REVINT SOLUTIONS INSIGHTS

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Is Your Organization Leaving Money on the Table?

To Our Healthcare Clients and Friends:

In today's digital age, we see vendors and technology think-tanks in Modern Healthcare advertisements and LinkedIn pages oversimplifying revenue cycle management (RCM) challenges that present themselves daily. If only it were that simple. Today's healthcare revenue cycle is far more complex than portrayed in media, and there are real challenges that need to be addressed.

The reality is that RCM challenges are constantly changing. Payers create new rules/denials criteria in their claims processing engines, charge interfaces break, staff turns over, and concurrent system implementations create an environment that's challenging to monitor and fix.

Adding to the mix is healthcare reimbursement is an ever-changing and complex environment. The Centers for Medicare and Medicaid Services (CMS) are consistently updating content and testing new reimbursement models, such as Accountable Care Organizations (ACOs) and Value-Based Reimbursement methodologies. Payment penalties due to hospital re-admissions and the two-midnight rule are infamous within the industry, and many Medicare Advantage (aka Medicare Part C) payers are following suit and modeling reimbursement methodologies to mirror changes in Medicare payment structures.

BACKGROUND

HFMA estimates that 3-5% of revenue for the average healthcare organization is lost due to missed, misplaced, or mis-coded charges. This suggests that most organizations are doing it correctly 95-97% of the time. Some are as good as 98-99%. In addition, few organizations have the time or resources to pursue the remaining 3-5% given the high demands placed on revenue cycle operators.

As a result, trends suggest that not enough time is spent performing true process improvement or root cause analysis. This may be driven by the misconception that there's no need to take a second look when performance is already near-optimal. However, in taking an alternative view, 3-5% also means that a healthcare organization that does hundreds of millions or billions in net patient revenue each year is missing out on considerable additional revenue they are entitled to receive.

CHALLENGES

Where does this extra 3-5% of revenue fall out? Well, as always in healthcare, the answer is complicated. Here are a few anecdotal examples that we see frequently:

- Many large Integrated Delivery Networks are rapidly growing or acquiring new facilities and medical groups, which operate on different electronic medical records (EMR) systems that have limited or no interoperability (and often have considerably different processes and workflows).
- Discrepancies occur when reconciling the professional and hospital claims, such as when a physician performs a procedure, but the drug, supply, or nursing charges aren't added to the bill.
- Physician groups vary in structure (owned, affiliated, and independent), and the complexities associated with their financial relationship with a hospital or health system can complicate the billing process.
- Cost pressures are an ever-present struggle for many care providers as Managed Care and Commercial insurance payers deploy large departments of savvy actuarial science experts that often out-negotiate healthcare providers in the contracting process.
- Insurance premiums continue to rise and shift additional payment responsibility to the patient, which is a more difficult audience to collect from and increases risk of higher uncompensated care (bad debt + charity care) totals for an organization.

INSIGHTS

Given these variables and complexities, organizations can start by focusing on the fundamentals to minimize the estimated 3-5% of lost revenue. It is impossible to control for everything, so it is best to prioritize. Here are common questions and tactics we recommend an organization should consider:
Are there currently multiple charge description masters (CDM) utilized throughout the organization, or is the chargemaster loosely monitored or too large to manage? If the answer to any of these questions is 'Yes,' it may be time to consider one or more of the following options:

- Consolidate and implement a single, standard CDM across all facilities
- Create a dynamic CDM that enables the organization to create a single charge code and map variable fee schedules to it based on the place of service
- Pay close attention to any HL7 or batch charge interfaces coming from other systems, especially during and immediately after system conversions and version upgrades
    - Lab and Surgery settings are common problem areas to keep a close eye on, and broken interfaces can quickly create large pockets of missed revenue
- Implement a Chargemaster committee that includes members of Front, Middle, and Back RCM operations, as well as Clinical stakeholders (think Nurse/Charge Auditors), Reimbursement, and Finance departments
    - Ensure the committee vets new charge recommendations and changes on a weekly or bi-weekly basis
- Evaluate new charge additions or charge modifications thoroughly to make certain that unnecessary charges are not being created that further complicate the existing CDM
- Avoid prematurely removing charges that are still utilized, such as those associated with an obscure patient care scenario, as they will adversely impact the billing process and revenue
    - Exploratory treatments and research pharmaceutical drug therapies are both great examples, and something to monitor closely

INSIGHTS CONT'D...

Is lower reimbursement-per-claim placing strain on the operation by increasing cost-to-collect? Organizations experiencing this trend must continue to innovate to do more with less. The following are a few approaches to consider in combatting this challenge:

- Engage with compliance and managed care teams to coordinate pricing strategies
- Leverage partners for monitoring services that capture missing or lost charges on claims
- Implement learnings from partners to improve internal practices to limit reoccurrence
- Deploy flex-staffing models that incorporate contract or offshore employees to lower the fixed labor cost structure and create a "right-sized" staffing model
- Utilize internal or vendor payment variance experts whose sole purpose is to investigate and pursue expected reimbursement variances and contractual disputes with payers (that the patient accounting system may not be sophisticated enough to identify)
- Implement effective technology to equip team members with better tools and resources at their disposal and automate administrative tasks
- Improve standardization and implement workflow efficiencies that simplify and streamline processes

SUMMARY

CDM management becomes a big headache for the business office when it is not managed well. High amounts of variability in physician documentation and claim edits complicate RCM processes after patient discharge. But when the needed charge code does not exist in the system, it is a complete non-starter for staff that delays billing and inflates discharged not final billed (DNFB) every time it occurs. This problem runs the risk of upsetting both staff and patients, and is preventable by taking measures to improve the CDM and implementing a committee to monitor it.

Planning for the unforeseen by implementing solution-oriented initiatives and teams will also help insulate an organization from some of the "fire-drills" that pop-up and steal time and resources away. Identifying reimbursement issues early on, having extra staff at the ready, and improving automation and process are all important measures to have in-place, and will ensure the revenue cycle remains a well-oiled machine.

We are pleased to have the opportunity to present this information to you. If you have any comments or questions, please contact me at john.lynch@revintsolutions.com.

Truly Yours,
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Meet the Author | John Lynch

John Lynch is an accomplished healthcare leader with revenue cycle experience spanning various leadership roles within consulting, operations, strategy, sales, and technology implementations for numerous integrated delivery networks nationally. He has led Revenue Cycle operations for multiple large health systems and medical groups. John lives in Milwaukee, WI, with his wife Brittany and daughter Ava, and enjoys all things outdoors.

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