Reducing Accounts Receivable Through Benchmarking and Best Practices Identification

by Tim Berkey

As HIM professionals look for ways to become more competitive and achieve the best results, the importance of discovering best practices becomes more apparent. Here's how one team used a benchmarking project to provide specific best practices that reduced accounts receivable days.

The accurate and timely processing of health information is essential for the financial success of hospitals in the competitive healthcare market. Every day, executive managers and medical records professionals are looking for ways to become more competitive and achieve the best results. They are attempting new approaches to processing medical records and in many cases are achieving marked improvements. This article explores the process of discovering best practices in a study of members of the Premier alliance—a consortium of hospitals affiliated with Premier, Inc.

Here's how an innovative medical records benchmarking team used a focused benchmarking project to provide specific results (best practices) to reduce accounts receivable days.

The Problem

According to the Hospital Accounts Receivable Analysis for the fourth quarter of Year 1 of the study, the billing delay (time from patient discharge to billing) averaged 15.9 days for Medicare inpatients in southeastern US hospitals. By comparison, the national average of all responding hospitals over the same period was 16.2 days. Billing delay averages for all responding hospitals over a recent one and a half year period can be seen in Figure 1. The data suggests that hospitals have not been consistently effective in the long-term reduction of accounts receivable days.

The Study—Methods

In May 1992, 20 Premier alliance hospitals began a benchmarking project in medical records. Their objective was to reduce A/R days in medical records.

The project focused primarily on reducing accounts receivable days for Medicare inpatients, so most of the practices listed in this article are focused on that type of patient. It should be noted, however, that several of the practices are more general and focus on process improvements without regard to payer type. Practices were selected based upon the confirmed benefits at each hospital, the number of benchmark hospitals employing the practice, and the opinion of the HIM directors of the core group (five hospitals from Kentucky and Tennessee).

All of the benchmark hospitals had accounts receivable days for Medicare inpatients that were significantly lower than the average of all project hospitals (see figure 2).

figure 1—HARA's average billing delay (3rd quarter year 1 - 4th quarter year 2)

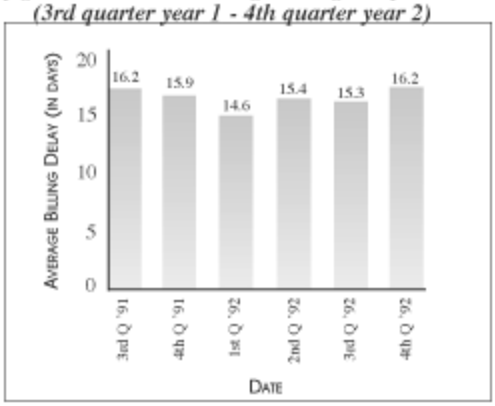
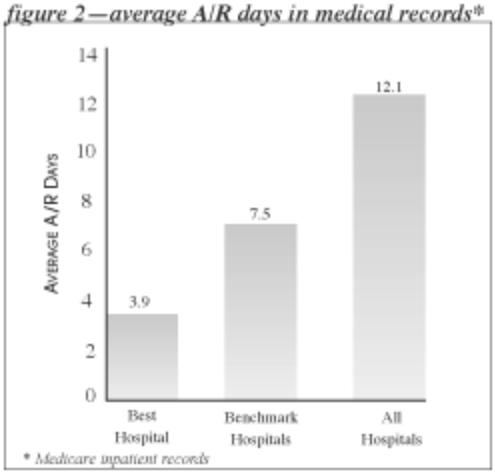


*figure 2—average A/R days in medical records**



The project was initiated after several hospitals in the Kentucky/Tennessee region displayed an interest in improving areas related to medical records. Our initial group consisted of five hospitals; however, the project expanded to include additional hospitals from across the southeast. The original five hospitals formed what Premier termed as the "core group." The core group's role was integrated with Premier's facilitation of the project from the first project meeting to the completion. The roles of the hospital participants were identified largely by the steps in the Premier Benchmarking Model, which focuses on a group approach to benchmarking.

In Premier's group approach, hospitals work together, not individually, to identify best practices through a specific series of steps. These steps form the outline for project events such as meetings, initial data collection, and final surveying of benchmark partners. Premier initially introduced the benchmarking model to the core group participants of this project at the first meeting. During that meeting, we narrowed the focus of the project to reducing A/R days for Medicare inpatient records. The team cited several reasons for wanting to focus on Medicare inpatients, which included:

- the complexity of Medicare coding
- the reimbursement issues regarding Medicare coding
- the necessity of obtaining physician signatures for attestation sheets (no longer a requirement)
- the fact that Medicare inpatients represent a large percentage of all patients

A review team completed the surveying and analysis of benchmark hospitals, making site visits to the four facilities. Each site visit included detailed interviews with key employees such as assembly/analysts, coders, transcriptionists, supervisors of incomplete chart areas, medical records directors, physicians, and some managers. Results from the site visits were summarized by Premier staff and confirmed by the core group participants, thus leading to the final identification of best practices (see "Summary of Best Practices Observed," below).

The team considered these issues and identified customers of the process, customer requirements, key process measures, and data collection requirements. All of these activities involved traditional quality improvement tools and specially designed documentation worksheets provided by Premier.

The definition of the process resulted in the identification of a general process flow: assembling the record, analyzing and coding it, performing reimbursement analysis, transcribing reports, and a physician signing attestations and completing deficiencies. While we realized that not all hospitals would perform the steps in this order, we thought that these steps represented a general flow for processing medical records.

To measure the defined process and identify potential benchmark hospitals, we selected the average processing time for Medicare inpatient records as the key measure of comparison among the hospitals. The team decided that each participating hospital should sample a specific portion of their Medicare inpatient records to determine the average amount of time needed to process those records. We defined the processing time of the medical record to be the elapsed time from patient discharge until the bill for the patient is dropped.

Results

Figures 3 and 4 show key data collection items from each hospital, including the sampled processing time averages for Medicare inpatient records. Hospitals that performed well in processing time were regarded as potential benchmark facilities; however, other factors such as discharges/day/FTE were also considered in selecting the benchmark facilities. Based on the results of the data collection and sampling results, our team selected four hospitals for further detailed benchmarking. These hospitals are labeled B, E, H, and N in Figure 3.

figure 3—key data points

Hospital	# of Operating Beds	% Medicare Discharge	Avg. Record Processing Time* (Rank)	Average Discharge/ Day/FTE**(Rank)	Selected as Benchmark Hospital?	Reason for Selection (Yes or No Selection)
B	502	37	3.9 days (1)	1.15 (13)	Y	Best processing time of the 20 hospitals
M	100	54	5.7 (2)	0.95 (17)	N	Good processing time, but 17th in discharges/day/FTE
N	158	37	7.5 (3)	1.30 (8)	Y	Good processing time and 8th in discharges/ day/FTE
F	190	30	7.7 (4)	1.21 (11)	N	Comes from state that does not require physician signatures on attestation sheets—a key step in the process
T	301	33	7.8 (5)	0.82 (20)	N	Good processing time, but 20th in discharges/day/FTE
H	450	56	9.1 (6)	1.12 (14)	Y	Good processing time and suggested by core group
A	403	34	9.5 (7)	1.54 (5)	N	Originally selected as benchmark hospital, but unable to participate further due to time constraints in hospital
G	393	35	9.5 (7)	1.21 (11)	N	Not chosen because Hospital E's results were felt to be better
E	305	38	9.6 (9)	2.04 (2)	Y	Good processing time and second in discharges/day/FTE
O	691	53	12.6 (10)	1.84 (4)	N	Four benchmark hospitals already selected
I	94	42	13.0 (11)	1.26 (10)	N	Four benchmark hospitals already selected
R	218	39	13.5 (12)	1.06 (15)	N	Four benchmark hospitals already selected
C	375	64	13.8 (13)	1.00 (16)	N	Four benchmark hospitals already selected
L	250	47	14.8 (14)	1.28 (9)	N	Four benchmark hospitals already selected
Q	182	47	15.0 (15)	0.91 (18)	N	Four benchmark hospitals already selected
S	N/A	33	15.5 (16)	1.32 (7)	N	Four benchmark hospitals already selected
J	319	37	16.3 (17)	1.50 (6)	N	Four benchmark hospitals already selected
K	134	60	17.9 (18)	2.05 (1)	N	Four benchmark hospitals already selected
D	428	45	18.0 (19)	2.02 (3)	N	Four benchmark hospitals already selected
P	106	42	20.6 (20)	0.84 (19)	N	Four benchmark hospitals already selected

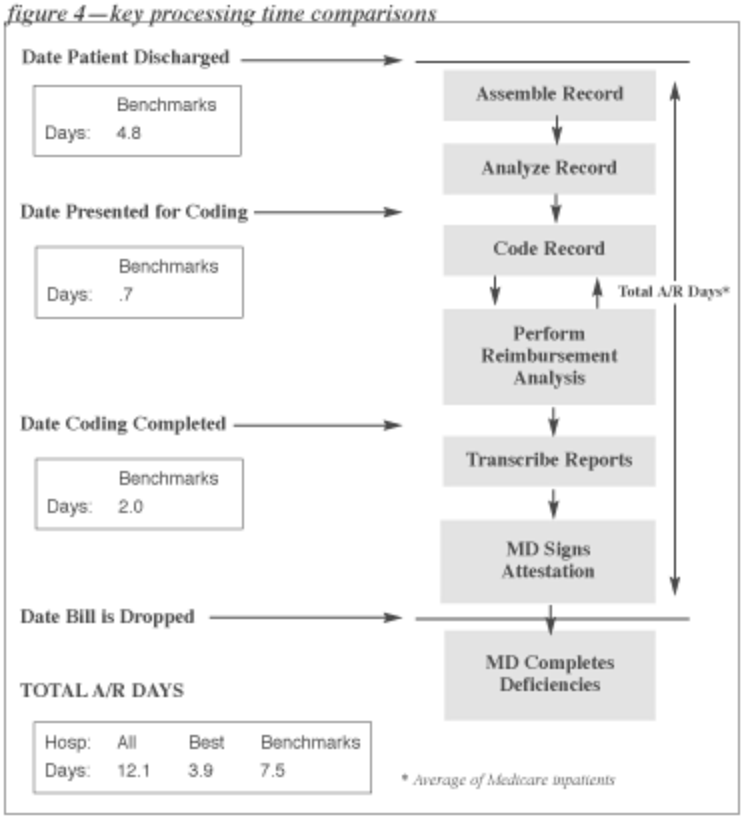
** A random sample of Medicare inpatient records from May/June 1992*

*** This FTE figure represents the number of FTEs in medical records that most directly affect the processing time of the record (as reported in a staffing summary from each hospital). Positions include transcription, chart assembly/analysis, coding, and record management employees.*

Figure 3 indicates that the four benchmark hospitals are very diverse in number of beds, number of daily discharges/FTEs, and percentage of Medicare population. All have a considerably lower than average processing time for Medicare inpatient records. In addition, the figure explains why hospitals B, E, H, and N were selected as benchmark hospitals. Finally, Figure 4 shows three key record processing time intervals for the four benchmark hospitals. It also includes a comparison of total record processing time averages for the best hospitals, the four benchmark hospitals, and all 20 hospitals. The benchmark hospitals had an average total record processing time of only 7.5 days—a significantly lower average than the 12.1 day average for all project hospitals. In keeping with the benchmarking model, the team next compared the practices and

measured the results of the practices at the four benchmark hospitals. This was accomplished through further surveying.

figure 4—key processing time comparisons



Conclusion

While we recognize that the practice discoveries presented within this article represent our view (based on the methodology we followed), we are confident that each hospital reading this article can benefit by following a few specific steps, as presented below:

- Initiate an effort to assess your hospital's performance against the benchmarks and determine the performance gap or possible opportunity for improvement
- By gathering your own medical records processing time data, as was done by the team in this study, you can compare your average accounts receivable (A/R) days against benchmark standards
- Analyze your medical records process. You may want to assemble a team to define and analyze the medical records process in your hospital. Assess your process in terms of how it differs from the processes and practices presented in this article. Then, consider what advantages or disadvantages may exist by being different and attempt to quantify this evaluation in terms of impact (cost, time, quality, etc.)
- Consider best practices and develop preliminary action steps. Begin to assess your identified positions of disadvantage in relation to the best practices in this report. Can any of these practices be easily adapted or modified to fit your process environment? What further analysis and efforts on your part might allow you to discover additional best practices or make feasible the implementation of a practice within this report? Would further knowledge gained from one of the benchmark hospitals provide the appropriate road map toward best practice implementation?

Answers to these questions can help develop preliminary action steps toward process improvement.

The Benefits Realized

1. Implementation of the best practices identified in this study resulted, on average, in a 4.6 day reduction in accounts receivable days, comparing the benchmark hospital group with the overall group.
2. The best hospital in this study was able to achieve an average accounts receivable wait of 3.9 days, one-third the average time for all hospitals. Can all hospitals meet the "best case" standard? While this is highly improbable, the potential revenue benefits make it worth pursuing.

3. Revenue benefits can be significant at the organizational level. One hospital in this study, for example, was able to decrease its outstanding accounts receivable balance by $4 million after implementing a best practice in this report. While this is not a typical result, it shows what is possible from a relatively minor innovation.
4. A comprehensive benchmarking process can have substantial unintended benefits. This study focused on reducing accounts receivable time for Medicare billings. Smoother work flow, more efficient record processing, and more efficient coding also resulted, with corresponding productivity gains in other areas. Moreover, Medicare billings and related documentation overall are often more labor intensive than private payer systems. It's possible that the innovations identified here have a greater effect when applied to accounts receivable days for non-Medicare billings. Perhaps more importantly, simply going through the steps of a benchmarking process often helps to focus goals and objectives more clearly and defines work processes more completely. Even without the tangible benefits identified here, benchmarking often becomes, in effect, a strategic management and planning tool that is inherently beneficial to any work setting.

Summary of Best Practices Observed

Record Assembly and Analysis

- Adjust and stagger working schedules for analyst and coder positions to increase productivity and smooth work flow; establish and monitor a specific indivator of analyst performance
- Assign assembly/analysis and coding employees to work in team concept

Coding

- Establish a noise-free environment for coders
- Employ incentive plan for coders to increase productivity and coder satisfaction
- Perform concurrent coding as primary method of coding

Reimbursement Analysis

- Dedicate personnel to perform reimbursement analysis for Medicare records to optimize reimbursement and improve coding accuracy

Report Transcription

- Dedicate one transcriptionist to perform all the daily clerical duties and rotate all transcriptionists through this role
- Employ incentive plan for transcriptionists
- Use a sign-off document to track the location of transcribed reports on hospital floors

Physician Attestation and Deficiency Analysis

- Implement courtesy practices to strengthen relationship with physician
- Display graphs in a highly visible physician location documenting the outstanding balance of undiagnosed records
- Establish a specific threshold, such as money or A/R days, for the unbilled balance and regularly monitor performance

General Practices

- Employ extensive cross training to employees to provide coverage for key areas of medical records; form quality improvement team that focuses on reducing A/R days and increasing cash
- Establish a formal surveying procedure to obtain physicians' input regarding their relationship with medical records
- Post results of A/R days in highly visible location in department

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Article Citation:

Berkey, Tim. "Reducing Accounts Receivable Through Benchmarking and Best Practices Identification." *Journal of AHIMA* 69, no.10 (1998): 30-34.