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# the hidden KPI registration accuracy

A registration quality assurance process can be used to improve performance of key revenue cycle indicators.

How would you like to discover a hidden key to improving your revenue cycle—one that gives you a powerful strategic performance indicator, yet actually changes the outcome by virtue of the tactical activity required to track it? That key measure, which can be found at the front end of the revenue cycle, is registration accuracy.

## AT A GLANCE

- > Determining the registration accuracy rate is fundamental to improving revenue cycle key performance indicators.
- > A registration quality assurance (QA) process allows errors to be corrected before bills are sent and helps registrars learn from their mistakes.
- > Tools are available to help patient access staff who perform registration QA manually.

Registration accuracy refers to more than verifying a patient's demographic information or an insurance policy number or plan code. Hundreds of financially potent error types occur every day when registrars input critical demographic, medical, and insurance data. The sidebar on page 127 lists a number of them. Most of the information required to bill claims is collected at the front end by low-wage patient access employees working in highly complex environments that emphasize speed, service, and collections over accuracy. These registrars are committed to high-quality work; however, a variety of environmental factors diminish their ability to consistently deliver accurate registrations, such as:

- > Registration (Admission-Discharge-Transfer) System gaps or recurring opportunities for failure
- > Changing payer and hospital rules
- > Inevitable human error, such as transposed digits
- > Increasing complexity and duties
- > Focus on speed, service, and copayments
- > Low compensation and high turnover of staff
- > Limitations of verification technology
- > Poor-quality data from patients or other providers

Without a consistent method to prioritize, monitor, and track accuracy, patient access staff sometimes fail to collect all of the information needed to file claims, leaving the patient financial services (PFS), health information management, and collections teams to fill in missing information, rework claims, and respond to denials later. Meanwhile, preventable errors made during scheduling, preregistration, and registration can lead to write-offs that erode net revenue.

See several tools for performing manual registration quality assurance at [www.hfma.org/hfm](http://www.hfma.org/hfm).

By focusing on improving registration accuracy, healthcare organizations can improve their revenue cycles overall and strengthen their performance on revenue cycle key performance indicators. Measuring how well multiple standards have been met by front-end staff working through myriad complex human and technical processes is not easy, however. It requires implementing a quality assurance (QA) process, which can vary in the number of errors targeted for review.

When the QA process is manual, the percentage of accounts reviewed and the consistency of the reviewers can vary considerably. A systematic, defined QA process is needed—whether it be manual or automatic—to find and correct the financial-impact errors listed in the sidebar (and hundreds of other unlisted compliance and operational errors). Using such a defined QA process reduces the complexity and variety of errors to one simple and powerful metric that revenue cycle managers can track and use to improve revenue cycle performance: the registration accuracy rate.

The defined QA process allows managers to calculate this metric by tallying the number of accounts that are error-free and dividing the sum

by the number of accounts reviewed. Some managers use review checklists to calculate a second metric: the registration error rate, which factors in multiple errors made in the same account. The error rate is calculated by dividing the number of errors by the number of accounts reviewed. If there are more errors than there are accounts reviewed, the error rate will be greater than 100 percent. Many revenue cycle managers prefer the accuracy rate because it is based on a 100-point scale and is a more positive metric for employees. Some managers group errors by a common category and weight and report them by type, such as financial impact errors, using the same calculations. As with any analysis, the larger the sample size, the more statistically significant the findings. At least 30 percent of total accounts should be reviewed.

A best-practice registration QA process allows errors to be corrected before bills are dropped, and more important, those who made the errors learn from their mistakes and improve over time because they receive ongoing feedback on quality. In this way, QA becomes a tactical “find-and-fix” activity that fulfills a strategic objective: The reduction of errors over time, with cleaner claims

## Registration Errors that Affect the Revenue Cycle

- > Incorrect insurance plan listed
- > Policy number or group number missing or invalid
- > Patient not eligible on date of service
- > Patient with insurance listed as private pay
- > Medicare listed when plan is Medicare HMO
- > Medicare listed as primary when should be secondary
- > Minors listed as guarantors
- > More than one medical record number per patient
- > Accident claims without occurrence codes
- > Patient relationship to insurance subscriber code errors
- > Failure to list medical necessity (RAC Alert!)
- > Missing guarantor or employer information
- > Physician orders incomplete or missing (RAC Alert!)
- > Internal coding mismatches (e.g., financial class to patient type to stay type to service code to admit code)
- > Missing prior authorization or pre-certification required for service provided
- > Transposed digits: Social Security number, date of birth, policy number, group number
- > Invalid punctuation in specified text fields
- > Misspelled name (No. 1 reason for Medicare return-to-provider rejections)
- > Insurance eligibility verification failure
- > Address verification failure (returned mail cost)
- > Observation patient with inpatient stay type (RAC Alert!)
- > Point-of-service collection failure
- > Incomplete or inaccurate Medicare secondary payer questionnaire (RAC Alert!)

entering the revenue stream, results in less rework, lower claims processing costs, fewer denials and payment delays, and faster payment. Most important, the results are achieved without expecting perfection from human beings in the demanding environment of today's patient access department.

**Tools for Performing Registration QA Manually**

Many hospitals are using automated QA tools, which enable greater depth of auditing and 100 percent account review for a fraction of the cost of performing the work manually. Still, manual QA is better than no QA, especially considering the Hawthorne Effect, a finding from a study that showed employee performance improves

| REGISTRATION ACCURACY RATE BENCHMARKS |                  |        |      |
|---------------------------------------|------------------|--------|------|
|                                       | Benchmark Goals: |        |      |
| No. Edits:                            | Good             | Better | Best |
| <25                                   | 85%              | 95%    | 98%  |
| 25-50                                 | 83%              | 93%    | 97%  |
| 50-75                                 | 81%              | 91%    | 96%  |
| 75-100                                | 79%              | 89%    | 95%  |
| 100-125                               | 77%              | 87%    | 94%  |
| 125-150                               | 75%              | 85%    | 93%  |
| 150-175                               | 73%              | 83%    | 92%  |
| 175-200                               | 71%              | 81%    | 91%  |
| >200                                  | 70%              | 80%    | 90%  |

**Points to remember:**

- > Hospital registration is a complex human process, so consistent 100% accuracy is not realistic.
- > For a goal to motivate, it must be attainable.
- > The more errors are audited, the more will be found.
- > Set goals after you determine your hospital's baseline accuracy rate.
- > Raise the bar over time. Once "good" goals are met, raise to medium, then high.
- > Above goals are guidelines only and should be adjusted based on your hospital's baseline.

Note: Results at your hospital may vary from above general guidelines.  
Source: AccuReg Software.

when employees are aware they are being monitored (*Counseling in an Organization*, Roethlisberger and William Dickson, 1966). The bottom line is that if hospitals want to significantly improve their revenue cycle performance, they need to provide their patient access departments with some form of QA. Several tools can be used to support a defined registration QA process that is performed by patient access staff manually.

**Registration QA daily checklist.** This tool lists 32 of the most common registration errors. The checklist provides QA reviewers with a structured auditing process and a framework for tracking and reporting a consistent accuracy rate metric by account. See the checklist at [www.hfma.org/hfm](http://www.hfma.org/hfm).

**Registration QA monthly tally.** Reviewers or patient access managers can use this list to tally an employee's error and accuracy rate on a monthly basis. See the tool at [www.hfma.org/hfm](http://www.hfma.org/hfm).

**Registration accuracy rate benchmark matrix.** The matrix at left provides sample benchmark goals. Accuracy goals should be attainable and flexible regarding the number of registration errors managers include in their QA process. Remember: The more errors an organization audits for, the harder it is to reach a given accuracy rate. Based on feedback from dozens of hospitals, this matrix can guide managers in setting realistic goals for their patient access departments.

In addition to the checklist, tally, and matrix, three spreadsheet tools can help revenue cycle managers calculate the ROI of performing registration QA, estimate the cost of manual QA compared with automated QA, and compare the functionality of automated QA tools.

**Manual QA cost-benefit calculator.** This tool estimates the relative labor cost for conducting manual QA at the depth and breadth desired and the associated financial benefit (ROI) of denials prevention. See the interactive calculator at [www.hfma.org/hfm](http://www.hfma.org/hfm) (vendor quotes are not included in this exhibit).

**Manual versus automated QA cost estimator.** This tool estimates the proportional investment in labor required to reach the desired manual audit level. If set to 100 percent account review, this tool can also be used to compare the cost of manual QA with automated QA, using vendor quotes. (The quotes are not included in the exhibit.) See the interactive cost estimator at [www.hfma.org/hfm](http://www.hfma.org/hfm).

**Automated QA functionality comparison tool.** This tool enables managers to compare the considerable variation in functionality of today's automated QA tools. See the tool at [www.hfma.org/hfm](http://www.hfma.org/hfm).

**Suggested Practices for Manual QA**

By implementing the following practices, PFS and patient access managers can implement a defined QA process that helps patient access staff improve registration accuracy:

- > Determine a fixed number of error types to consistently audit.
- > Create and use review checklists to promote auditing consistency, a record-keeping system, and a tally system for reporting registration accuracy by facility, location, and employee.
- > Provide the registrars with time and training to review 30 to 100 percent of accounts for the given number of error types.
- > Outsource or dedicate enough FTEs to conduct full-time manual review at the desired levels above. (Tip: See the manual QA cost-benefit calculator as [www.hfma.org/hfm](http://www.hfma.org/hfm) to determine the number of FTEs required to conduct the desired depth and breadth of auditing.)
- > Provide the reviewers with easily accessible verification information, such as internal coding rules and tables, eligibility verification systems, address verification systems, payer sites, payer contracts, physician orders, medical necessity, and scanned insurance and ID cards.
- > Require corrections to be made before bills are dropped.
- > Meet monthly to review registration accuracy rates, denials, and write-offs, and evaluate

ongoing performance of the QA process and revenue cycle impact.

- > Use accuracy and error rate trend reporting for goal setting, performance evaluations, and incentives.
- > Conduct weekly performance reviews with registrars to review individual measures, including each employee's top five errors for the previous week and goals for the next week.

**Finding the Key**

These tips and tools should help justify and simplify implementing a consistent registration QA process. Once the process is implemented, financial, patient access, and revenue cycle managers should be able to calculate and track registration accuracy metrics weekly and monthly. As a result, the cost of back-end rework, denials management, and fatally denied write-offs will be shifted to the front end, where denials can be prevented rather than managed, and for a fraction of the cost of back-end rework.

Whether manual or automated, the ROI for performing registration QA is found not only in errors corrected before billing, but also in fewer errors being made to begin with as registration accuracy improves. To see their organization's accounts receivable days, clean claim rate, denials rate, and unbilled days improve, revenue cycle leaders should take another look at the no-longer-hidden key: registration accuracy rate and its prerequisite, registration QA. ●

**About the author**



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