Back 2 Basics:  
Revenue Cycle: KPI, Risk Factors, and Compliance  

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-- the ART of HealthCare Finance

Our Time Together  
• List guidelines to develop your Key Indicators  
  • May be called Key Performance Indicators (KPIs)  
• Some commonly used KPIs & current trends  
• Revenue cycle leakage points  
  • Risks/opportunities  
• Some core compliance issues
Polling Question

Describe yourself:

- Provider, hospital
- Provider, physician
- Provider, other
- Payer
- Vendor, supplier, support provider/payer operations as well as Consultant or other

ACRONYMS

- ADR: Average Daily Revenue
- A/R: Accounts Receivable
  - AR “Days’
  - AR Dollar Amount
- CMS: Centers for Medicare & Medicaid Services
- DNFB: Discharged, not Final Billed

- HARA: Hospital Accounts Receivable Analysis
- HIM: Health Information Management Association
- HAC: Hospital Acquired Condition
- KPI: Key Performance Indicator
- POS: Point of Service (Collections)
TERMS

- Accounts Receivable
  - A/R Days - Refers to amount of money owed and the span of time between the date a service is rendered and the date paid; oftentimes referred to as A/R
  - A/R Dollars - Refers to the amount of money owed to a provider at a point in time; usually booked at month end; may be termed A/R
- Average Daily Revenue - Calculated by taking the amount of charges (revenue) generated during a period of time divided by the number of days in that period
- Bad Debt: Amount not recovered from a patient following exhaustion of all collection efforts

TERMS

- Cost to Collect: A figure that tabulates business office expense (or patient access and business office – or patient access, business office, and HIM) for a given period; divide the figure by the total number of dollars collected during the same period
- Credits; Credit Balances: Accounts that have been overpaid
- Days in AR: See A/R Days
- Outlier: Additional payment by a health plan or payer to a provider. The amount paid/formula depends on contract.
  - Medicare: OPPS and PPS
  - Others: varies
The Revenue Cycle

- Successfully managing the revenue cycle is the blood line of your organization
- Various revenue cycle stakeholders throughout the cycle
  - Let's review a simple diagram of the cycle
- What are you measuring?
  - If there are areas you believe are important, or areas “at risk,” you should measure them.

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Metrics: More than One Source

- HFMA’s Two-Day PFS BootCamp
- Claudia’s “Back to Basics”
  - Claudia published KPIs she has used
  - We’ll review some of those
- David Hammer
  - KPIs / Standards published on HFMA’s website

KPIs – Sources, continued

- HFMA developed common set of revenue cycle KPIs; published 8 in January, 2010
  - [http://www.hfma.org/library/revenue/improvement/KPI_Home.htm](http://www.hfma.org/library/revenue/improvement/KPI_Home.htm)
- HFMA: Glossary of Ratio Formulas
- HFMA developing next phase of KPIs;
  - Claudia: Chairing that subcommittee
KPIs – Sources, continued

- Multitude of other avenues to obtain KPIs
  - Hospital systems
  - Healthcare systems
  - Healthcare organizations
- HARA
  - URL: http://www.aspenpublishers.com/Product.asp?catalog_name=Aspen&product_id=SS10788123
  - Quarterly report; annual subscription

HFMA’s Research 2009 Initiative

- HFMA’s Patient Friendly Billing© - Strategies for High Performing Revenue Cycle
  - People
  - Processes
  - Technology
  - Communication
  - Culture
  - Metrics
    - Monitor & report frequently
    - Look beyond traditional metrics for success
    - Seek the consumer’s perspective
Polling Question

INSTRUCTIONS: Answer the situation that best describes your scenario.

My organization currently tracks Key Indicators and…

- We track but we are not confident that we’re tracking the right things
- We track and we’re quite confident that we track the right indicators
- We track but we’re considering, or I’m considering, modifying what we track
- Other (i.e. we don’t track, we track too much, we don’t understand what we’re tracking, we seem to change them too often, not applicable, etc…)

You Can’t Track Everything Well

- Suggest:
  - High-level indicators
  - Helicopter view
- Base-line indicators
  - The devil is in the details

- Be able to drill down into the details and sort by aging, insurance health plan, inpatient, outpatient, emergency room, etc

  - Health plan; aging category
  - HIM/DNFB, Quality Management
Polling Exercise

To calculate our A/R days and we use revenue: from the last three-month:

- From the last three months
- From the last four months
- Other (i.e. I’m not sure, not applicable)

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<table>
<thead>
<tr>
<th>High Level KPIs and Target Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receivables (track and monitor)</td>
</tr>
<tr>
<td>• <strong>AR Days</strong> (&lt; 50 days)</td>
</tr>
<tr>
<td>• <strong>AR Days over 120 days</strong> (you determine)</td>
</tr>
<tr>
<td>• <strong>Monthly AR Collections</strong> (not &lt; 100% of last three months average)</td>
</tr>
<tr>
<td>• <strong>DNFB</strong> (&lt; 5 days)</td>
</tr>
<tr>
<td>(note: includes HIM &amp; other teams that may affect DNFB – Quality Management, Insurance Verification; if significant, set a goal for each, monitor, track, and report)</td>
</tr>
<tr>
<td>• Plus any overall indicator you need to track – Examples?</td>
</tr>
<tr>
<td><strong>Base Level KPIs and Target Ranges - Middle</strong></td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>Middle – HIM, Case Management, Departments/Charges++</strong></td>
</tr>
<tr>
<td><strong>HIM DNFB</strong> (you determine goal; may be 5 days; sometimes additional reviews are being performed due to RACs or due to high overall charges before billing and they are held up in this category)</td>
</tr>
<tr>
<td><strong>Case Management/Quality Review/Utilization Review</strong> (you determine goal)</td>
</tr>
<tr>
<td><strong>Surgery Adding Charges Timely</strong> (Should be 100% within your time frames; consider one to three days)</td>
</tr>
<tr>
<td><strong>Other Key Departments/Charging</strong> (Should be 100% within your time frames; consider one to three days)</td>
</tr>
<tr>
<td><strong>Other ?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Base Level KPIs and Target Ranges - Front End</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front End - Patient Access</strong></td>
</tr>
<tr>
<td><strong>POS Collection</strong> (you determine goal; may be 50% of all self-pay amounts, 2% of overall net revenue, 50% of amount due at time of encounter, or a % from a specific department, such as ER)</td>
</tr>
<tr>
<td><strong>Pre-registrations verified</strong> (100%)</td>
</tr>
<tr>
<td><strong>Pre-registrations certified; pre-authorized</strong> (100%)</td>
</tr>
<tr>
<td><strong>Registration accuracy</strong> (&gt;95%)</td>
</tr>
<tr>
<td><strong>Plus any overall indicator you need to track – Examples?</strong></td>
</tr>
</tbody>
</table>
### Base Level KPIs and Target Ranges - Back End

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of accts &lt; 90 days</td>
<td>(80% of total gross AR)</td>
</tr>
<tr>
<td>% accts 91 to 180 days</td>
<td>(&lt; 17% total gross AR)</td>
</tr>
<tr>
<td>% accts over 180 days</td>
<td>(&lt; 3% total gross AR)</td>
</tr>
<tr>
<td>First time Billing</td>
<td>(5 days from discharge or date of service)</td>
</tr>
<tr>
<td>Medicare Suspense File and other electronic billing files</td>
<td>(&lt; or = 1 day)</td>
</tr>
<tr>
<td>Claim re-billings after denial/rejection</td>
<td>(15 days)</td>
</tr>
<tr>
<td>Secondary billings after payment or rejection</td>
<td>(5 days)</td>
</tr>
<tr>
<td>Credit Balances; Gross Amount</td>
<td>(1-2 days of gross revenue)</td>
</tr>
<tr>
<td>Credit Balances; Aging</td>
<td>(&lt; or = 30 days)</td>
</tr>
<tr>
<td>Re-billings</td>
<td>(&lt;5% of total claims)</td>
</tr>
<tr>
<td>Bad Debt Expense</td>
<td>(&lt;4% of gross revenue or &lt;2% net)</td>
</tr>
<tr>
<td>Cost-to-collect ratio</td>
<td>(2%)</td>
</tr>
<tr>
<td>• Plus any overall indicator you need to track – Examples?</td>
<td></td>
</tr>
</tbody>
</table>

### David Hammer’s Revenue Cycle KPI/Standards

- Scheduled patients’ preregistered rate 98%
- Deposit request rate for copayments & deductibles ≥ 98%
- Insurance verified of scheduled patients ≥ 98%
- Insurance verified of unscheduled inpatients within one business day ≥ 98%
- Patient access/registration; avg registration interview duration ≤ 10 minutes
- Average patient wait time ≤ 10 minutes
- Average inpatient registrations per registrar per shift 35
David Hammer, continued

- ABNs/MSPQs obtained when required 100%
- Collection of election services deposits prior to service 100%
- Collection of inpatient patient-pay balances prior to discharge ≥ 65%
- Collection of outpatient patient-pay balances prior to discharge ≥ 75%
- Collection of ED patient-pay balances prior to discharge ≥ 50%
- Screening of uninsured inpatients & high-balance outpatients for financial assistance ≥ 98%
- Prompt-payment discount % = from 5 to 20%

David Hammer, continued

- Inpatient charges coded per coder per day  23-26
- Observation charts coded per coder per day 36-40
- Ambulatory surgery charts coded per coder per day 36-40
- Outpatient charts coded per coder per day 150-230
- Chart deliquency greater than 30 days (Joint Commission definition) ≤ 5%
- HIM “DRG development” hold greater than late charge hold ≤ 2 A/R days
- MPI duplicates as a % of total MPI entries ≤ 0.5%
- PEPPER potential overcodes beyond 75th percentile ≤2%
David Hammer, continued

- Late charge hold period – 2 to 4 days
- Late charges as a % of total charges ≤ 2%
- Lost charges as a % of total charges ≤ 1%
- Chargemaster duplicate items – 0
- Chargemaster incorrect/missing HCPCS/CPT codes - 0
- Chargemaster incorrect/invalid revenue codes - 0
- Chargemaster item has incorrect modifier - 0
- Chargemaster item has missing modifier – 0
- Chargemaster price/item is editable on line - 0

David Hammer, continued

- Electronic claim submission rate 100%
- Final billed/claim not submitted; backlog ≤ 1 a/R day
- Medicare supplemental insurance billing following adjudication ≤ 2 business days
- Non-Medicare COB to insurance billing following COB payment ≤ 2 business days
- Medicare RTP denail rate ≤ 3%
- Insurance A/R aged more than 90 days from service/discharge ≤ 15-20%
- Insurance A/R aged more than 180 days ≤ 5%
- Insurance A/R aged more than 365 days ≤ 2%
- Bad debt write offs as a % of gross revenue ≤ 3%
National HFMA’s KPIs

- The next few slides will briefly give an overview of national HFMA’s KPIs
- Published January, 2010 HFMA
- HFMA Website

HFMA KPI #1

**Measure:** Net Days in Accounts Receivable (A/R)

**Purpose:** Trending indicator of overall A/R Performance

**Value:** Indicates revenue cycle (RC) efficiency

**Metric Calculation:**

\[
\text{Equation} = \frac{\text{Net A/R}}{\text{Net Patient Service Revenue}}
\]

**Variables to Numerator**
- Excludes credit balances, non-patient A/R related 3rd party settlements and non-patient A/R

**Variables to Denominator**
- Most recent three month daily average

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**HFMA KPI #2**

**Measure:** Aged A/R as a % of Billed A/R

**Purpose:** Trending indicator of receivable collectibility

**Value:** Indicates RC's ability to liquidate A/R

**Metric Calculation:**

<table>
<thead>
<tr>
<th>Equation</th>
<th>Variables to Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;30, &gt;60, &gt;90, &gt;120 days</td>
<td>• Aged from discharge date</td>
</tr>
<tr>
<td>Total A/R</td>
<td>• Includes all active billed debit balance accounts (self-pay, commercial, third-party)</td>
</tr>
<tr>
<td></td>
<td>• Excludes DNFB and in-house accounts</td>
</tr>
</tbody>
</table>

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**HFMA KPI #3**

**Measure:** Point of Service Cash (POS) Collections

**Purpose:** Trending indicator of point of service collection efforts

**Value:** Indicates potential exposure to bad debt, accelerates cash collections and can reduce collection costs

**Metric Calculation:**

<table>
<thead>
<tr>
<th>Equation</th>
<th>Variables to Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS Payments</td>
<td>• Patient payments collected prior to or up to 7 days after discharge</td>
</tr>
<tr>
<td>Total Patient Cash Collected</td>
<td>• Current encounter only</td>
</tr>
<tr>
<td></td>
<td>• Does not include cash collected on prior encounters</td>
</tr>
</tbody>
</table>

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HFMA KPI #4

**Measure:** Cost to Collect  
**Purpose:** Trending indicator of operational performance  
**Value:** Indicates the efficiency and productivity of RC process  
**Metric Calculation:**

\[
\text{Equation} \\
\frac{\text{Total RC Cost}}{\text{Total Cash Collected}}
\]

**Variables to Numerator**  
- Total RC cost includes: See next slide  
- Total Patient access costs includes:

**Variables to Denominator**  
- Cash collected must match the same time frame as cost in the numerator

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HFMA KPI #5

**Measure:** Cash Collection as a Percent of Adjusted- Net Patient Services Revenue  
**Purpose:** Trending indicator of RC to convert net patient services revenue to cash  
**Value:** Indicates fiscal integrity/financial health of the organization  
**Metric Calculation:**

\[
\text{Equation} \\
\frac{\text{Cash Collected}}{\text{Average Net Revenue}}
\]

**Variables to Numerator**  
- Use the current month’s cash collected

**Variables to Denominator**  
- Use prior three months average net revenue  
- Average net revenue is defined as patient service net revenue less bad debt

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HFMA KPI #6

Measure: Bad Debt

Purpose: Trending indicator of the effectiveness of self-pay collection efforts and financial counseling

Value: Indicates organizations ability to collect self-pay accounts and identifying payer sources for those who can't meet financial obligations

Metric Calculation:

\[ \text{Bad Debt Write-Off} \]
\[ \text{Gross Patient Service Revenue} \]

Variables to Numerator

- Expressed as a percentage

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HFMA KPI #7

Measure: Charity Care

Purpose: Trending indicator of local ability to pay

Value: Indicates services provided to patients deemed unable to pay

Metric Calculation:

\[ \text{Charity Care Write-Off} \]
\[ \text{Gross Patient Service Revenue} \]

Variables to Numerator

- Expressed as a percentage

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HFMA KPI #8

Measure: Days in Total Discharged Not Final Billed (DNFB)

Purpose: Trending indicator of claims generation process

Value: Indicates RC performance and can identify performance issues impacting cash flow

Metric Calculation:

Equation

\[
\text{Gross Days in A/R (not final billed)}
\]

\[
\text{Average Daily Gross Revenue}
\]

Variables to Numerator
- Includes inpatient and outpatient
- Excludes in-house claims
- Only days not final billed
- Expressed in days

Variables to Denominator
- From reporting month

Polling Question

Our organization:

- Uses many of the key indicators reviewed, but not necessarily in the manner described
- Uses some of the key indicators reviewed
- Uses just a few of the indicators described
- Other
One Approach - Develop Team to Select Which KPIs to Track

- What will you track?
- What is critical?
- Administrative support
- What will you do with the measures/reports?
- How will their significance be communicated?
- Determine: What will be done when there’s issues?
  - May be a significant challenge
- How will successes be celebrated?

Routinely Assess Other Factors

- Every month/quarter review & assess:
- What external and internal factors are significant?
  - What state and regulatory constraints are affecting the revenue cycle?
  - What are the risks and potential liability?
  - What changes should we make?
  - Do we need a SWAT team deployed?
    - May be a significant challenge
Additional Thoughts

- Staff may not do what’s *expected* but what’s *inspected*
- Track performance over time
- Communicate performance and areas of risk
- Monitor and modify critical KPIs

Revenue Cycle Leakage Points Pipeline

Health Care Advisory Board research indicates 2 to 5% of net revenues are lost
Issues

- Critical: performance-driven culture
- Professional & respectful interplay with customers
- How do you monitor staff one-on-one interplay?
  - Advanced Beneficiary Notice (ABN)
    - ABN process; potentially lost revenue
    - Medicare; other payers
    - Know when to obtain one
- POS collection? What areas? Why?
  - Plans for future?
  - ER admissions are typically over 50% of our admissions
  - Bad Debt is typically over 50% of uncollected copays/deductibles

Issues, Cont.

- How quickly do you:
  - Submit claims once “dropped” from system?
  - Processes to properly handle edits
  - Continually expanding CCI & OCE edits may cause delays
  - Address medical necessity issues
    - NCD
    - LCD
Delays May be Caused – Claims Not Paid or Incorrectly Paid

- Correct Coding Initiative (CCI) edits
  - Potential claim scrubber issues
  - Somewhere in your account flow
    - HIM
    - Coding specialist
- National Coverage Determinations (NCDs)
  - Medical necessity
- Medicare Secondary Payer (MSP)
  - Billing the correct payer
- Outpatient Code Editor (OCE)

Outpatient Code Editor (OCE)

- Over 1,000 edits in 2010; updated quarterly
- Facility OCE edits vs Physician OCE edits
  - Example: blood transfusion procedure code is on the claim but there is no code for the blood product
- Medicare FSSO system: RTP
Issues, Cont.

- How quickly do you follow up on:
  - Unpaid balances
  - “On-line” rejections
  - Credit balances
  - Ensuring that the payment received is accurate
  - Patient balances – what processes are in place
    - What education
    - What technology
    - Plans for the future
  - Medical necessity for “patient status”
  - Documentation
  - Observation vs Inpatient
  - RAC: hospital vs physician
  - Unit problems – over and under

RECOVERY AUDIT CONTRACTORS (RAC)

- 2010: Known issues
- Your responsibility: audit, self-check, analyze, document, fix, audit again
- Country divided into four RACs to cover all the providers throughout the country
- Other payers are duplicating these types of audits
  - Medicaid Integrity Contractors (MICs)

Information:
http://www.cms.hhs.gov/RAC/downloads/
Money Recovered

- Medically unnecessary
  - Inpatient hospital 30%
  - Inpatient rehab 5.6%
  - SNF 0.25%
  - Outpatient hospital 0.47%
- Incorrectly coded
  - Inpatient hospital 30%
  - Inpatient rehab 0%
  - SNF 0.62%
  - Outpatient hospital 2.44%
  - Physician 1%
- Insufficient documentation or none
  - Inpatient hospital 6.5%
  - Inpatient rehab 0.44%
  - SNF 0.48%
  - Outpatient hospital 0.11%
- Other
  - Inpatient hospital 12.5%
  - Inpatient rehab 0%
  - SNF 0.41%
  - Outpatient hospital 1.22%
  - Physician 1.44%

More Delays – More Non-Payment Issues

- Payer A denies patient’s inpatient stay
  - Wants service modified to Observation
  - Patient status
  - Issues – when advised by payer, physician’s order, patient’s perspective
  - Payer issues
  - Short inpatient stays – 1 to 3 days
    - Medical necessity
    - If RAC overturns hospital’s inpatient admission; physician impact
- Units incorrect or checked
- Inpatient only procedures; Medicare Addendum B – lists HCPCS with Status Indicator C

Coordinate education, audits, and consultants
You Lead the Way – Closing Thoughts

- Key performance indicators
  - Set attainable goals
    - Go for consensus & commitment from stakeholders on the KPI
      - How should the KPIs should be used to affect change
  - Celebrate successes

- Scheduling, Pre-registration and verification: insurance/demographics – automated?
- Registration accuracy – manual/automated?
- Managed care: PCP authorization, referrals
  - Need policies and procedures to cover all aspects
  - Emergency/urgent services vs elective services
  - “Late-boards” - surgery bookings
  - When service is not authorized properly – who follows up?

Polling Question

Indicate at least one thing you plan to do:

- Discuss one or some of these concepts with someone within the organization
- Share this information to a group of individuals
- Ask my vendor to help us develop some additional Key Indicators
- My brain hurts; I can’t think anymore
I love to help...

Contact -
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claudiab@bridgefront.com
Or call: 810-394-2777

Thank You!