How We Helped One Hospital Find $730 Million A Year In New Revenue Legitimately And Increased Cash As Well

The request was simple. A hospital in trouble, doesn't have a lot of money and going down fast.

Not the actual words, but that was the sentiment. The situation was dire; this was a hospital in distress that had lost more than $50 million dollars 3 years in a row. It was quickly headed towards bankruptcy, and was laden with consultants of all types. Perfect for a company like ours, as it was going to be a long term project with a specific set of eyes looking at a specific issue, that being revenue.

To be clear, not every hospital will achieve these kinds of results. However, the processes for verifying that all possible revenue is being captured is the same no matter who you are. Any hospital can increase revenue by just raising their prices but if it doesn't result in real cash coming in what's the point? The steps we undertook increased revenue via legitimate methods, increased the amount of true reimbursement across the board, and removed many issues that would have been seen as fraudulent.

At the beginning of this project, unlike other projects, the first thing we did was take a look at a charge master report that another company had performed four months earlier. The person who had been overseeing the charge master at this particular hospital was an accountant who had been given the assignment 18 months previous. With no experience this person basically just put in what he or she was told and that was pretty

much it. However, that person left just as the report came in so none of its recommendations or findings had been implemented.

Although there were a few things we disagreed with in the report, overall it was solid. We took that report and compared it with the existing charge master to see what types of changes needed to be made. It turned out that not only were updates needed based on the report, but there were multiple charges throughout charge master that were duplicated. Without a revenue report, there was no way to figure out which charges were being captured since there was no indication of which charges were active at the time.

We requested a revenue report so that we could try to figure out what was going on. Many of the numbers were disturbing, especially for hospital the size of this one. Some departments were perfectly fine, while others look like they were pulling their own weight. In some departments, charges with duplicate descriptions both had revenue, and in others there were multiple charges with the same description but only one with revenue. What was particularly disturbing was that one department showed no revenue at all, that being the PT/OT area. We would soon discover why, and that would prove to be distressing as well.

For those charges where revenue looked proper and changes were recommended based on the charge master report, we gained access to the computer system and did that ourselves. Before we got there all changes to files within the computer were done by the IT department, but because they didn't understand how crucial revenue issues were it was a project that was often put on the back burner. Based on a quick

conversation and proof of our authority in this matter, we were given access so that we could manually take care of this issue.

Once that had been completed, we decided to take a look at some system denials. The hospital had a daily report of denials based on CPT and HCPCS codes, and even though it didn't indicate what the denial was, it did track those denials by charge code number.

An overwhelming number of the denials were coming from the laboratory, and a quick review of the problem showed that the people working in the lab, on a daily basis, were adding physician profiles so that if the position was handling certain types of patients they could just select the profile instead of having to select all the charges.

This turned out to be problematic for two reasons.

One, almost all of the profiles for each physician began with the same CPT code and description, thus the computer was taking all of those out as duplicates even though each one had new charge code numbers. While it's true that charges such as allergy testing might have multiple charge codes using the same CPT code, there was something that was kicking these charges out onto a denial report.

Two, an issue that took a while to figure out because the laboratory kept denying it was occurring (which was finally observed visually, at which point the laboratory leadership, which turns out had never seen how charges were entered into their system, finally owned up to the problem), was that by creating these individual physician profiles, the laboratory

was only passing across one charge and not all of the lab tests a physician was requesting. Not only that but the initial problem was resolved by learning that the lab was creating these new profiles with new charge codes but only in their system, since they didn't have access to the hospital system. Thus, the hospital system was somehow grabbing the first charge code for the first CPT code listed, but was showing up as an error because of all the other codes on the profile that it didn't know what to do with.

The combination of these two issues resulted in lab revenue showing up at around 30% of what it should have been. Correcting this, along with some other lab issues, drastically improved lab revenue.

The question about missing physical and occupational therapy charges was easily and strangely answered. It turned out that previous hospital leadership looked at the revenue this department was generating and decided it wasn't generating enough revenue to be left as an existing department. Based on our analysis, the problem was that many of the charges weren't set up as timed charges, which many of their charges are, and the department was never trained on capturing charges based on 15 or 30 minute increments. Not only that, but the department had never been informed that someone needed to call insurance companies for authorization, so there was a high denial rate for services and thus low reimbursement. Unfortunately, this was one area where there was no resolution as the hospital had already contracted to send their patients to an offsite facility.

Another major issue that came up, which was not caught by the previous charge master review, involved transplants. This particular hospital

performed all of the major transplants including heart, liver, and stem cells. They had an agreement with some of the large local insurance companies that they would reimburse transplants at 50% of charges as long as they were coded with the transplant revenue codes. However, it turned out that no one at the hospital understood that there was a difference between transplant codes, which are in the 800s, and the implant code which is 278. This didn't affect revenue as much as cash, and once that change was made to hospital started getting reimburse significantly more money for transplant services than it had before.

After starting with the laboratory and addressing some of its issues, we began to have meetings with department directors and representatives of other departments. We started with the high revenue departments, which included all of the surgery areas. The problem with general surgery was that they had created multiple charges to try to capture the amount of time that was spent on surgical procedures along with multiple charges for similar supply items that were used. What happened most of the time is that the person who was designated to capture the charges would often check only the first charge, and if that person got confused on which supply items to select ignored those as well. It didn't help that no one in the surgical suite was verifying that every supply that was being used was being checked off or captured in some way, or that the supplies used during a procedure weren't always captured in the medical notes.

The way we solved this issue was fairly standard. For surgical procedures we went with two charges. The first charge captured the expenses for the first hour of surgery, and that charges always heavily laden because most of the expenses of all surgeries occur within the first hour. The

second charge was then every other hour charge, and it was selected when the time when more than 20 minutes into each additional hour.

When it came to supplies, we looked at items that were similar in description and price and created one charge for all of those instead of multiple charges. This works because the hospital had a separate inventory system in place already and that didn't need to track inventory via charges. We also created supply package rates for surgical procedures that were performed on a regular basis and thus used the same supplies over and over, while making sure any supply item that had its own reimbursable HCPCS code remained separate. This reduced the number of supply charges that had to be tracked on a regular basis from over 300 down to around 40, which made the charge capture process much easier for the person who was responsible for doing it.

One last thing we did was invite the medical records department into these meetings to help guide the surgery department in the types of things they should be capturing for the medical record for better accuracy.

We ended up doing the same thing for endoscopy and urology, which at this hospital were separate departments. With endoscopy, we actually had to move them to a time-based methodology in capturing charges because quite often the procedure they were selecting was being disputed by the medical records department. It was so much easier to allow medical records to code procedures on the backend and let endoscopy just worry about capturing time.

Medical records was also responsible for capturing emergency room revenue, which happens at many hospitals but probably isn't the preferred method. One thing this hospital got correct was they hired an outside auditing company to review emergency room records every 3 months to see if medical records was getting it correct. However, the department wasn't capturing any of the individual procedure codes that were performed in the emergency area, even though they were coding them as procedures for billing purposes.

The process of correcting this issue took a few months of meetings between medical records and the emergency room representatives. Then we reviewed the possibility of moving charge capture for this area back to the emergency room because the head physician of the department wanted that to occur. However, he left two weeks before the process was going to switch over and project management felt that without his support the timing didn't work, so it was put on hold. Still, there was a drastic increase in revenue and reimbursement for the department.

One of the biggest revenue generating departments was cardiology. They also ended up having the biggest problems. It turned out that revenue had dropped drastically from cardiology because the department had decided to go with a brand-new system to help the physician's capture the services they were doing while still in their surgical suite, but the ball had been dropped somewhere between cardiology and IT in making sure that charge codes entered into the cardiology system were coming across to the hospital system.

Although we couldn't figure out why it happened, there ended up being 3 to 5 different codes for each procedure that was being performed in

cardiology, yet only one of those codes was active in the hospital system. It took almost a month to identify which charge codes were the proper ones and then alterations had to be done in both systems to get things fixed. In just over 90 days, cardiology revenue increased around 120%.

In discussions with not only these departments but other departments, we found that removing old codes off of the charge master had been handled fairly well, but no one had gone around and worked with departments to determine whether they were doing any procedures that new codes indicated existed. This turned out to be a major issue for quite a few departments, not only because it helped to increase revenue, but it addressed fraudulent charge capture because the people responsible for capturing charges in those departments were picking services that they didn't do, trying to get close to the services they were providing. It wasn't intentional fraud, but audits wouldn't have seen it that way.

The one department we knew was going to be problematic was pharmacy. We have found that the majority of hospital pharmacies create charges based on what they buy and not the HCPCS codes that are associated with many of those pharmaceuticals. This usually results in a drastic loss of revenue. Also, many pharmaceuticals are called by multiple names, and not only is care isn't always taken in verifying that some of those pharmaceuticals actually have HCPCS codes, which would be separately reimbursable from those pharmaceuticals that don't have those codes, but often every different description, because of multiple suppliers, ends up being a new charge instead of just remembering one name and using it for everything. At the same time that we were addressing this issue, the hospital was going through a pharmacy system conversion which slowed things up.

This ended up being a major project. In working with pharmacy, we were eventually able to decide on one description for all the different pharmaceuticals and resolve the description and charging issues. It took longer to complete than other departments because of the new pharmacy system implementation, which included having to create new tables from scratch, and this project wasn't totally complete when we left. Still, with the work we did pharmacy revenue drastically increased and the charge capturing project was much easier.

Working with information technology was interesting. There had been a pattern of their being skeptical and hesitant to make charges because they didn't trust the information were being given by the department directors. Luckily we didn't have to wait for their approval to get the access we needed, but we did take the time to meet with them on multiple occasions because you can never move forward without good IT support.

This became extremely important when we met with certain departments that didn't have proper access to the mainframe system. For instance, one department was still using an old CRT system that was 15 years old, and the current IT system had problems converting newer charges that had been put into that system into proper charges that could go onto hospital bills. In another instance, it was discovered that half of their offsite clinic computers weren't connected to the main computer system, which meant that revenue and charges were being underreported. These issues were rectified and helped increase revenue.

Then it was time to meet more intimately with the billing department. This particular facility broke out the teams by insurance type, but not necessarily by inpatient versus outpatient. Of all things, the Medicare billers consisted of only two people, which meant their workload was overwhelming. This included many surgical denials, and it turned out that because the workload was overwhelming they never had time to look at the denial reasons to find out why the claims were being rejected. We looked at the reasons and realized that many procedures being billed to Medicare required specific supply HCPCS codes to be showing on the claim, and no one had ever been trained to add those supply codes.

We learned after one of our meetings with the Medicare billers that the hospital did not have a written markup policy for supply items, which were causing many claims to be billed and paid on an outlier basis, which was improper because some of the higher priced supply items were overpriced. This began a long process of both increasing and decreasing some supply charges, as well as creating a markup policy for the supply area. While we were at it we created a markup policy for any new procedure charges as well, which was approved by the vice president of finance.

During our meetings with the Medicaid department, we learned that whenever they got a denial from the surgical department they were changing the revenue codes from 360 to 490, even though they didn't have an offsite OR facility, just to get claims paid. This was gross negligence and fraud and we had them put a stop to it immediately. The issue was investigated with Medicaid, which had mentioned that they knew the problem existed on their website and already had instructions for hospitals that were having those types of claims denied, and that

process was immediately implemented. Because Medicaid reimbursed higher for 360 than 490, with approval we had the Medicaid department go back and readjust all surgical claims for the past year, which ended up increasing reimbursement by 20%.

The day we arrived at this hospital, they were generating $1.9 million a day in revenue. Exactly one year later, three days before our engagement ended, the hospital was generating $3.9 million a day in revenue, which meant that through our efforts the hospital's revenue went up $730 million in one calendar year. As a side benefit, cash collections for the hospital went up 61% for the year, some of which was the direct result of our efforts, some of it the direct effort of other consultants that help work on the billing and collection side of things.

Of course this was an extraordinary situation, yet it's one we've walked into on a couple other occasions. With every hospital we've worked with, revenue has gone up and cash has increased as well. Every hospital won't have the opportunity to increase its yearly revenue by $730 million, which is a good thing, but it can only help to have an independent review of your processes if you don't already have someone in that position full time with the proper knowledge and skill to affect positive changes.