Improving Revenue Capture

In 2000 the implementation of ambulatory payment classifications (APCs) resulted in devastating financial losses to many hospital-based outpatient oncology departments around the country. Flash forward a few years. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) alleviated some of these losses, but drug costs continue to escalate and a new reimbursement methodology—average sales prices (ASP)—looms on the horizon. To continue to provide quality care to their patients with cancer, today's hospitals *must* focus attention on revenue cycle management.

The Big Problems

HealthEast Cancer Care is a three acute-care hospital system that serves the east metro area of the Twin Cities of Minneapolis and St. Paul, Minn. A busy, thriving program, HealthEast Cancer Care treats nearly 1,800 new analytic cases per year.

When APCs were introduced, the process of adjusting the hospital's charging systems was managed "behind the scenes" by patient accounting and finance personnel, with very little communication, input, or even the knowledge of clinical leaders and staff. The hospital system did not actively scrutinize the new charging system until its three infusion therapy departments began to experience diminishing revenues. This disturbing trend continued for several consecutive months from August to October 2002.

To solve the problem, HealthEast Cancer Care brought together the leaders of the various departments involved in the revenue cycle. The hospital's infusion therapy departments manage their patient populations by admitting each patient to a series account that allows for recurring visits over the course of treatment. This system, which is common in hospital-based outpatient programs, is an adaptation of the inpatient charging system. It is very difficult to customize the system for changing needs. Leaders from Patient Accounting, Health Information Services, Compliance, and Information Technology (IT) were overwhelmed by the many process and system changes needed if the hospital were to achieve proper charge capture, document medical necessity to assure payment, and educate the nursing staff to assure a consistent and accurate charging practice. The group believed that the cost of revamping the systems might not be worth the effort.

In November 2002, HealthEast Cancer Care participated in a Center for Provider Education Cancer Program

How HealthEast Cancer Care revamped revenue cycle management

by Connie Selle, CPht, RPht

Improvement Project (CPIP) seminar offered by the Association of Community Cancer Centers. Approximately 25 leaders from the hospital's Corporate, Finance, Patient Accounting, and cancer service line attended the one-day program. The presenter provided ideas from an *Oncology Reimbursement Toolbox* that outlined a series of steps to use in analyzing and correcting the revenue cycle in order to achieve maximum charge capture. Our staff took the program's message to heart, and immediately created an action plan adopting the presenter's recommendations. Staff that attended that seminar understood that they could not pursue this initiative in a silo, independent of operations. If the hospital was to increase revenue charge capture, it would need significant collaboration with many department leaders across the organization.

Getting Started

HealthEast Cancer Care identified representatives from all the departments that shared responsibility for the revenue cycle. These individuals became part of a newly formed revenue cycle team. The team involved all stakeholders, including Patient Accounting, Compliance, Contracting, IT, Coding and Billing, Health Information Services (medical records), as well as the clinical staff who understand the clinical procedures and who generate the charges.

The team's first step was to flowchart the revenue cycle. This exercise helped the group identify rules, opportunities, optimal management features, and potential minefields within each segment of the revenue cycle. During the flowcharting process, the team identified the following questions that would need to be answered before revenue charge capture could be improved:

- What happens when a patient calls for an appointment?
- What happens when a patient walks in for services?
- What information is necessary throughout the processes?
- Once the physician's orders are received, what occurs when the information enters the clinical setting?
- How is medical necessity determined?
- How do we charge for services rendered?
- How and when do we submit claims to payers?
- How do we know we are being paid appropriately on these claims?

ILLUSTRATION BY NEIL BRENNAN

Analyzing the revenue cycle components, the team found problems in three major areas: payer problems, inter-departmental problems, and billing department software problems.

Payer problems. Looking at Medicare patients (close to 50 percent of the cancer center's payer mix), the revenue cycle team found that the chargemaster was inaccurate and did not keep up-to-date with regulatory requirements. Reportable and reimbursable items were not being captured on the chargemaster. Chargemaster review and coding updates occurred annually during the consulting review process, and the current process did not allow for regulatory updates within the year.

The revenue cycle team also found problems with its managed care patients. Managed care payers were inspecting charges, refusing to pay certain claims, and down coding for specific outpatient services. The team found that the hospital's managed care plans had little to no interaction with the oncology service line. A number of these plans were unaware of new technology that needed to be incorporated into contracts. The hospital's managed care contracts would need to be reviewed and updated to allow for adequate reimbursement of oncology outpatient services.

Inter-departmental problems. The revenue cycle team found that most of these issues related to a lack of established communication between the billing department and the cancer service line. For example, select line items such as new technology and pharmaceuticals were being denied payment. While the billing department was receiving the denied claims, the oncology department remained unaware of the denials. Because the cancer service-line leaders were not receiving denial or underpayment data, they could not initiate performance improvement.

The revenue cycle team also discovered that the billing department was handling edits and denials with limited clinical expertise and may have been stripping off questionable charges. This lack of clinical expertise meant that billing staff was spending less time on outpatient denials. Frequently, the hospital was forced to write-off outpatient denials or underpayments.

Billing department software problems. The revenue cycle team identified problems with the billing department's software edits. The hospital used claims scrubbers to generate pre-billing edits. A potential for line-item write-offs exists if the claims scrubber flags a certain charge edit. In many systems, the programmed edits differ from the Outpatient Code Editor. Often, claim-scrubbing software adopts the physician standard, which is incorrect in the outpatient prospective payment system (OPPS) environment and up to two reporting quarters behind the physician Correct Coding Initiative (CCI) standard issued by CMS. To resolve problems with software edits, the patient accounting department needed to check with the vendor of the claims edit software to determine whether the edits were based on hospital or physician standards.

Finally, the revenue cycle team identified problems with the diagnosis coding. Simply put, clinical staff did not have the expertise to ensure correct coding. To

continued on page 27

Lessons **Learned**

1. ***Dedicated oncology reimbursement specialists work.*** The cancer service-line leader at HealthEast Cancer Care made the case for a dedicated oncology reimbursement specialist position. She prepared a concise explanation of why the position was needed, stressing the benefit of having a dedicated staff member oversee the outpatient cancer care reimbursement process.

At HealthEast, a dedicated revenue cycle manager was added as soon as the system recognized several consecutive months of diminishing revenues. The revenue cycle action plan was developed in tandem by the revenue cycle manager and the cancer care program director. The revenue cycle manager position has a dual reporting relationship to both the cancer care program director and the pharmacy director.

A dedicated full-time employee can help coordinate the revenue cycle, analyze the infusion services treatment mix, and track revenue capture across the service line. (See July/August 2004 *Oncology Issues* for more on how dedicated financial coordinators can strengthen your cancer service line.)

Once the reimbursement specialist was in place, this individual coordinated the revenue cycle team's efforts. The reimbursement specialist had to first understand the current processes, then take these apart and redesign the cycle from the point of service to the point of the patient's exit from the service.

To produce accurate charges and reduce denials or underpayments and non-payments, back-end processes need as much attention as front-end processes. While the revenue cycle team refined the front-end processes, the oncology reimbursement specialist analyzed back-end processes by reviewing error rates.

2. ***Revenue charge capture is a team effort.*** A fragmented revenue cycle can result in poor communication, which hinders improvement. The revenue cycle team developed a Revenue Capture Accountability Grid (see Table 1) for the cancer program. This tool ensured that all responsibilities are covered across the revenue cycle. From nursing staff to cashiers, the staff at HealthEast Cancer Care worked as a team to increase revenue charge capture. The cancer service-line director and the reimbursement specialist in tandem put the grid to work and hold staff accountable.

Getting front-line clinical nurse managers involved on the front-end spreads buy-in and commitment farther and faster. Clinical managers and directors must know how their billing is done, who is doing it, how registration works, and what the local medical review policy (LMRP) issues are. It's part of doing business.

The revenue cycle management team worked closely with the clinical staff to educate them about new processes and expectations for performance. The team found that the clinical staff wanted to do the job well. Once mentored, their performance met or exceeded the targets.

In another display of teamwork, the hospital brought together the medical director, the oncology reimbursement specialist, and representatives from oncology administration, managed care, finance, and pharmacy staff and asked them to assume a more proactive role in assessing new drug technology. The hospital put a system in place to monitor new technologies that are likely to be introduced; assess the reimbursement landscape; and proactively work with insurers and industry to maximize reimbursement.

3. ***Stop duplicate billing.*** Medicare defines duplicate claims as ones that are submitted to one or more Medicare contractors from the same provider for one of the following: the same item or service, the same beneficiary, and/or for the same date of service. Medicare *does not* pay for duplicate claims, and the submission of duplicate claims is a major reason for many Medicare claim denials.

Medicare pays the first claim that is approved and denies subsequent claims for the same service as duplicate claims. Duplicate claims also may delay payment. Billing staff or the third-party billing services must understand and stay current on Medicare claim-filing rules.

The daily charge report that is distributed to each site leader has been an important tool in reducing duplicate billing. HealthEast Cancer Care's goal is to submit a "clean claim" the first time.

4. ***Leverage clinical expertise in the appeals process.*** The revenue cycle team found that outpatient denials and underpayments were not monitored in an efficient manner. Cross-department collaboration was critical if these appeals were to get the attention they deserved. Staff and department leaders were asked to determine break-even points for claims appeals—a typical threshold is $500—and focus on preventing future denials, as well as appealing current denials that are higher than the agreed upon threshold.

The first step in this process is to generate a monthly report of outpatient medical necessity denials. This report should be routed to department managers to analyze the denied claims and determine if appeal is possible. If a denial is appealed, these department managers must compile clinical information to assist with the appeal process. The Billing department uses this clinical information to create the formal appeal packet that is sent to the payer.

improve their diagnosis coding skills, staff would need to be trained about relevant ICD-9-CM codes.

The Big Fix

Once the revenue cycle team identified the barriers to successful charge capture, it was time to develop an action plan.

The oncology service line was charged with developing a program plan—a tool that would become the master revenue cycle management program. The plan would include a statement of understanding, objectives and goals (both long- and short-term), and schedules. Hospital administrators would need to give the plan their approval and total support.

Looking at the "big picture," the revenue cycle team carried out its action plan in phases. The action plan consisted of six key components:

1. Conduct a baseline net revenue audit of the oncology services provided.
2. Develop a paper-based Patient Encounter Form.
3. Conduct a daily retrospective charge review.
4. Maximize the revenue benefit from Evaluation and Management (E&M) codes
5. Implement a system to establish medical necessity.
6. Develop educational guides and conduct training for clinical charge staff.

HealthEast realized immediate improvement in charge capture by adding a dedicated revenue cycle manager to the cancer service line.

4 Tips for Creating Clean Claims

- Define the requirements for complete charge entry and develop the necessary tools to facilitate the process.
- Identify where errors occur in the work process.
- Determine whether systems and databases are mapped and integrated accurately among departments.
- Determine whether the existing system needs to be enhanced or replaced, or whether staff needs additional training.

The revenue cycle team started by conducting a baseline net revenue audit of the oncology services provided.

At the time, HealthEast Cancer Center did not have a process in place to ensure that it was being paid the anticipated reimbursement. To correct this problem, the team initiated a net revenue audit of patient charges. The revenue cycle team took a random sampling of three categories of service: chemotherapy, medical infusions, and blood product infusions. The sampling was performed for both Medicare and Medicaid patients and other third-party payers. The revenue cycle team compared the patient's medical record documentation with the UB-92. Numerous problems were causing claim denials and, even more important, underpayment. On average, the team's audit revealed that the hospital was losing almost $900 per patient/per billing cycle date. This shortfall was primarily due to five factors:

- Improper charge capture
- Improper use of modifiers
- No utilization of E&M codes
- Lack of medical necessity documentation
- Lack of consistent charging practices between cancer care sites.

As the analysis progressed, the revenue cycle team determined that a charge form was needed to capture key information. The group created the "Patient Encounter Form" to reflect the activities of the entire patient encounter. The form included commonly provided procedures, commonly used ICD-9-CM diagnosis codes that apply to these services, and a space to add any other activity not captured. This form helped link procedure coding with diagnosis coding relative to medical necessity in a format that had not previously existed.

The team then developed a daily charge report to monitor the previous day's charging activity. The IT department generates this report which is routed to each clinical site leader and also to the revenue cycle manager. This report resulted in total charges being reviewed in a timely manner. Modifications and cor-

Table 1: Revenue Capture Accountability Grid

ACTIVITY	STAFF RESONSIBILITIES
Registration	
Patient demographic and insurance information verified at each visit	Nursing staff
Referrals obtained prior to each visit	Nursing staff
Co-pays collected at registration	Cashier
Patients with financial issues identified at registration and referred to financial counselors	Nursing staff, reimbursement specialist, program director
Care Documentation	
Physician orders checked for signatures	Nursing staff
Patient orders, charts checked against medical necessity requirements coverage documentation requirements	Nursing staff
Clinical staff made aware of managed care contract details relating to coverage documentation requirement	Reimbursement specialist, program director
Contact person in billing for clinical staff	Reimbursement specialist
Charge Entry and Coding	
E&M codes used by nurses in all relevant situations	Nursing staff, reimbursement specialist
Charge slips reviewed for errors	Nursing staff, reimbursement specialist
Billing accounts compared against patient chart and treatment schedule	Nursing staff, reimbursement specialist to identify errors and omissions
Contact person(s) in coding for clinical staff, in oncology for coding staff	Reimbursement specialist
Billing	
Bills reviewed for missing charges before sent to payer	Billing staff, nursing staff, reimbursement specialist
Clinical documentation compared against medical necessity requirements for services provided	Nursing staff, coding staff
Contact person(s) in oncology for billers, in billing for oncology staff	Reimbursement specialist

rections could now be made *before* the charge reached the claims department. Although the clinical staff initially expressed strong resistance to monitoring the report on a daily basis, they now consider the added task to be the most valuable tool for ensuring charge accuracy.

The revenue cycle team also found that hospital-based resource consumption needed to be reconciled with codes that reflected staff effort. The work group designed an oncology-specific E&M (evaluation and management) scorecard with hospital-based visit level criteria to help staff determine appropriate level and care documentation requirements. The compliance staff reviewed the scorecard for hospital-wide consistency. The scorecard would also ensure that hospital-specific guidelines complied with Medicare regulations. Unit staff was asked to review and field test these guidelines, then, offer suggestions. Finally, staff were trained on how to use the scorecard and educated about the impor-

ACTIVITY	STAFF RESONSIBILITIES
Denial and Under-Payment Management	
Oncology department regularly informed of recent denials and underpayments by billing	Reimbursement specialist, nurse manager, program director
All denials over a certain amount analyzed for possible appeal	Reimbursement specialist, nurse managers, program director
Remittances from commercial payers analyzed for underpayments	Contracting, billing staff, reimbursement specialist
Oncology involved in appealing medical necessity denials	Reimbursement specialist, nurse managers, program director
Payment plans periodically reviewed to ensure patients following designated payment schedule	Financial counselors, reimbursement specialist
Administrative Oversight	
Regular meetings between all members of revenue cycle team to discuss process improvement opportunities and delegate tasks	Program director, reimbursement specialist
Regular meetings between oncology and contracting departments to discuss contract negotiations, ease of implementation of potential contract terms	Program director, billing staff, coders, contracting, pharmacy, reimbursement specialist
Denials data analyzed to identify causes and target process improvement opportunities	Reimbursement specialist, program director
Process in place for identifying and responding to new drugs and technology posing reimbursement problems	Reimbursement specialist, program director, nursing staff
Contact person(s) in contracting for clinical staff, in oncology for contracting	Reimbursement specialist
Regulatory Oversight	
Medicare and managed care communications reviewed regularly for reimbursement changes and additions	Reimbursement specialist, program director
CDM update with most recent reimbursement information	Reimbursement specialist, program director
Encounter forms updated with most recent reimbursement information	Reimbursement specialist, program director, nursing staff
Costs of drugs and supplies regularly reviewed, charges adjusted when appropriate	Pharmacy staff, reimbursement specialist, program director
Changes in reimbursement communicated to relevant staff (clinical staff, coders, billers)	Reimbursement specialist
CDM contact person(s) for clinical staff, in oncology for CDM.	Reimbursement specialist

tance of coding the correct visit levels. Today the hospital is realizing significant revenue from the correct usage of E&M services.

The ability to apply relevant medical necessity on recurring visits over the course of treatment is crucial to payer billing requirements. The revenue cycle team implemented "visit notification," to notify the Clinipac® system (an electronic admitting, coding, and charging system) of a patient visit that allowed management of medical necessity on a daily basis. The visit notification function generates an independent coding abstract that allowed the health information management department to place diagnosis coding for a single date of service. Prior to visit notification implementation, the diagnosis code was placed on the medical record at the time of initial annual registration of the monthly series patient.

The revenue cycle team worked closely with hospital staff on all these changes. Charging and coding guides or

After putting the revenue cycle management action plan into effect, the fiscal year 2004 error rate in charge capture plummeted to less than 10 percent.

"crib sheets" were developed for nursing staff. Staff was given E&M education training for coding and billing clinical services. The revenue cycle team educated staff about the importance of correct chart documentation to appropriately bill for services. The team stressed the importance of nursing staff learning to apply reimbursement strategies in the practice setting.

Challenges and Barriers

Of course, change is never easy. The revenue cycle team faced several key challenges and barriers as it implemented revenue cycle management at the service-line level.

Because no single department "owned" the entire revenue cycle process, mobilizing support and creating a "sphere of influence" with patient accounting, contracting, and compliance leaders presented a challenge. Staff needed to change from a "business as usual" attitude to one that embraced collaboration and teamwork. Flowcharting the responsibilities of each department helped break down the communication barriers that had existed.

While the initial net revenue audit captured people's attention, it also triggered a discussion about what constituted a "significant" financial loss. The finance department, which worked with total system revenues, described the financial losses of the outpatient infusion service as not that significant in the overall picture. On the other hand, the cancer service-line leader believed that she was being "held to the fire" for service-line profitability.

Finally, software and hardware coordination between departments was a primary challenge. Discovering that the inpatient charging system could be adapted and had the capability of visit notification allowed the IT department to streamline the process. A single additional computer workstation was installed to facilitate the charge entry and admitting process and to communicate to nursing staff.

The Final Analysis

An effective revenue cycle program plan will help oncology team members anticipate departmental changes and develop new processes that may be needed to provide quality cancer care. The revenue cycle program should be coordinated with any existing master oncology business plans. The revenue cycle program should also allow for progress assessments and changes to meet the program goals. Once the action plan has been carried out, the work is not over. In the ever-changing healthcare arena, keeping a vigilant eye on the management of the revenue cycle is critical.

HealthEast Cancer Care found that relying on a single outside general consulting service for Medicare billing compliance had limited the financial success of its oncology service. Contracting with an outside consultant specializing in cancer care and hospital-based billing requirements provided a return on investment for the hospital.

Making the changes suggested by the consultant and the revenue cycle team took time. The review and redesign of work flow and processes took two to three months. The staff education phase took 15 days to complete. HealthEast Cancer Care staggered the actual implementation timeline because the changes were so significant. By focusing upon one procedure at a time, the hospital did the job right.

Within the first month of the project implementation, the hospital saw results. A difference in revenue capture was reflected in the quarterly outpatient product-line profitability report. Fiscal year 2003 demonstrated an 88 percent error rate in charge capture. After putting the revenue cycle management action plan into effect, the fiscal year 2004 error rate in charge capture plummeted to less than 10 percent. Today, HealthEast Cancer Care is confident that it is accurately capturing 95 percent of all available charges.

These revenue cycle changes dramatically improved the relationship between the cancer service line, registration, and the business office, but the work is never done. If error rates climb, the cancer reimbursement specialist and the cancer service line leader meet with the revenue cycle team to review data, develop an action plan, educate staff, redesign the processes, and ensure implementation.

Corporate commitment to this initiative is strong. Revenue cycle management is a strategic initiative for the healthcare system and a priority for all staff. This project has been successful because leadership committed to becoming intimately acquainted with the revenue cycle and offered full support.

HealthEast Cancer Care achieved a sense of project ownership for nursing and clinical staff including learning and "speaking the language" of reimbursement. The hospital continues to enjoy a strong network of communication among the revenue cycle team. The revenue cycle management team is constantly vigilant. The team meets monthly to continue to work through the issues, sustain the gain, and identify other areas of opportunity.

Connie Selle CPht, RPht, is revenue cycle manager at HealthEast Cancer Care and Pharmaceutical Services in Maplewood, Minn.