Benchmarking RCM: Best Practices to Enhance the HIM Role in Revenue Cycle Management

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A new study identifies the HIM best practices that influence revenue cycle management.

Revenue cycle management (RCM) has been defined as "all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue."[1] RCM in hospitals is clearly a complex set of processes, involving many tasks, performed by many different departments, and relying upon many different people. Over the years, AHIMA has been an active participant in attempts to improve RCM, from coding education and certification to promoting greater involvement of HIM professionals in all aspects of the revenue cycle. Without accurate and timely coding, hospital bills simply cannot be generated.

In 2005 AHIMA's Foundation of Research and Education conducted a study to determine the HIM best practices that influence RCM. The result was the recognition that HIM departments can make contributions to effective RCM through credentialed staff who supply codes in a timely manner. The full findings offer HIM practitioners a tool for benchmarking and improving their practices.

DNFB Benchmarks

Determinants	Small Hospitals, 1-99 Beds		Medium Hospitals, 100-299 Beds		Large Hospitals, 300+ Beds	
	Best (n=15)	Other (n=37)	Best (n=15)	Other (n=34)	Best (n=11)	Other (n=28)
DNFB + days in A/R, average	10.0	66.2	7.0	27.5	8.9	53.1
DNFB + days in A/R, range	6-15	30-127	3-12	20-103	4-16	20-86
Spread of days between best performers and other performers	15		8		4	

"Best performing" hospitals have the shortest total revenue cycle—the combination of DNFB and days in A/R—averaging from 7 to 10 days, depending on hospital size.

Determining "Best Performing" Hospitals

The study surveyed directors of HIM departments on their RCM practices, the factors contributing to RCM, and their outcomes. RCM practices included the nature of the coding process (e.g., concurrent or retrospective), various forms of automation support, physician involvement in coding policy development, HIM participation in updating the charge master, and the presence of automated claims editing. They also included the existence of a coding compliance program, the extent of communication with patient accounting, and the average time for physicians to respond to coding questions.

Contributing factors included coder education, credentials, tenure, and training, as well as the reporting relationship of the HIM or coding department. Outcomes captured included average days discharged not final billed (DNFB), average days in A/R, percent of claims denied, labor costs for coders, percent of outsourcing, and training and resource costs for coders.

Coding productivity was calculated from coding volume. Because only the average DNFB and average days in A/R yielded significant results, these two factors ended up being the primary outcome metrics. The study found that the number of DNFB,

which is the outcome most influenced by HIM, was an important--but not sole--factor in contributing to hospital RCM.

A Benchmark for DNFB

In order to determine the HIM contribution, the study compared the number of DNFB in "best performing" hospitals to that in "other performing" hospitals. Best performing hospitals were determined by studying an array of the number of days in the total revenue cycle that was calculated for each respondent. Total revenue cycle is defined as the number of DNFB plus the number of days in A/R. As shown in the table above, there is a clear distinction in performance. This difference diminishes as hospital size increases; however, the measure still offers a benchmark for HIM practitioners.

Once best performing hospitals were distinguished, DNFB relative to total revenue cycle was determined for each performer category. These results are provided in the table "DNFB Compared to Total Revenue Cycle" on the following page. In half of the best performing hospitals, DNFB was equal to or less than three days. Approximately one-quarter of other performing hospitals met the same measure.

Factors for Success

Why do some hospitals achieve lower DNFB than others? Examining the contributing factors in best performing and other performing hospitals reveals some consistent differences in all three facility sizes:

- **Coding experience.** Best performing hospitals reported fewer inpatient coders with less than one year of experience.
- **Document imaging support.** Best performing hospitals reported higher use of document imaging support.
- **Physician involvement in coding policy.** Best performing hospitals reported a higher involvement of physicians in establishing coding policy.
- **Lack of newsletters.** Best performing hospitals were less likely to use in-house newsletters to communicate with medical staff than other performing hospitals.

Variables reported by best performing hospitals in at least two of the size ranges included:

- **HIM credentials.** Small and medium-sized best performing hospitals reported a higher percentage of AHIMA-credentialed coders.
- **Automated workflow management.** Medium and large best performing hospitals reported a higher use of automated workflow tools.

Tips from the Top

While these findings provide an interesting look at what comprises RCM best practices in HIM departments, they do not offer a definitive road map for other hospitals. To better understand why some hospitals manage revenue cycles better than others, researchers conducted follow-up phone interviews with selected respondents in the best performing category. This process identified additional RCM practices, often anecdotal, which may be of value to other HIM departments.

Formal cross-departmental groups or teams are helpful in addressing RCM issues. Some hospitals reported establishing standing committees specifically to address RCM improvements. Committee membership included clinicians, representatives from the business office, quality assurance staff, and HIM professionals. These groups address a wide range of topics including defining RCM, establishing the roles of various departments in relation to RCM, monitoring RCM performance, and problem solving.

DNFB Compared to Total Revenue Cycle

	Best Performing Hospitals		Other Performing Hospitals	
Hospital Size	DNFB <=3 # (%)	DNFB >3 # (%)	DNFB <=3 # (%)	DNFB >3 # (%)
Small (1-99 beds)	8 (53)	7 (47)	8 (29)	20 (71)

Medium (100-299 beds)	9 (60)	6 (40)	7 (21)	27 (79)
Large (300+ beds)	5 (45)	6 (55)	9 (32)	19 (68)

In half of "best performing" hospitals, DNFB compared to the total revenue cycle is equal to or less than three days.

Informal cross-departmental communication is also very successful. Some hospitals reported that while no formal RCM committee was established, informal cross-departmental teams had formed to address RCM issues. For example, one hospital reported that the assistant HIM director and business office manager meet regularly, and together they approach clinicians regarding issues surrounding clinical documentation required for coding.

HIM participation in various standing committees is very important to RCM. HIM participation in groups not specifically identified as RCM committees even seems to influence RCM processes. Examples included a charge master review committee and charge denial teams. These standing committees permit input from HIM and also give HIM professionals a better understanding of the total RCM processes in their hospitals.

Establishing clear HIM coding expectations is important. Where specific goals for coders are established and where performance data are shared on a regular basis with all HIM staff, RCM seemed to be better. Surprisingly, some hospitals reported that no clear expectations are set and that performance data are shared only with the director of the department, perhaps on a monthly or even quarterly basis. Best performing hospitals reported that information presented at regularly scheduled HIM staff meetings where problem solving and education also occur is especially effective.

Cross-training of HIM coders was mentioned by one hospital as a method to improve RCM. This hospital implemented a buddy system in which all coders (inpatient and outpatient) were cross-trained in coding requirements for all departments. This allows coders to work as a team to complete all outstanding coding rather than working only in a specific area.

Availability of coding talent was cited as important to RCM success by some best performing hospitals. Some hospitals indicated that they had no trouble attracting qualified coding staff because they are located relatively near community colleges that offer programs for HIM coders. This dependable labor supply was important in staffing the HIM departments by adding a stable and reliable source for trained staff. Some HIM managers taught courses at these colleges and were in a unique position to identify especially talented students.

Education in RCM processes for HIM staff was consistently cited either as a contributing factor in best performing hospitals or as a missing element in others. Several respondents indicated that senior management formally recognized the importance of their work and that they believe this contributed to positive results. Other hospitals indicated they only see senior management when there are problems. All respondents indicated they would like to learn more about the RCM process through formal educational courses, whether sponsored by their hospitals or outside sources. At least one respondent recommended that his or her hospital should consider a major reorganization to create an RCM department. Overall, respondents seemed very interested and aware of the growing concept of RCM, but they were unsure exactly how they fit in to the process.

HIM professionals involved in RCM can examine these study results to determine if their hospitals falls into the "best" or "other" performance category. Those in the best performer class can congratulate themselves and examine the list of practices for ideas to continue RCM improvement. Those in the "other" category can examine all areas of RCM within their spans of control to identify areas for improvement. The best practices gleaned from the survey offer a useful benchmark.

More RCM Resources Online

More resources on RCM are available online in the FORE Library: HIM body of Knowledge at www.ahima.org. Articles discuss RCM best practices as well as its relationship to current and emerging HIM roles. Following is a selection of available material:

AHIMA. "Embracing the Future: New Times, New Opportunities for Health Information Managers." Report. June 6, 2005.

Bronnert, June. "Coding Ethically." *Journal of AHIMA* 76, no. 10 (2005): 108-12.

Bronnert, June. "The Necessary Coding Skills: What Employers Are Looking for in Coding Professionals." *Journal of AHIMA* 76, no. 6 (2005): 60-61.

Cassidy, Bonnie, and Susan P. Hanson. "HIM Practice Transformation." *Journal of AHIMA* 76, no. 5 (2005): 56A-H.

Cummins, Ruth, and Julie Waddell. "Coding Connections in Revenue Cycle Management." *Journal of AHIMA* 76, no. 7 (2005): 72-74.

Parsons, Roger, Monica Lenahan, and Julie Micheletti. "Strategic Approaches to Data Management and Documentation Improvement." Presentation. 2004 IFHRO Congress and AHIMA convention. October 2004.

Price, Kurt, and Dean Farley. "How Does Your Coding Measure Up? Analyzing Performance Data Gives HIM a Boost in Managing Revenue." *Journal of AHIMA* 76, no. 7 (2005): 26-31.

You can also discuss RCM issues and best practices in the coding Communities of Practice at www.ahima.org.

Note

1. Biesboer, Pat, and Mary Anne Pace. "Partnering with Revenue Cycle for Success." Presentation. 2004 IFHRO Congress and AHIMA Convention. October 2004.

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Bauman, Carrie M. "'Chutes and Ladders' of the Revenue Cycle: Strategies for Understanding Data and Coding Quality Issues that Impact Your Ability to Successfully Play the Revenue Cycle Game." Presentation. 2004 IFHRO Congress and AHIMA Convention. October 2004.

Campbell, Thea. "Opportunities for HIM in Revenue Cycle Management." *Journal of AHIMA* 74, no. 10 (2003): 62-63.

Huber, Nancy, Maria Stolze, Karen Youmans, and Trish Wharton. "Improve Your Organization's Financial Health: Tools and Strategies to Manage Your Revenue Cycle." Presentation. 2004 IFHRO Congress and AHIMA Convention. October 2004.

Walters, Roy. "Five Steps to Great Revenue-Cycle Management." *HFM Magazine* 56, no. 5 (2002). Available online at www.hfma.org/publications/HFM_Magazine/management_issues.htm.

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