code and average pricing) to reach 75th percentile pricing. They also develop an annual evaluation process to update pricing and review third party contracts.

Charge capture, in general, is a significant performance improvement opportunity for majority of rural hospitals. Common areas that result in lost revenues are outpatient nursing procedures and pharmacy. Examples of outpatient services that are typically missed include IV therapy, injections, and Foley catheter insertions.

Many hospitals miss these charges and lose revenue because of lack of proper nursing documentation. Best practice facilities have teams from nursing and HIM meet weekly to discuss documentation and charge capture opportunities. The Chief Nursing Officer (CNO) or Director of Nursing (DON) leadership is critical to ensure that both the documentation is provided and the charges are captured. To improve performance, it's important for hospitals to develop and implement processes to capture revenues for services that are rendered. They also hold weekly interdisciplinary team meetings to review charge master for any potential RAC issues, conducted chart audits, reviewed system reports such as one day stays, cumulative totals for each ER level. The interdisciplinary team should be composed of representatives from the business office, admissions, nursing, care/case management, and HIM. The purpose of the team is to determine issues that put the facility at risk, engage manager and build department accountability. Ideal processes include:

- Clarification of what is actually a separately reportable charge for outpatient services
- Nursing documentation that affect charge capture such as start and stop times, site and drugs
- Weekly nursing and HIM team meetings to discuss documentation and charge capture opportunities
- Regular review process to ensure that charges are not being missed in pharmacy by either auditing the medical records versus charges or reviewing the claims for injections versus drugs
- Appropriate reporting of pharmacy dispensing units
- Regular review of pharmacy charges

Commonly in pharmacy, hospitals lose revenue by totally missing charges or errors in properly reporting of units. Most missed pharmacy charges are due to overreliance on systems to document dispensing units and unit conversion factors.

Successful facilities have processes in place to review the charts and claims for potentially missed pharmacy charges.

TIMELY FILING

Best practice hospitals:

- ✓ Monitor the filing of claims
- ✓ Determine the percent of claims not filed before deadline, which includes a separate account for tracking write-offs due to missed deadlines
- ✓ Have clearly defined policies and procedures

Many hospitals are not filing claims in a timely manner even if they capture the charges, and thus, miss the filing deadlines. Medicare has one year, but many commercial payers now have 90 days. The trend for commercial payers is less time to file the claim. Thus it's important to have processes in place to submit the claim in a timely manner. Progressive administrators develop and implement processes to monitor the filing of claims, and determine the percent of claims not filed before deadline. These successful facilities also have processes in place to monitor write-offs, which includes a separate account for tracking write-offs due to missed deadlines. Many times the Chief Executive Officer (CEO) is unaware of lost revenue due to claims not being submitted in time. By monitoring the percent of claims not filed in a timely manner and the write-off due to missed deadlines provides the executive team with a better understanding of performance improvement opportunities and allows them to be more proactive in submitting clean claims. The outcome commonly results in significantly increased gross revenue due to properly submitting the claim within a timely manner.

BILLING AND COLLECTIONS

Best practice hospitals:

- ✓ Stratify the accounts by amount
- ✓ Identify Medicare separate from commercial accounts
- ✓ Have clearly defined policies and procedures
- ✓ Educate staff on:
  - ➢ Payer contract requirements
  - ➢ How to verify coverage
  - ➢ How to appeal coverage determinations
  - ➢ Timely filing rules

- ➢ Fee schedules
- ➢ Special billing requirements

To ensure proper and prompt insurance payments, staff should be trained on insurance verification. It's important to educate staff not only to request coverage data, but also ask for quotes of anticipated reimbursement for the planned procedure, and preferable get it in writing. High performing hospitals identified the data that payers are using to determine the fee schedules, and work with the lower paying carriers to ensure they are not misinterpreting the data. Lastly, these hospitals also review the reductions to determine if they appear to be from fee schedules, are reasonable and customary rates, or due to down coding or audit issues.

Best practice hospitals have processes to identify Medicare bad debts and capture self-pay balances. They stratify the accounts by amount and Medicare cross overs to identify those that are secondary to separate from commercial accounts. This process frequently requires adjustment to collection policies to meet requirements to claim Medicare bad debt.

DENIAL MANAGEMENT

Best practice hospitals:

- ✓ Track denials to prevent oversight and monitor by:
    - ➢ Payer and type
    - ➢ Reason
    - ➢ Department
    - ➢ Percentage of revenue submitted
    - ➢ Denials as percent of gross revenue
    - ➢ Denial over-turned (%)
    - ➢ Payer rejects as percent of remit revenue processed
- ✓ Make ABN mandatory
- ✓ Provided ongoing education on ABN and medical necessity to staff and physicians
- ✓ Develop processes to pre-determine if services meet medical necessity criteria
- ✓ Have clearly defined policies and procedures

High performing hospitals focus on account management to build accountability within the departments. They also try to move from 'denial management' to 'denial

avoidance' through process improvements earlier in the revenue cycle as discussed above. Successful hospitals manage how much money is lost in denied claims by tracking denials by service, physicians, and staff performing service. They also track not just the total denials, but have processes to identify and stratify the problems by service, physicians, and staff performing services. Monitoring denials defines where breakdowns are in the process to identify opportunities for performance improvement. The impact of best practice commonly results in improved cash flow due to increase in clean claims and reduction in denials. It also supports increased revenue by potently reducing the losses in over utilization of services. Denial management processes include:

- Interpreting the carrier contracts to ensure that you do not receive incorrect "denial reasons"
- Tracking denials to prevent oversight of a denial
- Reporting overturned denials to leadership for use during contract negotiations
- Creating of an interdepartmental task force to mitigate denials
- Educating staff to help to identify upstream issues that might be causing the denials

The most effective mechanism to prevent denials is to communicate to revenue cycle/denial management team(s), and be transparent by tracking the following KPI:

- Payer and type
- Reason
- Department
- Percentage of revenue submitted
- Denials as percent of gross revenue
- Denial over-turned (%)
- Payer rejects as percent of remit revenue processed

The department accountability will follow with increased transparency, which should support positive performance improvements earlier in the revenue cycle.

To effectively appeal incorrect payments, high performers:

- Cite [Employee Retirement Income Security Act (ERISA)](#) and state statutes/laws that support the hospital's position

- Provide average stats on the anticipated reimbursement amount, and are prepared to challenge their citing of other providers who are out of the region and/or do not provide the same level of care
- Stand firm that the hospital only offer discounts to those who pay promptly
- Request prompt payment

If the denial is upheld, request that they send supporting documentation. For incorrect payments, ask the carrier to supply a copy of the fee schedule or other data used to determine the payment level. Many insurers balk at providing hard copies of the data used to determine the payment levels. However, some state and federal disclosure laws appear to support the providers' right to review the actual data used to determine payment levels.

ER services are not exempt from denial management. Best practice facilities track denials from ER on the back-end to improve processes and physician practice patterns. Most denials in the ER are caused by orders that do not meet medical necessity. Following a review by services and physicians, typically it's discovered that a few doctors are over utilizing services and ordering services that don't meet medical necessity. High performers monitor ER denials by service and physician after the fact, and follow up with providers with education to address causes of denials.

Not providing ABN can result in loss of significant dollars, especially in laboratory and imaging services. ABN is not optional. The ABN determines the liability for payment by defining who pays the bill, especially for laboratory and imaging services. It clarifies that the patient is responsible for payment since the particular service will not be covered by Medicare. It's important to understand that the ABN does not define proper care of a patient nor relate to quality of care provided to the patient. ABN and medical necessity are key to managing denials. Progressive administrators and managers make ABN a requirement and develop a process to ensure that staff provides ABN to the appropriate patients. In addition, they provided ongoing education on ABN and medical necessity to staff and physicians, and develop a process to pre-determine if services will meet medical necessity criteria. For more information on ABN, refer to http:\\www.cms.gov\\outreach-and-education\\medicare-learning-network-MLN\\MLNProducts\\downloads\\abn_booklet_icn006266.pdf.

MONITORING REVENUE CYCLE METRICS

Best Practice Hospitals:

- ✓ Hold weekly revenue cycle team meetings
- ✓ Benchmark externally against peer hospitals
- ✓ Benchmark internally to monitor trends over time
- ✓ Benchmark internally against best historical level and target department performance to the historical level
- ✓ Establish targets based on HFMA suggested key performance indicators
- ✓ Track and monitor key performance indicators
- ✓ Use a dashboard to manage to revenue cycle improvement goals

Peter Drucker is famous for his quote, "*What gets measured gets managed*"[12]. Hospital performance improvement, particularly within the revenue cycle, is dependent upon ongoing monitoring of KPI along with effective management that includes department accountability. Performance improvement actually starts with leadership involvement and commitment, and their understanding of accountability. According to HFMA, "organizational commitment to measuring and monitoring performance is key for setting appropriate goals and making process adjustments necessary for achieving those goals." Refer to **Figure 6** below for the roles of the executive team according to HFMA's *Strategies for a High-Performance Revenue Cycle*. [13]

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[12] http://www.entheos.com/quotes/by_topic/Peter+Drucker

[13] Table 1 image obtain from *HFMA's Strategies for a High-Performance Revenue Cycle; A Report from the Patient Friendly Billing Project*

Figure 6: HFMA's Roles in a High-Performance Revenue Cycle

	People	Processes	Technology	Metrics	Communication	Culture
C-Suite	Set high expectations for revenue cycle positions Devote organizational resources to improved training and compensation	Develop and participate in intraorganizational teams around revenue cycle Use patient experience as the cornerstone for setting revenue cycle strategy	Appreciate community dynamics and those with the greatest impact to the organization when prioritizing technology needs	Encourage improved monitoring of revenue cycle processes through use of traditional and nontraditional metrics Develop and enforce systems of accountability around monitoring and reporting practices	Support organizational alignment around clear, correct, and patient-friendly messaging Set clear and transparent financial assistance policies and procedures	Demonstrate value for the revenue cycle through significant commitment of time and resources Establish systems to reward high revenue cycle performance
Revenue Cycle Leadership	Apply high standards to hiring Emphasize education Take a career approach to revenue cycle positions Leverage compensation and work arrangements for employee satisfaction	Use formal structures to obtain stakeholder input Target revenue cycle improvements around the consumer's experience Adopt established improvement methodologies including those not traditionally used in health care	Selectively use technology for interactions with customers Manage for investment value Dedicate IT staff to the revenue cycle	Measure and report frequently Look beyond traditional metrics for success Seek the consumer's perspective	Drive a positive scheduling/ registration experience Provide estimates of financial obligations Promote financial assistance Support clear and simple billing and collections materials Recognize the importance of external communications	Support revenue cycle at the highest level Garner appreciation for the revenue cycle from nonfinance staff Find purpose through the patient Demand high performance Celebrate success Make innovation a priority

It's important for executive leadership to publicly support the notion that the revenue cycle is not a "money thing", but it is a hospital wide responsibility as well as a patient responsibility. High performing hospitals hold regularly scheduled RCT meetings, at least two times per month, to address systemic issues, reduce silos within the revenue cycle functions as well as between revenue cycle and clinical departments. Leaders that create a positive change and influence a culture do so by driving performance standards that are backed by real data. They also share goals with their teams and help them understand:

- How their goals are established
- How individual accountability is just as important to one's self as it is to overall good of their team and the hospital over-all
- That to support the team, management will have real-time course correction plans to influence improvement
- That progress will be measured daily/weekly/monthly

- That management will report positive as well as negative results with senior leadership as well as the entire team
- That there will be accountability for all actions taken and those missed

High performing hospitals benchmarks against national standards. These facilities develop strategies for benchmarking externally against peer facilities and internally against their own best historical levels. External and internal benchmarking is key in evaluating performance goals. External benchmarks can provide the greatest benefit in determining overall performance because it allows hospitals to compare themselves against peer facilities. Best practice facilities target at least 75th percentile or greater. However, it's imperative to understand the methodology for gathering the statistics so that the leadership may be able to 'compare apples to apples'. External data is the most difficult to obtain. Internal benchmarks allow the hospital to monitor trends over time. To ensure long term success, the RCT should develop internal benchmarks based on detailed study of historical data. Besides determining the current direction in which the hospital is moving, another goal of internal benchmarking is to provide an incentive for departments to operate at their best historical levels of performance. This typically results in the hospitals experiencing better financial performance. Many facilities would experience better financial performance if they could perform at their best historical levels, which first requires the monitoring of trends over at least three, if not five year period. Monitoring internal trends can help provide administrators and managers solutions and reduce resistance from clinicians by providing evidence.

Most importantly, high performing hospitals track and monitor KPI to improve performance and sustain gains over time. Best practice facilities establish targets based on KPI, and track and manage them on a dashboard to improve performance and meet the intended goals. **Appendix D** provides a list of revenue cycle KPI recommended by the HFMA. Rural hospitals should be able to track and monitor the HFMA recommended KPI. Some of the metrics could be challenging for small rural hospitals, and particularly CAHs. According to the majority of the RHPI consultation reports, rural hospitals should track and monitor, at a minimum, the below HFMA recommended KPIs:

- Cash collected and cash percentage of net revenue
- Gross accounts receivable
- Gross accounts receivable days
- Net accounts receivable
- Net accounts receivable days
- In-house and discharged not-final-billed receivables

- Third party aging over 90 days
- Cost to collect
- Bad debt and charity as a percent of gross charges
- Denials as a fraction of gross charges
- POS collections as a fraction of gross charges

These KPI should be relatively easy for all rural hospitals to track compared to the full HFMA recommended list. In addition, these KPI have been shown to be used with success by RHPI participating hospitals, at least to some degree as determined through post-project program evaluations.

If CAHs are unable to track the above recommended KPI, then they should at least track and monitor following ten metrics:

- Days in Net Accounts Receivable
- Days in Gross Accounts Receivable
- Days Cash on Hand
- Total Margin
- Operating Margin
- Debt Service Coverage Ratio
- Salaries to Net Patient Revenue
- Payor Mix Percentage
- Average Age of Plant
- Long Term Debt to capitalization

These indicators are determined to be KPI for CAHs in the *CAH 2012 Financial Leadership Summit Report*. The KPI were identified by The National Rural Health Resource Center Technical Assistance and Services Center (TASC) Financial Summit team for the Federal Office of Rural Health Policy (HRSA, DHHS) and the Medicare Rural Hospital Flexibility (Flex) Program. While these metrics are primarily financial indicators, they were determined by the Financial Summit team to be closely aligned with financial strength of a CAH, and could be used to determine the financial status of a CAH. Financial Summit team members also concluded that the days in net accounts receivable and days in gross accounts receivable indicators were directly relevant to CAH revenue cycle performance improvement.

In addition to the above resources, The Flex Monitoring Team outlines twenty financial indicators in the annual *CAH Financial Indicators Reports*. These KPI were specifically designed to capture the financial performance of CAHs. The creation of these indicators are based on three criteria: feasibility (whether the indicator can

be accurately calculated from Medicare cost report data), importance (whether the indicator is an important measure of the financial management of CAHs), and usefulness (whether the indicator is useful to CAH administrators). These resources are available to all CAHs free of charge, and provide valuable tools for administrators to use for financial performance improvement.

Another free, but very valuable, resource tool that's made available by CMS to all hospitals is the [Program for Evaluating Payment Patterns Electronic Report (PEPPER)](#). "PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. PEPPERresources.org is the official site for information, training and support related to the PEPPER Program."[14] The PEPPER Program also provides hospitals with online tools and information on various topics such as, for example, monitoring, compliance, CAH billing, and medical necessity through the [PEPPER News](#).

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[14] http://www.pepperresources.org/Home.aspx

CONCLUSION

As the health care industry continues to evolve hospitals are making adjustments to their long utilized processes. Patients are becoming more involved in their health care decision and they are expecting higher quality for their financial contributions. Processes are being developed to ensure transparency, quality, value and options for their patients. Through a well-designed revenue cycle hospitals can rise up to meet these changes head on.

Well executed payer contracts, clear value maps that lead to patient centric policies and procedures, robust self-pay and denial management processes, consistent customer service, well designed and communicated expectations all contribute to the highest standards within the revenue cycle. These standards when acted upon correctly and with passion will help to deliver a positive patient experience as well as drive positive revenue resolution.

Leaders must focus on each process to ensure that value is delivered consistently. Key performance indicator tracking and process improvement will continue to contribute to success within the revenue cycle. Implementing these best practice suggestions can have a positive impact on the facility and the community that is served.

APPENDIX A: Sample Staff Pre-collection Scripts

*Key Point to Remember: It is a **contract** between the patient and the insurance.*

Example 1: Mr. Jones – We have verified your insurance and they require us to collect a $50 copay for each visit. How would you like to take care of this today, cash or credit? (Then be silent)

Example 2: Mr. Jones – you are having a procedure today that requires a deposit of $_____ I see that Amy our financial counselor spoke with you on Tuesday and you indicated that you would be paying by check, is that still the method of payment that you would like to use? (then be silent)

Example 3: We look forward to seeing you on _(appt. date)_. Please be sure to bring your insurance card, and your identification card to the visit. We will collect your co-pay/co-insurance/deductible (give specific amount) required by your insurance plan.

Scenario 1: Never Had to Pay Before

Patient: I have never had to pay at the time of service before.

Registrar: Mr. /Mrs. (patient/responsible party's name), I understand your concern, however, changes in office procedure were needed to ensure compliance insurance company requirements. Paying at the time of service ensures that you have honored your insurance company policies and that we have been able to avoid additional administrative costs, which in turn helps to save you the patient money. It also allows you to take care of all of your financial items up front so that you can focus on healing and not worry about your bills later. Would you like to pay by cash, debit/credit card?

Scenario 2: Insurance Will Pay

Patient: My insurance will pay.

Registrar: Mr. /Mrs. (patient/responsible party's name), your insurance indicated that you have (not met your deductible or, you have a copayment of $_____, or they will not cover this service), and that this amount would be your responsibility. Would you like to pay cash, debit/credit card?

APPENDIX B: National Rural Health Resource Center Educational Training & Online Resources

The National Rural Health Resource Center (The Center) provides access to the [RHPI Health Education and Learning Program (HELP) webinar library](#) to assist hospitals with:

- Staff capacity building
- Performance improvement
- Sustainability

The Center's HELP webinar library provides rural hospitals access to a wide range of trainings. The previously recorded HELP webinars are available to rural hospitals for free, at no cost, to assist them with improving and sustaining financial, operational and quality performance. These trainings are developed to support the executive team, and are targeted to the front-line staff, supervisors, managers, and board members. The Center also maintains a resource library of online resources are available to rural hospitals at http://www.ruralcenter.org/resource-library.

Revenue cycle performance improvement HELP Playback Links

Revenue Cycle Management:

[Keeping your Patient at the Heart of your Revenue Cycle](#)

[Financial Clearance and Pre-Registration: Steps for Success](#)

[Account Management: Move from Denial Management to Denial Avoidance with Process Improvement](#)

[Becoming a Patient Focused but Metrics Driven Revenue Cycle Team](#)

[Best Practice Business Office Policies and Procedures](#)

[Chargemaster Fundamentals for a Solid Revenue Cycle Foundation](#)

[How to Create a Defensible Pricing Strategy](#)

[How to Ensure Departmental Revenue Cycle Accountability and Ownership](#)

[Charge Capture Part 1: Departmental Responsibilities for Charge](#)

[Charge Capture Part 2: Departmental Responsibilities for Charge Description Master](#)

Care Management:

[Observation vs. Inpatient Status - Part 1](#)

[Observation vs. Inpatient Status - Part 2](#)

[Observation vs. Inpatient Status - Part 3](#)

Hospital Fiscal Management for Department Managers:

[CAH Financial Management](#)

[PPS Hospital Financial Management](#)

[Hospital Fiscal Management: Part I](#)

[Hospital Fiscal Management: Part II](#)

[Hospital Fiscal Management: Part III](#)

[Hospital Fiscal Management: Part IV](#)

APPENDIX C: Best Practice Check List

Patient Centered Revenue Cycle

Best Practice Hospitals:

- ✓ Put the patient at the heart of the revenue cycle process
- ✓ Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management
- ✓ Provide both verbal and written explanation to patients

Scheduling and Pre-Registration

Best Practice Hospitals:

- ✓ Have centralized scheduling to receive patient
- ✓ Schedule patients for services
- ✓ Draft scripts for staff to follow to support customer service
- ✓ Complete prior-authorization to meet medical necessity
- ✓ Educate patients about what their insurance covers to include the amount of copayments, deductibles, and coinsurance for which they would be responsible for paying at the time of service
- ✓ Provide patients with cost estimates at pre-registration
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Assist uninsured patients by scheduling a meeting with financial counselors to complete financial assistance applications
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures
- ✓ Enter all tests into the online scheduling system
- ✓ Integrate IT systems for scheduling and pre-registration functions
- ✓ Develop process to ensure physician order is available at the time of scheduling
- ✓ Provide verbal and written explanation of the hospital policy to the patient
- ✓ Provide reminder calls to patients and include discussion regarding patient balances and point of service (POS) collection policies, confirm third party coverage, and restate proper clinical preparation for the service

Patient Registration and Admissions

Best Practice Hospitals:

- ✓ Complete patient insurance verification
- ✓ Pre-determine if services will meet medical necessity
- ✓ Utilize electronic tools such as to support clinical decisions for evaluating patient placement
- ✓ Provide ongoing education on medical necessity to staff and physicians
- ✓ Make the Advanced Beneficiary Notice of Non-coverage (ABN) a requirement
- ✓ Identify charity care patients early and offer sliding fee scale options
- ✓ Collect co-payments, deductibles, and previous balances at time of service
- ✓ Offer prompt pay and self-pay discounts
- ✓ Have clearly defined policies and procedures

Emergency Room Admissions

Best Practice Hospitals:

- ✓ Assess how the emergency department reaches the Evaluation & Management (E/M) levels
- ✓ Determine the actual distribution of E/M levels following correction
- ✓ Pull out procedure charges and bill separately
- ✓ Monitor the ER admission rate for inpatient and observation services
- ✓ Manage an ER re-direct program to collect co-payments, deductibles, and any previous balances from non-emergent patients following the EMTALA screening and/or attempt to move the patient to the more appropriate level of care by either redirecting them to a walk-in clinic or scheduling them in the clinic the next day
- ✓ Have clearly defined policies and procedures

Charge Capture

Best Practice Hospitals:

- ✓ Use concurrent coding to improve medical necessity documentation
- ✓ Hold weekly nursing and Health Information Management (HIM) team meetings to discuss medical necessity documentation and charge capture opportunities

- ✓ Hold ancillary department managers responsible for reviewing the prior day's charges in order to identify errors
- ✓ Train ancillary staff on appropriate charging and reconciliation
- ✓ Hold weekly interdisciplinary team meetings to engage managers and build department accountability
- ✓ Hold weekly interdisciplinary team meetings to determine issues that put the facility at risk, which may include:
  - o Conducted chart audits
  - o Review system reports such as one day stays and cumulative totals for each ER level
- ✓ Develop processes that clarify what a separately reportable charge for outpatient services is
- ✓ Develop a process for regularly reviewing pharmacy charges by auditing the medical records versus charges and claims for injections versus drugs
- ✓ Establish a formal process that involves the business office and department managers to review existing charge codes and to establish new charge codes
- ✓ Develop pricing strategies based on market based data
- ✓ Perform an annual review to update pricing
- ✓ Hold quarterly meetings with department managers and BO to conduct a review and update chargemaster
- ✓ Review third party contracts
- ✓ Have clearly defined policies and procedures

Timely Filling

Best practice hospitals:

- ✓ Monitor the filing of claims
- ✓ Determine the percent of claims not filed before deadline, which includes a separate account for tracking write-offs due to missed deadlines
- ✓ Have clearly defined policies and procedures

Billing and Collections

Best practice hospitals:

- ✓ Stratify the accounts by amount
- ✓ Identify Medicare separate from commercial accounts
- ✓ Have clearly defined policies and procedures
- ✓ Educate staff on:

- ➢ Payer contract requirements
- ➢ How to verify coverage
- ➢ How to appeal coverage determinations
- ➢ Timely filing rules
- ➢ Fee schedules
- ➢ Special billing requirements

Denial Management

Best practice hospitals:

- ✓ Track denials to prevent oversight and monitor by:
    - ➢ Payer and type
    - ➢ Reason
    - ➢ Department
    - ➢ Percentage of revenue submitted
    - ➢ Denials as percent of gross revenue
    - ➢ Denial over-turned (%)
    - ➢ Payer rejects as percent of remit revenue processed
- ✓ Make ABN mandatory
- ✓ Provided ongoing education on ABN and medical necessity to staff and physicians
- ✓ Develop processes to pre-determine if services meet medical necessity criteria
- ✓ Have clearly defined policies and procedures

Monitoring Revenue Cycle Metrics

Best Practice Hospitals:

- ✓ Hold weekly revenue cycle team meetings
- ✓ Benchmark externally against peer hospitals
- ✓ Benchmark internally to monitor trends over time
- ✓ Benchmark internally against best historical level and target department performance to the historical level
- ✓ Establish targets based on HFMA suggested key performance indicators
- ✓ Track and monitor key performance indicators
- ✓ Use a dashboard to manage to revenue cycle improvement goals

APPENDIX D: Healthcare Financial Management Association (HFMA) Recommended Key Performance Indicators (KPI)

Healthcare Financial Management Association (HFMA) recommends the below key performance indicators (KPI) for tracking, monitoring, and improving revenue cycle performance[15]. HFMA has selected these KPI because they represent the entire revenue cycle and the processes associated with management, patient access, revenue, and claims. For more information regarding revenue cycle management performance improvement and recommended KPI, visit HFMA website to learn more about *HFMA's MAP Initiative* and *Map Keys.*

Management Processes

Measure: Days in Accounts Receivable
Purpose: Trending indicator of overall A/R performance
Value: Indicates revenue cycle efficiency
Benchmark: 40-50 days (variable based upon payer mix)
Equation: (Measure with and with-out Credit Balances included)
N: Gross A/R
D: Average daily net patient service revenue

Measure: Aged A/R as a Percentage of Billed A/R
Purpose: Trending indicator of receivable collectability
Value: Indicates revenue cycle's ability to liquidate A/R
Equation: N: 0-30, >30, >60, >90, >120 days
D: Total billed A/R

Measure: Cash Collection as a Percentage of Adjusted Net Patient Service Revenue
Purpose: Trending indicator of revenue cycle to convert net patient services revenue to cash
Value: Indicates fiscal integrity/financial health of the organization
Equation: N: Total cash collected
D: Average monthly net revenue

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[15] Healthcare Financial Management Association (HFMA) recommended key performance indicators were obtained from the website at http://www.hfma.org/ and http://www.hfma.org/mapkeys/

Measure: Bad Debt
Purpose: Trending indicator of the effectiveness of self-pay collection efforts and financial counseling
Value: Indicates organization's ability to collect self-pay accounts and identify payer sources for those who can't meet financial obligations
Equation:
N: Bad debt
D: Gross patient service revenue

Measure: Charity Care
Purpose: Trending indicator of local ability to pay
Value: Indicates services provided to patients deemed unable to pay
Equation:
N: Charity care
D: Gross patient service revenue

Measure: Charity as a Percent of Uncompensated Care
Purpose: Trending indicator that monitors charity care versus bad debt
Value: Reflection of charity care (provided to the community)
Equation:
N: Charity care
D: Total uncompensated care (bad debt + charity care)

Measure: Uninsured Discount
Purpose: Trending indicator of amounts not expected to be paid by uninsured patients
Value: Indicates the portion of the self-pay gross revenue not included in cash, charity or bad debt metrics
Equation:
N: Uninsured discounts
D: Gross patient service revenue

Measure: Total Uncompensated Care
Purpose: Trending indicator of total amounts not collected from patients related to charity and bad debt combined
Value: Indicates the total amount of self-pay gross revenue that is not collectable or expected to be collected
Benchmark: <5% of Gross Revenue
Equation:
N: Uninsured and uncompensated care (bad debt + charity care + uninsured care discount)
D: Gross patient service revenue

Measure: Cost to Collect
Purpose: Trending indicator of operational performance
Value: Indicates the efficiency and productivity of revenue cycle (RC) process
Benchmark: 2% of total Revenue Cycle costs (Patient Access + Business office)*
Equation:
N: Total Revenue Cycle (RC) Cost
D: Total cash collected
*HFMA is attempting to create industry awareness around the need to include: Patient Access, Financial Counseling, Business office, HIM and Revenue Cycle dedicated IT

Measure: Cost to Collect by Functional Area
Purpose: Trending indicator of operational performance by functional area as reported in Cost to Collect
Value: Indicates the efficiency and productivity of revenue cycle process by functional area
Equation:
N: Total x (x = the cost of each functional area) cost*
D: Total cash collected
Sum total of all x's (i.e. sum of the cost of each functional area) should equal total cost of Cost to Collect

Measure: Case Mix Index
Purpose: Trending indicator of patient acuity, clinical documentation, and coding
Value: Supports appropriate reimbursement for services performed and accurate clinical reporting
Equation:
N: CMI (average RW/Patient) = sum of relative weights for all inpatients*
D: Number of inpatients in the month*
Excludes normal newborns and Medicare-exempt units

Patient Access Processes

Measure: Pre-Registration Rate
Purpose: Trending indicator that patient access processes are timely, accurate, and efficient
Value: Indicates revenue cycle efficiency and effectiveness
Equation:
N: Number of patient encounters pre-registered
D: Number of scheduled patient encounters

Measure: Insurance Verification Rate
Purpose: Trending indicator that patient access functions are timely, accurate, and efficient
Value: Indicates revenue cycle process efficiency and effectiveness
Equation:
N: Total number of verified encounters
D: Total number of registered encounters

Measure: Service Authorization Rate
Purpose: Trending indicator that patient access functions are timely, accurate, and efficient
Value: Indicates revenue cycle process efficiency and effectiveness
Equation:
N: Number of encounters authorized
D: Number of encounters requiring authorization

Measure: Point-of-Service (POS) Cash Collections
Purpose: Trending indicator of point-of-service collection efforts
Value: Indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs
Equation:
N: POS payments
D: Total patient cash collected

Measure: Conversion Rate of Uninsured Patient to Payer Source
Purpose: Trending indicator of qualifying uninsured patients for a funding source
Value: Indicates organization's ability to successfully secure funding for uninsured patients and improve customer satisfaction
Equation:
N: Total uninsured patients converted to insurance
D: Total uninsured discharges and visit

Revenue Processes

Measure: Days in Total Discharged Not Final Billed (DNFB)
Purpose: Trending indicator of claims generation process
Value: Indicates revenue cycle performance and can identify performance issues impacting cash flow (from discharge to transfer to business office – also identify days from transfer to final billing)
Benchmark: 9 days
Equation:
N: Gross dollars in A/R (not final billed)
D: Average daily gross revenue

Measure: Days in Total Discharged Not Submitted to Payer (DNSP)

Purpose: Trending indicator of total claims generation and submission process

Value: Indicates revenue cycle performance and can identify performance issues impacting cash flow

Equation:

N: Gross dollars in DNFB + Gross dollars in FBNS

D: Average daily gross revenue

Measure: Late Charges as a Percentage of Total Charges

Purpose: Measure of revenue capture efficiency

Value: Identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance, and accelerate cash flow

Equation:

N: Charges with postdate greater than three days from service date

D: Total gross charges

Measure: Net Days in Credit Balance

Purpose: Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness

Value: indicates whether credit balances are being managed to appropriate levels and are compliant to regulatory requirements

Equation:

N: Dollars in credit balance

D: Average daily net patient service revenue

Claims Processes

Measure: Days in Final Billed Not Submitted to Payer (FBNS)

Purpose: Trending indicator of claims impacted by payer/regulatory edits within claims processing system

Value: Track the impact of internal/external requirements to clean claim production, which impacts positive cash flow

Equation:

N: Gross dollars in FBNS

D: Average daily gross revenue

Measure: Clean Claim Rate

Purpose: Trending indicator of claims data as it impacts revenue cycle performance

Value: Indicates quality of data collected and reported

Equation:

N: Number of claims that pass edits requiring no manual intervention

D: Total claims accepted into claims scrubber tool for billing prior to submission

Measure: Denial Rate – Zero Pay
Purpose: Trending indicator of % claims not paid
Value: Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
Equation:
N: Number of zero paid claims denied
D: Number of total claims remitted

Measure: Denial Rate– Partial Pay
Purpose: Trending indicator of % claims partially paid
Value: Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
Equation:
N: Number of partially paid claims denied
D: Number of total claims remitted

Measure: Denials Overturned by Appeal
Purpose: Trending indicator of hospital's success in managing the appeal process
Value: Indicates opportunities for payer and provider process improvement and improves cash flow
Equation:
N: Number of appealed claims paid
D: Total number of claims appealed and finalized or closed

Measure: Denial Write-Offs as a Percent of Net Revenue
Purpose: Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount
Value: Indicates provider's ability to comply with payer requirement and payers ability to accurately pay the claim
Benchmark: 1-3%
Equation:
N: Net dollars written off as denials
D: Average monthly net revenue

Measure: Aged A/R as a Percent of Billed A/R by Payer Group
Purpose: Trending indicator of receivable collectability by payer group
Value: Indicates revenue cycle's ability to liquidate A/R by payer group
Equation:
N: Billed payer group by aging (0-30, >30, >60, >90, >120 days)
D: Total billed A/R by payer group