5 Ways to Improve a Hospital's Bottom Line Through the Revenue Cycle

By Bob Herman

A hospital's revenue cycle management team has to balance a large amount of tasks at once every day: preauthorization, precertification, underpayment collection, delays in payments, ICD-10 transition and more. With so many tasks to juggle at once, methods for improvement might get pushed on the backburner in the quest for simply finishing projects now. Becky Black, vice president of revenue cycle at Saint Joseph's Hospital of Atlanta, gives five ways any hospital can improve its revenue cycle, overall bottom line and efficiency.

1. Documentation of communication. While it's common for hospitals to document all conversations and communication in a patient's case, it's also common for those documents to be misplaced. Saint Joseph's Hospital of Atlanta recently installed the Trace communication platform, which is a centralized portal that stores various forms of revenue cycle communication such as phone conversations, patient eligibility information, emails, incoming and outgoing faxes and more and indexes it by patient account.

Ms. Black says this has been a lifesaver for her hospital's revenue cycle because it allows them to go to one location to find all forms of communication regarding a patient's account and removes the "he said/she said" of reimbursement disputes. For example, the system can immediately pull up how the payor was contacted, who contacted the payor and if any authorization number on the patient's claim was obtained. In a way, it's like an electronic medical record for the revenue cycle as it eliminates paper records and hand-written notes and electronically stores all information on the business side of patient care. Within nine months of implementing this process, the hospital was able to use records to overturn more than 100 denials, resulting in nearly $200,000 in cash collections.

While those are the primary benefits of that type of repository, Ms. Black says it also keeps the management team attentive. "It also underscores the professionalism of our staff," she says. "They know when they are using that system, they are being recorded as well, and it puts the onus on us to exhibit professionalism at all times."

2. Precertification of patients. Reviewing a patient's preadmission status blends the "business with the clinical excellence," Ms. Black says. Patient satisfaction isn't scored from the clinical side only, and making sure the patient is financially clear to come into the hospital puts all minds at ease. "What you do before the patient shows up is good for the organization and the patient," Ms. Black says. "It takes the financial worry off the patient, and it sets the stage on the front end for what the patient can expect to encounter on the clinical side." Additionally, by capturing this communication with patients on the front-end, hospitals can review conversations to ensure patients receive clear instructions before coming to the hospital.

Some younger patients take advantage of preregistration online, but Ms. Black emphasizes that a hospital must know its audience when it comes to utilizing technology to accomplish tasks such as patient preregistration. For example, some patients may want to sit with hospital staff and may prefer the direct contact to complete complex paperwork because that might fit their preference, whereas other patients may prefer to do this online without an interview process. "You have to gauge what your patients need," Ms. Black says. "We're not in the business these days of 'It's my way or the highway.' We are actually an extension of the marking and business development efforts of the hospital."

3. Payment estimates. When a patient is scheduled for a hospital procedure, Ms. Black says it is paramount the team gives the patient an estimate of their out-of-pocket costs. Recording these conversations can also ensure estimates are communicated clearly prior to service, and if questions arise once the patient receives a bill, the hospital can reference those estimate records to resolve any misunderstandings. While giving estimates may be difficult for complex or exploratory procedures, she says patients who will be receiving planned procedures with case histories should get a reasonably accurate estimate.

For example, an estimate for a patient with UnitedHealthcare PPO receiving a hip replacement can be researched and refined, giving the patient a solid figure to contemplate. "Help the patient if it's far enough ahead of time, and do it as soon as a procedure is scheduled," Ms. Black says. "Patients are footing a lot of costs out-of-pocket today and are shopping around at different hospitals, so every effort needs to be made to make such estimates as accurate as possible."

4. Meticulous managed care contract negotiation. Ms. Black says in a perfect world, there would be one agreed-upon managed care contract methodology, but unfortunately, this is not a perfect world. To lower administrative costs, she says every good organization should review every managed care contract for clauses that are executable (e.g., the managed care company says they cannot pay for a certain type item unless it is billed a certain way even though doing so may not be a commonly accepted billing practice).

All accounts must also be religiously reviewed to detect underpayments and underpayment trends. When finding trends on underpaid claims, the revenue cycle team should take these back to contracting and then sit to review these disconnects with the payor. Documenting these discussions and the details of contract interpretation also assist in battling denied or underpaid claims. "Part of this is just the way that our current system works," Ms. Black says. "The question is: Is your staff good enough to seek and find all of these underpayment opportunities, or do you hand the underpaid claim off to someone else and pay them a finder's fee?"

5. Education on ICD-10. Ms. Black considers the conversion to ICD-10 as one of the biggest nail biters hospitals must confront today. Hospitals have to pay the inevitable costs to make the transition, but she says mass-scale education of hospital staff and clinical providers could help mitigate the hiccups that will occur when it goes into effect on Oct. 1, 2013. Weathering the storm for the first few months will be key to the hospital's bottom line, and the amount of work to do with ICD-10 simply should not be overlooked. "There are so many coding-specific things that need to be laid out. There's a lot to do, and you must retrain your hospital staff, especially your physicians and anyone else that documents within the record," she says. ■

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Survey: Roughly 7 out of 10 Hospitals Collect Less Than 30% of Payments at Point of Service

By Bob Herman

Approximately 70 percent of hospitals and health systems collect less than 30 percent of their payments at the point of service, according to a TransUnion Healthcare survey.

The survey polled more than 300 attendees of the Healthcare Financial Management Association's Annual National Institute Conference. Respondents said the two biggest challenges for collecting payments at the point of service are determining what is owed and training staff to ask for the payments.

Other highlights of the survey include the following:

In your opinion, what is the biggest challenge for patients when it comes to paying at the point of service?

- Patients are unprepared to make the payment: 36.79 percent
- Patients are uneducated on the option to pay at time of service: 25.47 percent
- Patient can't afford to pay at the time of service: 21.38 percent
- Patients are unwilling to make the payment: 16.35 percent

Of payments that go into back-end collections, what is the approximate recover rate at your hospital?

- Between 15 and 30 percent: 29.17 percent
- Between 0 and 15 percent: 22.76 percent
- Between 30 and 45 percent: 17.31 percent
- Not sure: 11.22 percent
- Between 45 and 60 percent: 9.29 percent
- Between 60 and 75 percent: 7.05 percent
- Between 75 and 90 percent: 2.24 percent
- More than 90 percent: 0.96 percent

In your opinion, how much of your net revenue in 2010 was lost to bad debt?

- Between 3 and 5 percent: 30.19 percent
- Between 1 and 3 percent: 26.73 percent
- Between 5 and 7 percent: 16.67 percent
- More than 7 percent: 16.35 percent
- Not sure: 6.6 percent
- Less than 1 percent: 3.46 percent ■

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To see a 90-second cartoon about the revenue cycle black box, visit TraceCommunication.com/Beckers

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HHS Announces New Bundled Payment Initiative

By Bob Herman

The Department of Health and Human Services has introduced a new program, Bundled Payments for Care Improvement, to improve healthcare for patients while they are in a hospital and after they are discharged.

Bundled Payments for Care Improvement, which was created by the Patient Protection and Affordable Care Act, will align payments for services across the entire episode of a patient's care instead of paying for services separately, the release said. For example, instead of a surgical procedure creating multiple claims from several different providers, the entire team of providers is compensated with a shared, bundled payment. HHS expects the program to improve the quality of care, incent physicians and hospitals to coordinate care and save money for Medicare.

There are four different models CMS will be testing and developing for these bundled payments: Models 1, 2, 3 and 4.

In Model 1, the episode of care would be defined as the inpatient stay in a general acute-care hospital. Medicare will pay hospitals a discounted amount based on the Inpatient Prospective Payment System, and Medicare would pay physicians separately under the Medicare Physician Fee Schedule. Hospitals and physicians will then be able to share gains that result from better care coordination.

In Models 2 and 3, the bundle payments would include physicians' services, post-acute providers, related readmissions and other services such as clinical lab services. However, in Model 2, the episode of care would include the inpatient stay and post-acute care and would then end either a minimum of 30 or 90 days after discharge. In Model 3, the episode of care only beings at discharge from the inpatient stay and would end no sooner than 30 days after discharge. Payments for both Models 2 and 3 will be made at the usual fee-for-service payment rates, and any reduction in expenditures will be paid to the participating providers to share.

In Model 4, CMS would create a single, prospectively determined bundle payment to the hospital that would encompass all services provided by the hospital, physicians and other practitioners during the inpatient stay. Those physicians and practitioners would submit "no-pay" claims to Medicare, and the hospital would then pay them out of the bundled payment.

Healthcare organizations interested in applying to the Bundled Payments for Care Improvement initiative must have submitted a letter of intent by Sept. 22, 2011, for Model 1 and by Nov. 4, 2011, for Models 2, 3 and 4. ■

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Trace by The White Stone Group is a browser-based software platform that captures communication from any medium — voice, fax or electronic — and indexes records by patient for efficient retrieval, sorting and routing. Nearly 400 hospitals nationwide are using Trace to capture information related to processes such as patient authorization, eligibility, scheduling, registration and more. Records are used to protect revenue, prove compliance and drive performance enterprise-wide.

What are revenue cycle professionals saying about Trace?

"Monitoring communication across our revenue cycle helps us improve customer service and issue resolution."
Director of Revenue Cycle

"Gives us a permanent record for follow-up discussions with patients and insurance carriers."
Director, Patient Financial Services

"A tremendous recourse with payors that want to disclaim commitments."
VP, Revenue Operations

"Trace gives us an accurate and indisputable record of communication."
Chief Financial Officer

"Provided ROI within the first four months."
Chief Administrative Officer

"Helps us resolve 'he-said, she-said' scenarios."
Director of Patient Financial Services

To find out why nearly 400 hospitals are using Trace to capture communication across the revenue cycle, visit TraceCommunication.com/Beckers.

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