improving outpatient charge capture

Healthcare reform, an unstable economy, and other factors have increased revenue pressure on hospitals across the nation. Perhaps the most promising opportunity to enhance revenue is through improvement of outpatient charge capture.

Outpatient charge capture generally presents a number of opportunities—more so than on the inpatient side—to fix processes quickly and protect revenue integrity. Hospitals routinely collect vast amounts of patient and financial data related to charge capture, and can use these data along with additional analysis to pinpoint opportunities for improvement and effectively allocate scarce resources as they seek to optimize revenue.

Limitations of Common Charge-Capture Analytics

Improvements in technology have allowed hospitals to gather a tremendous amount of data as part of their daily operations, including information that can shed valuable light on where they might be struggling to capture charges. These data reside primarily in the billing and accounts receivable (A/R) system, the patient clinical information system, and subsystems such as the radiology, pharmacy, and laboratory information systems. Data also come from existing charge-capture software tools that ferret out missing charges.

Historically, however, hospitals have not proved to be adept at mining such information. They have lacked the tools and expertise to pull relevant data, convert the data to an accessible format highlighting the most useful information, and generally support the charge-integrity function.

The charge-integrity function typically focuses on several common analytics.

Chargemaster assessments. Although maintenance of the chargemaster is critical, it may be of little help in uncovering issues related to charge capture and how a
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department actually applies the charges. A hospital can have the cleanest, most comprehensive charge-master, but if the charge-capture methods for a given service are not clear to department staff, the hospital could still lose revenue for the patient services it provides.

Patient-account assessments. These assessments generally concentrate on the accuracy of CPT and HCPCS codes for charged services, but they are ineffective for identifying charges that might be missing. For example, if services were performed but not documented in a patient’s medical record, the person conducting a patient-account assessment has no way of knowing that the services have been delivered and the corresponding charges are missing.

Late-charge assessments. Many hospitals assess late charges to determine whether any departments might be tardy in submitting charges, and if so, to what extent. Late-charge reports are a good indicator of the timing in the charge entry process but not of where specific opportunities to improve charge capture might lie. For example, the late-charge report indicates the efficiency of the emergency department (ED) in entering charges but not whether the ED captured a charge for each patient seen in the department.

Revenue and usage statistics. Most hospitals provide each department director with a monthly revenue and usage report that shows all the charges available for each department, how often each charge was used, and the gross revenue for each charge. These reports are important for checking general accuracy and helping department leaders understand charge activity, but they are a limited aid for recognizing missing charges. A department director can see whether gross charges are consistent with historical levels but will have a hard time diagnosing particular charge-capture issues without specific report customization and additional training. Department managers and directors typically are trained to provide patient care, not to analyze data from a lost-charge perspective.

Departmental charge reconciliation. Every hospital department should perform daily, weekly, or monthly reconciliations of its activity against its charges. But this exercise, while vital, might not identify additional lost charges; it flags that a certain patient received a service and some charges were captured, but it does not confirm the accuracy and comprehensiveness of the charges. To get the full picture, the department director must use a combination of basic charge reconciliation (e.g., 100 patients seen and 100 charges entered) and customized reporting that allows more detailed drill-downs into the charges captured by department staff.

Focusing Charge-Integrity Resources

Misaligned staff is a potential charge-capture issue for hospitals of all sizes. Larger hospitals and academic institutions might have charge-integrity staff members located in separate pods or silos across revenue-producing departments that have their own staffs, tools, and processes. Many community hospitals lack formal charge-integrity functions altogether, leading to a haphazard approach.

All hospitals can benefit from scrutinizing their charge-integrity functions and aligning resources appropriately. To improve outpatient charge capture, a hospital should direct charge-integrity resources toward efforts that are most likely to return revenue instead of those that are more maintenance-oriented.

Hospitals already possess data that can support several types of worthwhile charge-capture analytics. Specifically, a hospital should consider performing the following four assessments.

Charge-capture process walk-through. The charge-integrity team should have clinical staff take the team step by step from service delivery to charge entry. Understanding clinical protocols and clinical services delivered and translating that information into charge capture is essential.

In the case of an outpatient infusion department, for example, learning about the major types of infusions performed and clinical protocols followed (e.g., the length of the infusion, any additional injections given,
types of drugs administered) would provide the charge-integrity team with valuable insight. With any department, the team should start by interviewing clinical staff and directly observing the charge-capture methodologies and tools used in each step of the process.

The team also should compare the services provided by department staff with the chargemaster and charge-capture system to verify that all the necessary charges are available for capturing, and compare the department’s volume and revenue statistics with the clinical-service protocols to determine whether the associated charges are reasonable and accurate.

Subsystem linkage analysis. Validation of the links between a charge-capture subsystem and the chargemaster can identify major charge-capture opportunities. Testing by IT tends to be insufficiently accurate to assess charge capture, instead validating only the general functioning of the system (i.e., passing charges from point A to point B).

To precisely analyze the accuracy of charge links, the charge-integrity team first should have IT generate a report that identifies the specific department subsystem line items (e.g., in the radiology information system) and the corresponding charge line item (or items) to which they link in the chargemaster.

The team then should analyze the report to identify any clearly mismatched line items (e.g., a chest two-view X-ray mapped to the charge for a computed tomography scan of the abdomen), review any mismatched line items with the clinical department staff, and analyze billing samples for mismatched items to validate the findings.

Third-party payer contract analysis. Understanding how charge-capture processes match up to the specifics of payment terms in contracts is critical and can produce significant net revenue results. Charge-integrity staff should obtain payment terms for the hospital’s top five nongovernmental payers and identify instances in which specific requirements are necessary for the hospital to receive the appropriate payment. These instances may include carve-out provisions that require the use of certain revenue codes to receive payment for particular charges (e.g., using a specific revenue code for implant supplies) and lesser-of-fee-schedule-or-charge provisions, according to which payment is the lesser of the hospital’s charge or the specified payment on a fee schedule.

The charge-integrity staff then should compare the specific provisions to the hospital’s chargemaster and verify that the required revenue codes are being used and that prices are above fee schedule amounts. The team also should analyze a billing sample for suspected issues and validate payment schedule discrepancies by reviewing the specific payer’s remittance advice for the charges in question.

Electronic health record (EHR) structure analysis. Many hospitals and health systems have implemented EHRs with the expectation that they will improve charge capture, only to find that the opposite is happening. Charge capture might deteriorate after EHR implementation because of the EHR’s lack of automated charge-capture functionality or clinical staff’s confusion about how to document the required information to support coding and charging processes.

Identifying charge-capture issues within the EHR is critical for stopping revenue leakage. The charge-integrity team should be an integral part of the EHR selection process to help quickly identify potential charge-capture deficiencies. Once such issues are identified, they can be either rectified with the vendor or more fully understood with an eye toward enhancing training of clinical department staff on how to use the new system effectively.

Integration of Charge Integrity in Clinical Departments
The tools and processes created as part of a hospital’s charge-integrity function should be formally incorporated into the regular charge-reconciliation processes of clinical departments, thereby empowering departments to act on charge capture. To accomplish this goal, hospitals can take a four-step approach.
Assessing Charge-Integrity Performance

How does a hospital evaluate the performance of the charge-integrity function? Metrics should cover the following areas.

Revenue improvement
- Identify lost charges for patient services.
- Close process gaps that cause revenue leaks.
- Protect existing revenue.

Operational improvement
- Lead clinical departments’ charge-capture monitoring processes.
- Create tools and reports from data to assist the organization and each department in managing revenue risk.
- Integrate charge integrity into all phases of the revenue cycle.

Special projects
- Provide support for new services.
- Provide electronic health record and ICD-10 support.
- Resolve billing and subsystem issues.
- Manage third-party and consulting projects.

Develop charge-reconciliation tools and reports.
Valuable custom reports can be created from the following data sets:
- Departmental clinical systems, which contain information on the number of patients seen in a particular time frame
- Central scheduling systems, which indicate how many patients should have reported to the department for services
- Revenue and usage statistics, which provide essential raw data on the department’s actual use of its charges
- Claims data (specifically Electronic Remittance Advice [i.e., 835] files that detail the items for which payers compensate the hospital), which can provide a wealth of information related to accurate charge capture

Train each department on using the new tools and reports and on its analysis responsibilities. This step should involve, for example:
- Conducting training sessions with department managers on how to analyze the data in the new reports
- Creating clear action steps for department managers and establishing deadlines for analyzing the data
- Teaching department managers to identify the core issues that need to be addressed regarding charge capture and the steps the department should take to remedy the issues

Formally monitor each department’s compliance.
The hospital should establish an automated report distribution system (via e-mail or intranet) to track each department’s review of the reports. A standard meeting schedule should be set that allows charge-integrity staff to regularly discuss each department’s results and observations.

Incorporate charge-reconciliation responsibilities into clinical department managers’ job descriptions and goals. Specific work tasks related to charge-capture monitoring (e.g., work steps and frequency) should be added to department managers’ annual plans to create a higher level of accountability.

The Rewards of Data-Driven Change
A hospital’s charge data is valuable not only to the charge-capture process, but also in support of projects such as ICD-10 preparation. In fact, charge-capture data should be interwoven with ICD-10 implementation. For example, data collected in the billing and A/R system can be wielded to determine the frequency of charge activity, which in turn identifies the areas most likely to encounter additional ICD-10 issues.

Every hospital has a universe of outpatient charge-capture data just waiting to be tapped. Making sense of it to improve performance is challenging, but the challenge is not insurmountable. Hospitals should focus resources wisely, take advantage of available technology, and concentrate on the basics to effect real change and boost revenues.

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