The Road to Revenue Capture in Hospital Medicine

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IHA, one of Michigan's largest multispecialty group practices, has been ahead of the curve on two recent trends in the healthcare delivery landscape. First, when it comes to utilizing hospitalists, the American Hospital Association reported that 60 percent of hospitals staff these specialists today, up from only 30 percent 10 years ago.[1] Merger activity—trend number two—is experiencing an uptick in momentum largely due to the formation of accountable care organizations (ACOs) and anticipated reimbursement model changes that better align care provided with patient outcomes. As a result of a 2010 merger with St. Joseph Mercy Health System, IHA has more than 100 hospital medicine providers.

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IHA first implemented its hospitalist program in 2006, starting with only six hospitalists. With a small hospitalist practice, IHA relied on manual processes for physician coding and billing. This is not unusual for inpatient-focused practices; paper forms and/or index cards are still common despite the prevalence of electronic medical record (EMR) systems. Unfortunately, these EMR tools, when owned by the hospital entity, often lack integration with the physician practice billing system, which necessitates a workaround.

For IHA, this meant that providers who treated patients at multiple hospitals were responsible for turning in charge tickets with their own handwritten demographic and procedure/diagnosis code data. A courier would collect the tickets and bring them to the central billing office for data entry—sometimes days, weeks, or even months after the patient encounter. The consequences of this workflow included higher charge lag than desired and a lack of reconciliation capability. IHA could correlate at a high level a physician's on-call schedule with the presence of at least one submitted charge, but there was little ability to get more granular and track discrete charge opportunities.

With concerns around revenue performance and knowledge that the group was about to merge and grow significantly, a search for an electronic charge capture tool was initiated. The goal was to integrate the hospital registration, EMR, and IHA billing systems, and be deemed user-friendly by physicians. In June 2011, a beta group of hospitalists turned in their last paper charge tickets and started to use web-based charge capture from MedAptus, a revenue cycle software company.[2] A financial benefit study undertaken six months later documented quantifiable benefit around increased gross revenue, improved charge capture performance, and enhanced coder throughput. With proof of concept established, full deployment was approved.

Physician Impacts

Formed in 1994 with only a few independent private-practice groups, IHA grew by placing great emphasis on selecting only the best physicians and practitioners to ensure its patients received the highest possible care. Today, IHA has over 300 providers and treats nearly 300,000 patients at 35 locations throughout its service area. IHA has strong physician leadership which serves as a model for effective program management, including successful charge capture technology.

Given the positive pilot results of the new MedAptus technology, particularly an almost 15 percent increase in gross charges, IHA made the decision to mandate its use in provider contracts. The mandate stipulates that providers have 72 hours from patient encounter to submit a professional charge for billing. IHA staff run reports to identify providers who are out of compliance with the "3-day rule," and from here providers are contacted about any missing charge opportunity via integrated messaging within MedAptus. This notification is visible the next time the provider logs on and provider management is also notified.

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IHA relies on a number of physician champions to help secure and maintain timely charge submission. Mohammed Salameh, M.D., IHA's director of hospital medicine, is one of these leaders. Dr. Salameh engages closely with his hospitalist peers to keep them enthused about the project. He solicits feedback for potential modifications that would keep providers on board proactively. This keeps the IHA software project team focused on incorporating feedback to ensure that the technology remains easy to use. The goal is for providers to accomplish charge documentation rapidly—typically from the point-of-care immediately following a patient encounter. This is IHA best practice and how providers are trained.

Another factor that has helped secure high and timely adoption is seamless integration between the MedAptus tool and the St. Joseph Mercy Hospital EMR system, PowerChart®. With a single sign-on access to both charting and charging tasks, providers complete both forms of documentation efficiently. Charge capture is further expedited by providers having access to their most frequently used procedure and diagnosis tools as well as charge history as entered by the entire team and across hospitalizations. Providers further benefit from features that complement the code search-and-selection process, such as personal rounding list creation and management. Providers see patients at four IHA hospitals, and having real-time access to patient status and an ability to organize patient lists that align with each doctor's unique workflow style is another boost to efficiency.

Throughput at the CBO

Physician adoption of charge capture technology is only half the IHA equation for driving revenue improvement. The second half is operational charge management, which happens at the IHA central billing office (CBO) through a complementary Coder Workstation tool. With this tool, once providers submit charges from the hospital, the data enters a queue in Coder Workstation for review by coding staff. Any needed corrections are made prior to electronic export from MedAptus to the IHA billing system. When charges were submitted on paper, claims were only billed once or twice a week. However, with a full electronic workflow, charges are now processed for billing on a daily basis, decreasing charge lag by about eight days on average.

Another significant administrative benefit to the hospitalist support team is improved individual efficiency. Just over one year ago, the hospitalist program was billing 400 claims per month; the team is now billing 14,000 claims per month. When the program was much smaller, the physician-to-biller ratio was 9:1. With nearly 120 providers now, the ratio is 20:1. Two core factors enable the group to bring on more physicians with less administrative support:

1. Staff spend less time following up with providers on missing charges or questions.

2. New patients are automatically created in the billing system via an interface that utilizes HL7 electronic messaging, reducing data entry tasks and potential claim rejects/rework.

With increased productivity, these same nine staff are also addressing front-end revenue cycle issues such as registration and eligibility as well as back-end issues such as collections and followup.

A final administrative benefit worth mentioning is the ability to benchmark operational and financial performance. With a complete electronic workflow in place, IHA has access to data around charge lag, missing charges, relative value unit (RVU) performance, Evaluation & Management (E&M) distribution (among others) across individual providers, groups, and even coders for certain measures. The IHA team

is in the midst of setting benchmarks for revenue performance so that team members can continuously improve, enabling further expansion while maintaining ideal administrative staffing ratios.

Lessons Learned

When reflecting on what factors enabled IHA to improve its revenue capture rate across its hospital medicine providers, a few key items come to mind. One cannot exaggerate the importance of physician adoption. While it's true that IHA elected to mandate adoption, this was not done in a vacuum. Balancing this approach with ensured usability made it as easy as possible for physicians to access the charge capture software with minimal typing and clicking. This is evident in physician training, which takes less than an hour and relies on actual patient encounters so that the physician experiences getting work done at the same time as learning something new.

Another indicator for success was the involvement of multiple IHA stakeholders, bringing physicians, operations, and IT to the table at the same time with the same stated goals—to improve revenue, decrease charge lag, and enhance efficiency. These groups worked collaboratively, starting with the initial pilot group, and they continue to work closely to ensure that IHA experiences ongoing financial benefit through new deployments, upgrades, and ICD-10.

A final insight has to do with the importance of system flexibility. While the core functionality of electronic charge capture is accurate and timely documentation of charges, there are tasks that "touch" this process for physicians. Whenever a physician can complete two things at once administratively, that drives adoption. One example of this is a new group of users requesting a field to communicate needs directly to the practice around patient labs and follow-up visits. While this falls outside the realm of encounter coding, it fits nicely within the provider's new workflow, and the MedAptus system is able to support such a customization.

Getting Competitive, Staying Competitive

As for what the future holds for charge capture technology at IHA, the organization is focused on deployment to another 100-plus providers who treat inpatients. The World Health Organization (WHO) ICD-10 is also starting to gain momentum in project planning. Physician champions will again play a pivotal role in understanding what the greater physician population needs from a training and education point of view. IHA will likely pilot ICD-10 via MedAptus with a small number of physicians to understand coding challenges and needed support prior to deploying the code set on a larger scale across specialties.

As the utilization of hospitalists continues to grow for the provision of quality treatment to hospitalized patients, so must the sophistication of practice administration when it comes to revenue cycle operations, particularly if paper is any part of the billing equation. Electronic charge capture enables IHA to take a program that was losing revenue and turn it profitable while at the same time expanding its capacity without additional overhead support.

References

1. American Hospital Association. 2012. AHA Hospital Statistics. Health Forum, LLC.
2. More information on MedAptus can be found at www.medaptus.com.

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