HIM Spin on the Revenue Cycle

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by Karen Youmans, MPA, RHIA, CCS

HIM plays an integral role in an organization's revenue cycle. That means health information managers have a role to play in revenue cycle management.

Is the following scenario familiar? The CEO is complaining about accounts receivable (AR) climbing to $10 million. The coders are working hard and appear to have the shelves of uncoded records under control. Now you, the HIM director, have been invited to attend a revenue cycle management (RCM) meeting. Are you familiar with the elements of RCM—and prepared to sit at that table?

Effectively managing the revenue cycle is an important piece of improving net revenue in any business. In healthcare, where reimbursement grows increasingly complicated, skill is required throughout the organization to manage the administrative and clinical processes that form the revenue cycle.

HIM professionals are responsible for key functions in the cycle. Understanding the big picture helps HIM professionals capitalize on their expertise and take an active role in helping effectively manage income.

What Is the Revenue Cycle?

Simply put, revenue is regular income, and the cycle is the regularly repeating set of events that produces it. In a health-care facility, many administrative and clinical functions from patient access to collections comprise the revenue cycle. The major functions typically included are:

- Admitting, access management
- Case management
- Charge capture
- HIM
- Patient financial services, business office
- Finance
- Compliance
- Information technology

In larger healthcare organizations, each function may be assigned to a different department; in smaller organizations, one department may perform several functions.

Admitting, or access management, is the front-end registration of the patient encounter. This function typically includes verification of eligibility, certification, registration, and scheduling. Admitting also includes collection of insurance information, collection of co-pays, consents and notices, and issuance of advanced beneficiary notices.

Case management seeks to efficiently match an individual's health requirements with appropriate resources. A goal of the case management function is to minimize retrospective processes. The main aspects of case management include documentation review, provider interaction and education, criteria monitoring, critical pathway guidelines, and concurrent diagnosis related group (DRG) assignment.

Charge capture ensures that the charge entry is the correct patient and verifies the account number, the service and account type, and the charges for the dates of service. Additional elements of the charge capture function include point of care versus batch entry, linking to order entry, late charges, data dictionary (charge description master), and code updates.

Patient financial services (or business office) functions involve the collection of revenue for the patient encounter. These actions include generation and resolution of edits (front end, pre- and post-billing), generation of bills, denials and return to providers, and postings (remits, payments). Patient financial services functions also include the coordination of additional information requests, bill hold settings, chargemaster maintenance, appeals, and collections.

Finance functions include in-depth analysis of the facility's overall financial picture. The main elements include case mix analysis, patient volume data (DRG review), service line analysis, decision support, data benchmarking (as performed by organizations such as Child Health Corporation of America and the University HealthSystem Consortium), AR days (the number of days' worth of net patient revenue that is uncollected and tied up in accounts receivable), and source of primary data.

Compliance staff serve as the facility's legal watchdog. They possess expertise in regulatory requirements and usually administer the coding accuracy reviews.

Information technology is key throughout the entire revenue cycle. For data collection and accessibility, there are various component systems, including admission, discharge, and transfer (collects and stores registration information, assigns medical record and account numbers), billing (generates bills and monitoring and edit reports), and abstracting. Further, the function typically provides decision support and support for the financial and encoder (grouper) systems. The IT department often assists in revenue cycle management by generating requested reports based on source data from the above functions.

RCM Measurements

The RCM team will want to study the efficiency of functions along the entire revenue cycle. RCM measurements and indicators include:
• Value and volume of discharged not final billed encounters
• Number of AR days
• Number of bill hold days
• Percentage and amount of write offs
• Percentage of clean claims
• Percentage of claims returned to provider
• Percentage of denials
• Percentage of accounts missing documents
• Number of query forms
• Percentage of late charges
• Percentage of accurate registrations
• Percentage increased point-of-service collections for elective procedures
• Percentage increased DRG payments due to improved documentation and coding

The RCM Team

Once assembled, the revenue cycle management team begins its work by assessing the knowledge level of individual members and determining if initial education is required. The team then defines its goals, identifies any data needs, and establishes standardized language and format for reporting data.

The team may also set operational guidelines, such as defining team and organization responsibilities and identifying appropriate types of issues for the team to address. Other examples include resolving to solve problems collaboratively and committing to ongoing education for the team.

Team objectives will vary depending upon the environment. Sample objectives include:

- Identifying issues resulting in increased AR
- Communicating issues to appropriate areas
- Developing educational material such as a revenue cycle manual or annual updates and providing staff education
- Creating a map or blueprint on how to bring up new services

- Reviewing denials and actively discussing appeal process and success
- Discussing intermediate indicators and measures
- Coordinating upgrades or updates to all interrelated systems (e.g., ICD-9-CM updates or OCE editor)

The team's work may begin with a gap analysis (determining what functions are and are not being done) or the development of key indicators and measurements along the entire revenue cycle. An important team action will be prioritizing attention to issues and problem areas once they have been identified.

HIM's Important Role

HIM plays an integral part in the revenue cycle management. Unfortunately, the occasional misperception that HIM professionals "just code" can lead to the exclusion of HIM participation from the RCM team. It is extremely important for HIM directors to become fully educated about the RCM process in order to join the team and contribute to its work.

Typically, the HIM function within organizations includes:

- Reconciliation of accounts versus documentation received
- Order and timeliness of the processing cycle
- Coding
- Physician query processes
- Internal and external coding accuracy audits
- Requests for records, documentation

As owners of these functions, HIM professionals should also direct an ongoing effort for quality improvement. Beyond managing these functions, HIM directors should join the RCM team in actively addressing the following issues:

- Return to provider, denials management
- Response to patient financial services (or business office) requests
- Edit correction (outpatient code editors and groupers)
- Policy development based on corporate guidance
- Data presentation
- Data analysis
- Write-off preparation
- Additional documentation requests

As they work with the RCM team, HIM professionals should be acutely aware of their areas of expertise. HIM team members should capitalize on experience in the following areas:

- Facility-wide liaisons
- Coded data experts
- Coding accuracy and consistency
- Case mix analysis
- DRG and APC experts
- Education
- Holder of the "rework" effort
- Coding a common focus
- Integral to the unbilled management functions

Reaching A-1 RCM

Effective RCM adheres to five broad principles, according to the Healthcare Financial Management Association: (1) consider the complex set of interrelated processes; (2) benchmark continuously; (3) assiduously monitor and manage to key metrics; (4) hire and retain the best workers; and (5) use information systems appropriately.

Before recommending best practices for its organization, the RCM team should assess current operating levels, which areas require improvement, and which areas require targeting and monitoring. Resulting best practices might include:

- Value of discharged not final billed cases not to exceed two days of average daily revenue
- AR days not to exceed 60 days
- Bill hold days set at four days post discharge
- Late charges not to exceed 10 percent
- Accurate registrations no lower than 95 percent

HIM functions play an important part in the revenue cycle. Understanding that cycle helps HIM professionals apply RCM best practices to their departments and can lead them to active roles in effectively managing their organizations' revenue cycles.

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Terms Related to the Revenue Cycle

Accounts Receivable (AR)
Accounts receivable should include patient-specific amounts less all applied and unapplied interim or advance payments, credit balances, and all allowances including amounts for dispute resolution, for bad debts, and for charity service. (Source: Healthcare Financial Management Association)

Advanced Beneficiary Notice (ABN)
A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases: A doctor gives a patient a service that he or she believes that Medicare does not consider medically necessary; and the doctor gives the patient a service that he or she believes Medicare will not pay for. (Source: Centers for Medicare and Medicaid Services)

Ambulatory Payment Classification (APC)
All services paid under the new Outpatient Prospective Payment System are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. (Source: Centers for Medicare and Medicaid Services)

Average Daily Revenue (ADR)
The average daily amount is determined by dividing revenue for the three-month period ending on the date of the calculation by the number of days in the three-month period. (Source: Healthcare Financial Management Association)
Note that revenue cycle management has its own meaning for ADR, which in HIM and business office functions typically refers to "additional documentation request" and in chargemaster refers to "additions, deletions, revisions."

Charge Description Master (CDM)
This is essentially a price list outlining the procedures performed in a hospital and the charges associated with each.

Clean Claim
A "clean" claim is one that has no defect or impropriety (including lack of any required substantiating documentation). (Source: Centers for Medicare and Medicaid Services)

Corrective Coding Initiative (CCI)
CCI is used for carrier processing of physician services under the Medicare physician fee schedule. CCI edits are based on coding conventions defined in the AMA's *CPT Manual*, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice. CCI edits were incorporated into the OCE with the exception of anesthesiology, E/M, mental health, and dermabond.

Critical Pathway Guidelines
In an era of increasing competition in medical care, critical pathway guidelines have emerged as one of the most popular new initiatives intended to reduce costs while maintaining or even improving the quality of care. Developed primarily for high-volume hospital diagnoses, critical pathways display goals for patients and provide the corresponding ideal sequence and timing of staff actions for achieving those goals with optimal efficiency. (Source: Annals of Internal Medicine)

Diagnosis Related Group (DRG)
A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under

the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. (Source: Centers for Medicare and Medicaid Services)

Discharged Not Final Billed (DNFB)
Inpatients who have been discharged but whose bills to payers have not been processed or for outpatient services for which bills have not been processed. (Source: Healthcare Financial Management Association)

Outpatient Code Editor (OCE)
OCE is used by intermediaries to process hospital outpatient services. Within the OCE are more than 50 OCE edits, which determine whether a specific code is payable under the Centers for Medicare and Medicaid's Outpatient Prospective Payment System.

Return on Investment (ROI)
A measure of how effectively an organization uses its capital to generate profit. Note that RCM has its own meaning for ROI, which in the HIM function refers to "release of information."

Return to Provider (RTP)
If a claim is not billed correctly and contains errors, it is returned to the provider for further clarification or denial.

Revenue Cycle Management (RCM)
All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue. (Source: Healthcare Financial Management Association)

References

Case Management Society of America. "Definition of Case Management." Available online at www.cmsa.org/AboutUs/CMDefinition.aspx.

Centers for Medicare and Medicaid Services (CMS). "Glossary of Terms." Available online at www.cms.hhs.gov/glossary.

CMS. "Hospital Manual."Available online at www.cms.hhs.gov/ manuals/10_hospital.

CMS. "MedLearn." Available online at www.cms.hhs.gov/medlearn/ncci.asp.

Child Health Corporation of America. Available online at www.chca.com.

Healthcare Financial Management Association (HFMA). "Principles and Practices Board Statement Number 16: Classifying, Valuing, and Analyzing Accounts Receivable Related to Patient Services." Available online at www.hfma.org/resource/P_and_P_board/statement_16.htm.

HFMA. "Revenue Cycle Director Job Description Reflects the Complexity of Healthcare Reimbursement." Available online at www.hfma.org/publications/HFMA_WantsYouTo Know/102302_revenue.htm.

Pearson, Steven D., Dorothy Goulart-Fisher, and Thomas H. Lee. "Critical Pathways as a Strategy for Improving Care." *Annals of Internal Medicine* 123, no. 12 (1995): 941–48. Available online at www.annals.org/cgi/content/full/123/12/941.

University HealthSystem Consortium. Available online at www.uhc.edu/home.asp.

VHA, Inc. "Revenue Cycle Management: The Paradigm Shift for Success." VHA Research Series. Available online at www.vha.com/research/public/revenuecyclemgmt_meth.pdf.

Walters, Roy. "Five Steps to Great Revenue-Cycle Management." *Healthcare Financial Management (*May 2002): 82–84. Available online at www.hfma.org/publications/HFM_Magazine/management_issues.htm.

Walters, Roy, David Kiehn, and Bruce Hallowell. "'New New' Things for Revenue-Cycle Improvement." *Patient Accounts (*February 2003): 2–4. Available online at www.hfma.org/publications/HFM_Magazine/management_issues_b.htm.

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