

REVENUE CYCLE

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healthcare financial management association www.hfma.org

improving registration accuracy

As an industry, we've made great strides in developing innovative technologies for patient account management, which has significantly improved the financial picture of many hospitals. Many of the technologies focus on the back end of the revenue cycle: claims editing management, remittance and denial management, and contract management. In other words, we are managing the same problems over and over again—problems that start at the front end of the revenue cycle, during registration.

AT A GLANCE

A registration quality assurance initiative—whether manual or automated—can result in benefits such as:

- > Cleaner claims
- > Reduced cost to collect
- > Enhanced revenue
- > Decreased registration error rates
- > Improved staff morale
- > Fewer customer complaints

Why manage when there is a better solution—prevent?

Consider that 70 percent of a claim form is generated during the registration process. Often, there is high turnover in registration areas, which leaves the registration departments in constant training mode. When staffing in registration is short, hospitals tend to cut the detailed training that is needed and initiate “all-hands-on-deck” mode, resulting in on-the-job training for new registration staff. What happens if the “trainer” for a new staff member was not trained completely or correctly? The downfall begins.

Implementing a quality assurance (QA) process in registration—whether a manual process or an automated process—can improve morale and reduce complaints, denials, and rework. At Thomas Hospital in Fairhope, Ala., a QA initiative in registration reduced the cost to collect and days in A/R, significantly decreased the registration error rate, eliminated monthly outsourcing fees, increased point-of-service collections, and resulted in cleaner claims.

The ROI of Registration QA

A time and motion study performed at Springhill Medical Center in Mobile, Ala., found that the average amount of time for a billing representative to identify, research, and correct one error was 10 minutes (Shorrosh, P., 2004 study). Let's say it costs the hospital \$15 per hour, on average, for a single billing staff member, taking into consideration salary, benefits, and overhead. If it takes an average of 10 minutes to correct one registration error, each error costs the hospital \$2.50 to correct.

Web Exclusive!

Find an example of a daily checklist to use for quality assurance initiatives in registration on HFMA's web site! Visit www.hfma.org/hfm.

By talking with business staff about registration errors they most frequently encounter, your organization will obtain valuable data needed to help correct problems in registration.

How much is a hospital that registers 300,000 patients a year with a 25 percent error rate spending on managing denials? Based on this information, the hospital could be spending \$180,000 on back-end rework and denials management! What would happen if we took that money and invested it in a dedicated front-end QA process that prevented those denials from ever occurring, and in the process, reduced the number of errors being made?

Let's expand this analysis a little further and identify the potential loss of revenue due to these errors. If only 4 percent of the hospital's accounts had fatal errors caused by registration, this hospital would have encountered \$39 million in denials, equating to \$13.5 million of potential revenue at risk for write-off (based on an average charge of \$3,250 with a 35 percent reimbursement-to-charge ratio). If only 5 percent of the fatal errors were caught, corrected, and recovered through a QA program, the hospital would save \$675,000 from potential write-offs. In other words, every \$1 spent on registration accuracy could save up to \$10 in rework, denials management, and write-offs. In addition to the dollars saved, the frustration level in the patient accounts department would be dramatically reduced, creating a more productive and happier place for all.

Where to Start

Whether you are developing a manual QA program or a fully automated program, here are 10 tips for getting started.

Identify and understand your facility's top 30 registration errors (in terms of greatest financial impact). There are

three ways to collect this information:

- > Interview all business office staff, concentrating on the billing and follow-up staff.
- > Review payer remittance advices to identify the top 20 reasons for denials.
- > Review your claims editing software system reports to identify the top 10 flagged errors at your organization.

Be sure to focus on the issues that are the responsibility of registration. Talk with your business office staff about the errors they most frequently encounter, such as missing or incorrect identification numbers, patient relationship to subscriber, and minor guarantor. The goal of the business office is to get claims out the door as quickly as possible. Unfortunately, this means business office staff do not always have time to inform registration staff of the errors they are making. By talking with business staff about the registration errors they most frequently encounter, your organization will obtain valuable data needed to help correct problems in registration.

Dedicate and train an adequate number of QA specialists to audit 30 percent to 100 percent of your accounts.

If you decide to begin a manual QA process, a rule of thumb is that one FTE can review 24,000 to 48,000 accounts per year or 50 to 100 per day, depending on the depth of review. Of course, if you decide to start an automated QA program, fewer FTEs will be needed, and more errors will be identified.

In 2002, Thomas Hospital dedicated one FTE to registration QA, with a goal of reviewing all accounts for accuracy. What a job! Although the FTE was very effective in reducing denials and rework, one FTE was not enough when the hospital was booming in growth (registrations grew from 71,000 in 2002 to 95,000 in 2007) and all efforts needed to be focused on proactive rather than reactive work. The QA employee's actual review rate consisted of 30 percent of accounts, and the depth of the review was limited to whether insurance information and payer ID numbers were entered correctly. The limited manpower for registration QA resulted in inconsistent feedback to the hospital's registration

manager and inconsistent (if any) feedback to registrars.

Ultimately, Thomas Hospital automated its registration QA processes—a decision that enhanced both staff morale and the hospital’s bottom line. Today, the hospital boasts a registration error rate of just 15 percent and a clean claim rate of 90 percent. Yearly registrations have increased—95,000 in 2007, compared with 71,000 in 2002—yet the hospital has been able to reduce staffing in its business office from 16 FTEs in 2002 to 11 FTEs in 2007. Days in net A/R were 32.2 in 2007, compared with 55.5 in 2002, and point-of-service collections have increased by nearly \$94,000 a month. The hospital’s business department also eliminated outsourcing fees, which formerly totaled more than \$32,000 a month.

Develop adequate reports, coding and business rules, and checklists to support in-depth manual review. Automated tools are available to make these reports readily accessible, providing immediate feedback to all staff.

Involve patient financial services and health information management in the development of the QA program and training of QA staff. Staff from both areas are critical to understanding where errors exist in registration processes and the impact these errors have on the hospital’s revenue cycle.

checklist to double-check the accuracy of information input during registration.

Enforce error correction prior to bill drop. Time is of the utmost importance. Taking this step will result in decreased denials and rework.

Encourage individual responsibility. Registration staff should be responsible for correcting their own errors, if at all possible.

Track and report errors by location, supervisor, and employee to monitor individual and team performance. This will enable your hospital to pinpoint where high percentages of errors are coming from and provide education to the appropriate staff.

Share trends in error rates with registration staff. Use graphs and diagrams to drive home results.

Do not expect perfection. Set attainable goals—and celebrate successes!

Automating Your QA Program

Although establishing a manual QA process is worthwhile, a manual QA review is typically limited to 20 percent to 30 percent of random accounts, and can be subjective and inconsistent. Only a limited number of error types can be targeted for manual QA review, depending on the staff available to do the job. The alternative to manual QA is automation technology.

An automated QA program will review 100 percent of accounts for virtually hundreds of error types that the hospital can specify and customize as needed. The speed of automation allows these systems to report errors back to the registrar who made the error in a

timely fashion, prior to bill-drop, to improve accountability and to educate staff.

Registration employees cannot help but learn from their mistakes when a daily list of errors is presented to them with an opportunity to self-correct. Most

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Provide easily accessible verification information to registration QA staff. This information includes internal coding rules, insurance eligibility verification, address verification, scanned images of patient ID cards, payer contracts, physician orders, and medical necessity information. QA staff can then use a

registrars appreciate this feedback, especially when they realize it helps them do a better job and avoid complaints. Registrars can take pride in the fact that they can have a direct impact on the bottom line and patient care by self-correcting inevitable human errors and improving their accuracy rate.

Automated QA programs also provide patient access managers with powerful reports for improved management and retraining of front-end staff. The ROI for these products is typically realized in three to nine months.

Front-to-Back Improvement

Although some hospitals have learned to live with constant rework, denials, and morale-harming complaints caused by inevitable human error in registration, many managers are forging ahead with initiatives to improve this pivotal starting point of the revenue cycle. It's time for quality improvement to move beyond the clinical cycle to the revenue cycle.

Take a closer look at your registration department—staff there may hold the keys to moving your revenue

cycle one step closer to reaching your organization's financial goals. Implementing automated QA technology will produce significantly greater results and ROI than a manual program, but every hospital should at least implement a manual QA process to improve morale and reduce complaints, denials, and rework.

Shifting from higher-cost denials management to lower-cost denials prevention and education is certainly a good financial move for any hospital. Instead of back-to-front management, registration QA introduces front-to-back continuous quality improvement and prevention rather than correction. An ounce of prevention at the front door is worth a pound of rework at the back door. ●

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