# Revenue Cycle Rehab:

## Five Ways to Optimize the Healthcare Provider's Revenue Cycle

While revenue cycle management is critical to a healthcare organization's overall performance and financial health, the rush to comply with mandates such as meaningful use and ICD-10 may result in healthcare organizations overlooking problems and opportunities in day-to-day operations.

"It's important to revisit long-standing processes in revenue cycle management to make sure habits haven't set in that are slowly degrading performance," said Jason Williams, Vice President of Business Analytics at RelayHealth, a leading provider of revenue cycle solutions. "Even with rapid changes in our reimbursement environment, we can rethink our current processes and use data to capture new value," he noted, in highlighting the concept of revenue cycle optimization in a recent webinar presentation, "Rev Cycle Rehab: Five Ways to Help Build on a Solid Foundation."

### Three critical questions

Revenue cycle optimization begins with answering three critical questions:

Healthcare organizations need to look at their existing processes first: Are daily processes running as expected? Are teams doing what they should be doing? Are these teams operating efficiently? Are they achieving the results needed for success?

Determining whether healthcare organizations are doing the right things today requires resource prioritization. "In a 'do-more-with-less' environment, it's important for organizations to be certain they are spending their time and resources on the processes that will have the most positive financial impact," Williams said.

Focusing on the right things for tomorrow enables healthcare organizations to make strategic decisions that will allow them to confidently participate in pay-for-performance and other related initiatives. "In this environment, it is certain that some of the things you are doing now will need to change," he said. "But how do you determine what needs to change?"

Produced in partnership with

HIMSS Media

*"Even with rapid changes in our reimbursement environment, we can rethink our current processes to capture new value.*

*In a 'do-more-with-less' environment, it's important for organizations to be certain they are spending their time and resources on the processes that will have the most positive financial impact."*

**Jason Williams** | Vice President of Business Analytics | RelayHealth

## A Solid decision framework

Healthcare organizations need to have a solid decision framework in place in order to make effective and strategic business decisions. A sound decision framework includes three elements: performance management, business intelligence and comparative intelligence.

Performance Management refers to the foundational processes and activities healthcare organizations engage in on a daily basis. With respect to the revenue cycle, this includes activities such as collecting accurate patient information, verifying insurance eligibility, determining upfront patient collection amounts, coding claims accurately for services provided, delivering clean claims to third-party payers and efficiently managing remittances and denials.

Business Intelligence encompasses healthcare organizations' ability to capture and use data that provides insight into internal operations. Business intelligence needs to be timely, actionable, easy-to-access and trustworthy in order to be useful. Unfortunately, even after healthcare organizations spend significant amounts of time and money acquiring enterprise data warehouse technology, they often still have trouble getting the data they need to inform operational decision-making.

"You shouldn't be serving the data warehouse; it should be serving you," Williams stressed. Some healthcare organizations are finding that the data warehouse doesn't provide easily accessible data that is both valid and relevant to manage operations. Some healthcare organizations are turning to solutions that support and augment the data available in the data warehouse.

Comparative Intelligence of industry data, especially data from peers that are similar in terms of size and geographic region, provides context for business intelligence. Business intelligence might indicate, for example, a healthcare organization's average service to payment (AR days) is 42 days. However, without the context of comparative intelligence, determining whether that average aligns with industry best practices or not is difficult. "Without comparative intelligence to provide a context for your business intelligence, you don't know whether to congratulate or castigate your staff," said Williams.

Comparative intelligence is not the same as benchmarking. Typical benchmarking data sources often are self-reported numbers with significant lag times between when the data is collected and when it is made publicly available, which can limit the data's usefulness and reliability for real-time decision-making. High-level benchmarks also may require significant analysis to determine root cause for which some organizations may not be staffed to handle. In contrast, comparative intelligence offers visibility and actionable insights into specific improvement opportunities based on real-time data from similar peers. It also offers the ability to quickly determine the source of payment obstacles and delays and helps quantify the value of making improvements.

*"You shouldn't be serving the data warehouse; it should be serving you."*

*"It takes courage to use data for feedback, especially when the data is telling you things you don't want to know."*

## Context for strategic decision-making

Taken together, insights from these three components – performance management, business intelligence and comparative intelligence – provide a framework for decisions that affect the healthcare organizations' present and future. The data these analytic insights provide can offer valuable feedback about where changes need to be made to position healthcare organizations for success.

"It takes courage to use data for feedback, especially when the data is telling you things you don't want to know," said Williams. "However, you have to be willing to use operational business intelligence to have hard conversations with your team about what they can be doing differently, or better. You have to be willing to use comparative intelligence on a recurring basis to keep your organization honest about whether you really are a model operation. This can mean challenging years-old beliefs in your organization to drive change."

## Real-world ROI

Five healthcare organizations adopted data-driven revenue cycle optimization and were able to demonstrate how analytic insights into day-to-day operations resulted in significant financial performance improvements. Other healthcare organizations can adopt this approach to achieve similar outcomes.

### Preventing denials for untimely filing

Business intelligence applied at a 600-plus bed hospital in the Southeast uncovered the fact that 13 percent of total claim dollars were being denied due to untimely filing. Comparative intelligence indicated that untimely claim dollars at peer institutions averaged around 4 percent of total claims. The comparison to peers convinced the hospital that it needed to do better and it could do better. The hospital instituted a performance management solution, creating three categories for claims, including a "warning" category for claims within 30 days of hitting filing deadlines. This solution resulted in the timely filing of approximately $2 million in claims that previously would have been denied.

### Reducing unreleased claims

A 177-bed hospital in the Midwest used business intelligence to identify problems with claims that had been passed over by the host system, but were spending nearly four additional days in the system before being released to payers. Comparative intelligence demonstrated that peer institutions were releasing claims nearly 30 percent faster. After six weeks of focused effort, the hospital reduced unreleased claims days by 2.5 days, resulting in more than $3.8 million in unreleased charges being removed from cash-flow limbo.

### Creating standards for timely documentation

A detailed analysis of service-to-submission days revealed that a 50-bed hospital in the West was struggling with cash-flow issues because of delays in chart sign-offs. It was taking more than 26 days for claims to be submitted to the business office. Data on how delayed documentation impacted overall service-to-payment days was presented to physician groups. In response, physician groups focused on the issue of timely documentation and established standards for timely documentation and penalties for non-compliance. Within three months, the hospital had reduced service-to-submission days by half, reducing gross unbilled charges by 20 percent.

### Establishing patient eligibility status

Bad debt was on the rise at a 150-bed hospital in the Midwest due to an increasing number of patients presenting as self-pay. The hospital used business intelligence to develop a performance

management solution, drilling down deeper into the eligibility status of each patient. Within three months, 2,298 patients who originally presented as self-pay were converted to third-party payer status through a comprehensive review of eligibility. This freed up $1.5 million in institutional dollars for true charity cases.

### Applying self-audits to identify improper payments

Each year the Department of Health and Human Services' Office of the Inspector General (OIG) publishes a work plan that identifies areas of particular scrutiny. In this case, a healthcare system in the Southeast was aware that the OIG was looking for fraudulent billing claims related to a diagnosis of kwashiorkor, which is a severe protein deficiency typically associated with pediatric populations in developing countries. The OIG found hundreds of audited Medicare claims inappropriately coded with kwashiorkor as the diagnosis. Knowing this, the hospital preemptively self-audited on the kwashiorkor diagnoses code and found two claims for senior citizens that had been incorrectly coded. By performing a self-audit prior to submitting the claims, the hospital avoided penalties associated with false or erroneous claims.

## Analytic insights lead to positive change

In each of these real-world applications of revenue cycle optimization, a combination of business intelligence, comparative intelligence and performance management was used to identify foundational problems within each organization's revenue cycle management process. Analytic insight provided the visibility into areas lagging in performance, which enabled the ability to drill deeply into the data to identify problems, assess root causes and make decisions about the most appropriate course of action.

Healthcare organizations need the analytical insights that good data provides in order to continue making effective strategic decisions. "Like it or not, your hospital's performance will continue to be compared to others, as the healthcare industry shifts to payment for high-quality outcomes combined with low-cost operations," said Williams. "In this environment, effectively and courageously using analytic insight, including comparative intelligence, is critical."

For additional details about how analytical insights can facilitate the optimization of revenue cycle management at your organization, visit the Webinar Archive in RelayHealth's free Resource Library and watch *Rev Cycle Rehab: Five Ways to Help Build on a Solid Foundation.*

**About Relay Health:**

Every day across America, more than 2,000 hospitals and health systems rely on RelayHealth to help them process over 5 million patient claims, worth over $1.1 trillion annually. Our broad array of revenue cycle management solutions use the power of the cloud and big data to help healthcare professionals make better financial decisions for their organizations and patients, right at the point of care. Nobody does more than RelayHealth to bring healthcare connections to life. For more information, visit www.relayhealthfinancial.com.