Uncovering outpatient operations’ hidden revenue busters

Our client’s need
This case study will discuss the findings and implementation recommendations following a comprehensive review of a large New Jersey tertiary facility’s outpatient operations. The initial review revealed that the hospital’s outpatient operations were home to sixty-five outpatient service and registration areas and approximately fifteen different job types processing outpatient registrations.

Due to recent capital investments and medical staff additions at the hospital, it had recently experienced a rapid expansion of outpatient services. The review also revealed multiple ambulatory reporting relationships, inconsistent training and policy dissemination and confirmed that insurance denials were above tolerable levels.

Baker Tilly solution
The Baker Tilly team was engaged to perform an operations review of three of the medical center’s high-volume departments: cancer center, primary care clinics, and radiology. The review found increased staff workload, significant managed care technical denial rates, significant Medicare denials, fragmented revenue cycle functions, inconsistent workflows and processes, and informal inter-departmental linkages.

When taking the full-time employee inventory, we found over 125 administrative personnel were processing outpatients, led by more than forty management employees. Further, revenue cycle functions were often “buried” under the responsibilities, personnel performance evaluations were not focused on revenue cycle functions, and job descriptions were not consistent with actual performed daily functions.

The project segments were as follows:

> Redesign the patient access processes to deliver a positive and consistent experience to patients across departments and sites
> Standardize processes across sites to promote cost efficiency and eliminate errors and denials
> Invest in technology and leverage across sites
> Enhance patient and physician satisfaction
> Develop benchmarks and measurements
> Develop a process for monitoring progress and measuring performance
Improvement opportunities
The Baker Tilly team identified many opportunities for improvement, including:

> Integration (and prioritization) of revenue cycle functions
> Revised workflows and processes
> Focused enforcement of existing policies
> Enhanced formal staff training
> Re-distribution of employee workloads
> Revenue cycle-focused organizational structure

Baker Tilly advised the hospital that the following goals and objectives would make the operations more effective:

> Create a new organizational structure led by finance that focused on ambulatory revenue cycle
> Standardize patient registration and financial clearance processes in all ambulatory areas
> Improve revenue and cash collections through enhanced registration, diagnosis, and charge capture processes
> Monitor duties against job descriptions across ambulatory service areas
> Introduce targeted performance benchmarks into the revised job descriptions
> Create opportunities for the professional advancement of administrative personnel
> Centralize key revenue cycle functions (including scheduling and insurance verification)

Integration challenges were identified early on, including multiple service areas in different locations, variations in job descriptions for the same role, some resistance to clinical and administrative integration, lack of universal training, multiple IT interfaces, fragmented management control, sites using paper versus electronic registration, as well as cultural differences.

Beyond the typical cultural issues that had to be addressed, the single most challenging hurdle was the existing decentralization and lack of focus on the revenue cycle aspects of ambulatory care. Most of the revenue cycle functions were being performed by clinical personnel on an “after-thought” basis. Secondly, the clean flow of financial information in two directions (from the clinical areas to finance and vice versa) was extremely challenging given the unregulated IT process that was in place at the outset of the project.

Both of these challenges were addressed head-on by methodically identifying the problematic nodes in each area, consolidating these issues at the enterprise level, and then generating enterprise-wide processes and systems that could be accommodated by the organization.

The components of the revenue cycle process that were targeted for change are highlighted below:
Understanding outpatient operations’ hidden revenue busters
Results achieved

As a result of the review, the hospital saw increased customer satisfaction. This encompassed patients, physicians, and employees.

Productivity was increased and the hospital was on its way to meeting its proposed goals:

- Reduced denials and increased POS cash collections
- Administrative cost efficiency and economies of scale
- Delivering a consistent positive patient access experience
- Clinical process integration where appropriate
- Improved opportunities to advance within the organization for patient access/revenue cycle personnel

The engagement led to creating an ambulatory revenue cycle committee, comprised of representative staff members from finance (vice president and director levels), operations (vice president and director levels), health information management (HIM) (director level), registration (director and manager levels), compliance (vice president level), clinical department leaders (director levels), nursing (vice president level), and information systems (vice president and director levels).
The review also led to a revised organizational structure, with the new director of ambulatory operations reporting to the vice president of finance and being responsible and accountable for the entire ambulatory revenue cycle. This professional supervises all registration personnel through a focused management structure and has a dotted-line relationship with the scheduling, HIM, and training functions. In addition, he or she facilitates the migration of claim denial information to the accountable areas / personnel and interfaces with managed care personnel on administrative requirements and improvements.

Based on the full-time employee inventory, 110 personnel were re-assigned to a new finance cost center managed by the director of ambulatory operations. This re-assignment was based on the proportion of revenue cycle functions performed prior to re-organization. Most were re-assigned to a standard “ambulatory registrar” job description.

**Scheduling**

With the creation of a new scheduling administrator position, the role’s requirements included key pre-registration items. The scheduling function was revised, most notably to require insurance authorizations prior to scheduling elective treatment. Hard-copy submission of scheduling information was eliminated, and the function was formally integrated with the other revenue cycle management functions.

During this engagement, the hospital decided to implement a prominent enterprise-wide scheduling software to facilitate many of the changes noted above. The system’s user levels included IT system administrator, the new ambulatory scheduling manager, a super user in each department and scheduler(s) in each department. Key department-specific rules were established and the initiative was rolled out department by department.

**Registration**

In the registration area as well, a new structure was created: a manager of ambulatory registration who would have up to five area supervisors reporting to him or her. A single, integrated job description for the registrars was developed. Pre-registration functions were assigned to specific personnel, now reporting to the finance teams. All patients receiving elective outpatient treatment were now pre-registered and the department maximized the existing automated pre-registration and insurance verification functionality of the hospital and its contracted payors.
The review also led to the adoption of standardized pre-registration and registration scripts. Additional changes included a consistent recurrent visit protocol, review of cash collection strategies, modified registration processes, on-going quality assurance teams, and reviews and weekly audits ensuring compliance.

**Medical Records**

The Medical Records department also moved forward on establishing new roles, including a manager of ambulatory health information and medical coding educator positions. The medical coding training and education for employees in all ambulatory areas became an assigned role. Other changes included standardized medical record administrative policies and regular audits of superbills, medical coding reference guides, and the Charge Description Master (CDM).

**Denial and appeal management**

Changes for the denial and appeal management functions centered around training. Training became the group’s major priority moving forward. In addition, the existing denial and appeal tracking system on the hospital’s intranet was expanded. Payor-specific analyses were performed with a primary focus on recovery and prevention efforts. Moving forward, a process was installed to track technical denials as a percentage of expected reimbursement as a way to identify problem areas for timely intervention.

**Managed care policy and procedures**

Revisions were implemented after the team’s review. For example, the hospital financial system and intranet MCO matrices were updated and consolidated. Updated MCO contract information was distributed to all departments to maximize contract compliance and minimize denials. The denial management program was coordinated with MCO negotiators and the team identified onerous MCO administrative requirements for future negotiations.

**Employee training**

Employee training remained at the forefront of all recommendations. After the consulting team review, a universal training approach across all service areas was implemented. In addition, future monitoring and evaluation procedures would become more aggressive. All employees were required to attend specific continuing education programs. Most impressively, over 100 front line personnel received revised training.

**Information systems**

Changes to the information systems procedures included coordination with the prominent enterprise-wide scheduling system’s implementation timetable, targeted modifications to the patient accounting system, and a new centralized management policy around new IT interfaces.

**Benchmarks and outcomes**

At the conclusion of the hospital review, industry benchmarks were established. Going forward, scheduling productivity, pre-registration productivity, average time for pre-certification, point of service (POS) registration productivity, POS cash collections, and denial rates are consistently evaluated.