

FOR THE Record

May 9, 2011

Revenue Generators
By Susan Chapman
For The Record
Vol. 23 No. 9 P. 20

HIM departments stand front and center in the constant struggle to keep hospital finances solvent.

In a seemingly never-ending battle, healthcare organizations continue to search for ways to improve revenue flow. Often, revenue loss occurs in unforeseen areas, among them HIM and the department's many components.

"Where hospitals are losing money is not totally unknown but also seldom addressed," says a 35-year veteran of the healthcare profession who requested anonymity. "First, the model is wrong. Hospitals operate like car companies, on an 8-to-5 schedule, while they're open on a 24-hour basis. Patients can easily slip in without being properly vetted. And hospitals' paper-based world leaves plenty of room for things to fall through the cracks. On top of that, HIM is old-fashioned and archaic. Coding is subjective and not necessarily a valid truth, so there are missed opportunities and revenue is lost."

Billy K. Richburg, MS, FHFMA, director of government programs at MedAssets Revenue Cycle Technologies, highlights specific phases in the revenue cycle, including patient eligibility, where leaks can occur. "Far too many patients are designated uninsured, underinsured, or charity when providers don't use an eligibility system and depend on the insurance information provided by the patients themselves," he says.

Another area of concern is post-acute care transfers, according to Richburg. "A patient discharged to one of several care facilities will be paid as a transfer, provided the patient is admitted to the inpatient care venue on the same day—or to home health within three days—and with exactly the same diagnosis," he explains. "Providers are entitled to the full diagnosis-related group [DRG] payment if they have a mechanism in place to determine when any of those conditions are not met." However, if that is not the case, then only transfer or partial payment applies, and the hospital loses revenue.

Additionally, providers must practice due diligence and cannot assume payers will always be accurate when paying claims. Because many providers do not have contract management systems to verify how much they should receive, they are unable to compare that amount with their actual payments.

Richburg also notes that "many providers don't have a denials management system, so they are at the mercy of the payers when claims are denied, whether for technical reasons or for lack of medical necessity. Further, many of those providers that do have a denials management system don't use it in conjunction with a contract management system, limiting them to identify only entire claims or line items that are denied.

"A denials management system alone cannot identify underpayments so long as some sort of payment is received. Think of this as a silent denial," he adds.

HIM at the Heart

Richburg believes it is imperative that HIM personnel understand how vital their role is in the revenue cycle.

"HIM directly affects both collections and revenue. Payers won't pay for services not documented in the medical record. Records must be completed as quickly as possible to avoid delaying the bill drop after the provider's bill hold or suspense days have been met," he says. "Transcription must be timely in order to

complete records promptly, which means considerable—but respectful—pressure must be exerted on those physicians who typically fail to comply with medical staff bylaws requiring timely transcription. HIM is really the heart of the patient revenue cycle and can make or break a hospital's cash flow."

John Dugan, a partner and revenue performance management practice leader at PricewaterhouseCoopers, points to ongoing preparation for the October 2013 deadline for ICD-10 implementation as another reason facilities may not be paying enough attention to areas where revenue is being lost.

"For example, with ICD-10 planning, hospitals may not take into account how much money is lost to obtaining clarification from physicians in order to improve the DRG case mix," he says.

Dugan notes that the Recovery Audit Contractor (RAC) program, which is designed to recover improperly paid Medicare payments to providers, has also placed a strain on HIM functions. For this reason, providers must grapple with producing a large amount of medical records.

"Sometimes hundreds per month," he says of the records. "And executives want to understand records before they turn them over. There has to be adequate structure and coordination in place to deal with those [RAC] requests."

Moreover, providers are unable to bill if they do not issue an advance beneficiary notice of noncoverage (ABN), a Medicare requirement. The ABN informs patients in advance of receiving care if Medicare will not pay for the service and allows patients to refuse the service or pay for it themselves. If an ABN is not issued, then payment must be refunded, adversely affecting the provider both in lost revenue and additional accounting costs.

Beyond HIM

Richburg looks to other areas that hospitals and other providers often fail to notice or adequately address. "Unfortunately, most of them affect people," he says, "and all of them are difficult."

For example, over the last three decades, many hospital functions have emerged that no longer support providers' primary goals of care and survival. Richburg believes administrators should review these positions and clinicians to ensure best practices in workforce management.

He also emphasizes the power of group purchasing. "There still are institutional providers that don't participate in group purchasing systems or participate in small groups that lack the purchasing power to save significant money on the cost of food, supplies, x-ray film, medical supplies, and pharmaceuticals," he says. "Generally, the stronger your purchasing group and more focused on financial improvement related to quality and utilization, the better your savings."

Automation and cost accounting are additional areas that Richburg suggests can be fine-tuned. "By being myopic in always wanting to see a quick, tangible return on investment or internal rate of return on their technology acquisitions, hospital CFOs [chief financial officers] limit long-term improvements," he says. "Some IT solutions don't save money in the short-term but may hold down costs in the future, protect against liability, or enhance the hospital's image in the community and with the medical staff. If you are a hospital executive and you depend on cost-to-charge and Medicare cost reports to identify your costs, you are not seeing the big picture because that process has no value. Too often, a good cost-accounting system is the last IT solution a board will approve, where it ought to be the first."

Seeking Solutions

Particularly when it comes to HIM and finding cost-saving solutions, there is reason for optimism. "There are opportunities to find and mitigate lost revenue from beginning to end," notes the veteran healthcare professional. "HIM is currently not looked to as an authority. However, HIM staff should be used to better educate physicians and clinical staff. It would be beneficial for nurses, coding staff, and physicians to collaborate. In addition, HIM needs more community college-based training in areas like IT and documentation."

The pressure to implement EMR systems further complicates matters. "We're facing an epic implementation as we move toward electronic medical records, and we must get coding and billing people involved to ensure

correct documentation," the veteran says. "Now is the time to build things into EMRs, and HIM people need to be involved to see where they are losing money."

With respect to coding, Dugan offers an alternate solution. "We are looking at ways to outsource coding. Right now, there is a shortage of coding professionals, primarily women who often leave the workforce to start families," he notes. "Now these professionals are setting up virtual private networks, and hospitals are allowing them to work at home. But we're also looking at international outsourcing to a certified coder population. In India, we can access quality at a lower cost."

Dugan points to technology as another component to investigate. "The EMR advent is huge. Doctors' offices and hospitals will need dedicated coders," he says. "Advances like computer-assisted coding with natural language capability take a digital record and assign codes. All of that now can be done through system capabilities, and coding by people really then becomes editing."

Overall, Dugan believes now is an excellent time for HIM to examine its overall cost model and how it benefits an organization. "It's important to ask questions," he says. "Do we have the right people? Do we have the right resources? How are we working with university talent? Is our workforce IT savvy?"

How EMRs Can Help

Patrick Gardner, director of product management for McKesson's Enterprise Imaging Group, identifies cost-saving opportunities as hospitals and providers adopt EMRs.

"Cost management is obviously something hospitals are looking at," Gardner says, "but because of ARRA, HIM is being overlooked. Medical records are not being brought to the table. Still, important things are happening today, and we can ensure that the revenue cycle remains efficient through automation."

Digital solutions designed by vendors such as McKesson can ease the burden. "With our products, medical records collect all components of a patient's chart into one EMR at the point of discharge," Gardner says. "Right away, they can identify what documents are missing and deficiencies. With an electronic inbox, which is Web based, deficiencies can be completed. Coders can then identify other deficiencies and query clinicians. The process significantly shortens accounts receivable days."

Gardner contrasts this transformation with the paper-based process, which he describes as much more labor intensive and time and space consuming.

"First, staff would have to collect loose papers, append them to the patient's record, and deliver it all to the medical record department," he says. "By hand, deficiencies would have to be identified and indicated. Physicians would then have to go to medical records, interact with clerks to retrieve the files, and sign off on records. Coders then would begin to look through the paper file. Now the process is infinitely more efficient."

Gardner notes that the transition to electronic records also provides several different levels of backup. "Countless charts were lost in Hurricane Katrina, for instance. Electronic records are easily recoverable," he says, adding that because electronic records are episodic based, hospitals can maintain a record of each episode to better shield themselves from costly litigation.

By implementing electronic processes, providers expect to improve workflow. Doctors can see more patients, and healthcare organizations are able to reduce full-time equivalents (FTEs) in coding and medical records, Gardner says.

"No longer is there a need to rent huge storage spaces," he adds. "Floor space can be repurposed. With virtualization, we've reduced electronic storage. We've reduced the amount of rack space and IT costs."

For example, the HIM department at Tuomey Healthcare, a 301-bed hospital in Sumter, S.C., had little room to maneuver thanks to the volume of paper records that filled its floor. As a result, it was necessary to rent off-site storage space (at a cost of \$24,000 per year), which made the records difficult to access.

Adding to the inconvenience, whenever physicians needed to access records to complete their deficiencies, they had to go to the medical records office and rifle through charts. This led to a physician delinquency rate of approximately 95%, resulting in high accounts receivable days. Because physicians would often remove

charts from the HIM floor, the availability of comprehensive patient records quickly became a concern, making it a challenge for the department to provide complete legal medical records to requestors.

By implementing technology that allowed for medical record scanning, production, and storage as well as physician access, Tuomey reduced delinquency rates to between 2% and 5%, as the system allowed for physicians to complete their deficiencies from any location. Furthermore, workflow improvements enabled the hospital to eliminate five FTEs, which created a savings of \$155,000 per year. By adding an information-release module, Tuomey was able to streamline that process and realize an additional savings of \$80,000 annually.

A Look Ahead

Experts emphasize that for hospitals to begin recapturing lost revenue, leadership must examine and recognize the model that is currently in place, knowing that as more healthcare organizations shift to electronic systems, the model that now exists may not be what is needed in the future. As such, leaders must be open to taking a long-range view—particularly when it comes to investments such as HIT—to gain a strong economic foothold.

— *Susan Chapman is a Los Angeles-based writer and author of the book **My Life Is Magic**, which is due to be released later this year.*