Understanding the Revenue Cycle: Coordinated Billing Process Key to Radiology Success

By Elizabeth DeBlock, MPA

The compartmentalized nature of most hospital organizations has long thwarted integrated financial management in the radiology department. A lack of coordination between radiology, physicians, the patient financial services department, and the managed care contracting department frequently results in substandard financial performance and an inordinate number of denials and write-offs.

Fortunately, a growing number of institutions have recognized the value of adopting a more cohesive, integrated approach to radiology revenue capture and management. By viewing the components of revenue production not in isolation but as part of a dynamic, continuous cycle, providers are improving customer service, reducing denials, and boosting bottom line results.

As the transition toward a more comprehensive revenue cycle model gains momentum, administrators can benefit by developing a clearer understanding of the various elements that make up the revenue cycle process. Armed with knowledge about how these parts interact, they will be in a position to more quickly identify problems and assist the appropriate individual or department in developing workable, long term solutions.

Instead of laboring at cross purposes and creating additional workloads for others, hospital managers can pull together to generate financial results that both the imaging services and finance departments can be proud of.

Data Integrity

The revenue cycle involves patients, providers, and payors and consists of the process required to schedule a medical

EXECUTIVE SUMMARY

- An integrated approach across all involved departments is the key to revenue cycle success.
- Accurate, complete, and timely data drives the revenue cycle.
- Up-to-date and accurate coding and charge capture will help ensure that the institution is reimbursed correctly.

The credit earned from the Quick Credit™ test accompanying this article may be applied to the AHRA certified radiology administrator (CRA) fiscal management domain.
The primary objective of revenue cycle management is to ensure full and appropriate reimbursement by improving the accuracy and integrity of the data used to determine how and when a claim will be paid.

Service and provide that service and then bill and receive payment for same. At each step, inaccurate or incomplete information can infect the revenue cycle and lead to less than optimal reimbursement or no payment at all. Radiology departments are particularly vulnerable to revenue loss, given the high volume and increasingly low reimbursement nature of the business. Lower reimbursements per procedure means departments must operate with maximum efficiency to increase margins. At the same time, the greater volume creates more opportunities for erroneous data to enter the system. Investment in robust financial information systems capable of interfacing with institutional clinical systems should be a priority since they will help ensure the transfer of accurate demographic information.

Therefore, the primary objective of revenue cycle management is to ensure full and appropriate reimbursement by improving the accuracy and integrity of the data used to determine how and when a claim will be paid. Practically speaking, optimal revenue cycle management puts the department in control of its data and allows personnel to:

- Easily identify and access information on patient and guarantor
- Track, document, and report services provided to the patient
- Code for services completely and accurately
- Receive appropriate payment for the patient stay or encounter
- Quickly and effectively challenge and resolve underpayments and denials

**Patient Access**

The starting point in the revenue cycle is patient access. Because the collection of key demographic patient information—including name, Social Security number, and insurance coverage—serves as the foundation for payment of services, it is critical that this information be accurate. Radiology departments typically depend on the hospital’s centralized registration or pre-registration systems and consequently have little or no control over the veracity of the demographic data.

Problems with hospital registration systems can be compounded if pre-registration and hospital admission systems do not talk to each other, or if separate hospital locations use incompatible registration software. The resulting duplication in collecting patient data can lead to customer dissatisfaction and frustration. This kind of redundancy is also extremely inefficient and undermines department workflow. If radiology departments find themselves on the receiving end of this unhappiness, they should alert hospital registration personnel and push for a unified scheduling and registration solution. Similarly, if demographic information provided by the hospital is chronically inaccurate, the radiology administrator should document the problem and bring the matter to the attention of the admissions department. Periodic audits of the patient access department are useful for determining where, when, and how erroneous information is entering the system, and regular training aimed at improving the skills of registrars should be a hospital priority.

Radiology managers can help by offering to assist in educating the registrars. Administrators should reinforce the importance of the registrar’s role in the provision of patient care and provide examples of how inaccurate information can impact not only reimbursement but also the quality of care.

**ABNs**

A problem that can have major financial repercussions and occurs frequently during the patient access process is the failure to obtain signed Advanced Beneficiary Notices (ABNs). ABNs are documents required by the Centers for Medicare and Medicaid (CMS) to inform patients that a particular procedure or service may not be covered by Medicare. If the patient decides to proceed with the service, the patient is financially liable for the cost of that service. In instances where a physician orders a service or exam that Medicare does not consider to be medically necessary, it is the hospital’s responsibility to provide the ABN to the patient and to obtain a signed copy. ABN information should be communicated to the patient during appointment confirmation or prior to the patient’s arrival. Educating the patient about the payment options typically leads to a better collection success rate. Conversely, failure to obtain a signed ABN will prevent the hospital from collecting on the balance due from the patient.

There are a variety of reasons why hospitals do not obtain ABNs prior to service being rendered. Some worry about negative public perceptions that could result from presenting patients with what effectively amounts to a bill before service is provided. The probability of a negative patient response is increased if the physician has not warned the patient that Medicare may not pay. In other instances, the ordering physician may not provide the proper diagnosis codes required to alert the department that an ABN will be necessary. Regardless of the reason, failure to systematically obtain ABNs can lead to major financial write-offs for the hospital.

To alleviate the problem, radiology departments should develop a current list of exams that require an ABN and make sure the radiology registration staff has access to the list.
If incorrect or incomplete diagnosis codes provided by a physician repeatedly result in the necessity of providing patients with ABNs, the radiology administrator should either take the matter up with the physician directly to make certain the doctor is providing the proper diagnosis codes or bring the problem to the attention of the hospital’s medical director.

Cooperation and education are the keys to making this process as painless as possible for both the patient and referring physician. Positive and frequent communication with physicians and their staff will assist the hospital in obtaining a correct diagnosis (if, in fact, there is a medically necessary diagnosis that fits CMS guidelines) and communicating ABN requirements. This communication will reduce the likelihood of a patient being surprised when presented with an ABN in the radiology department. The radiology administrator should also offer to provide physician offices with a list of frequently asked questions (FAQs) that explains Medicare’s position on excluded procedures to patients. The list will help reinforce the idea that ABNs are not an institutional policy, but simply reflect the requirements of the Medicare program.

**Patient Copays**

Another area that can produce serious leakage in the revenue cycle is patient copays. Policies regarding copays vary among provider organizations. Some hospitals collect copays at the time of service. Others wait until the claim has been filed before billing the patient. Each approach has its benefits. Collecting at the time of service increases the likelihood that the patient will pay, as well as accelerates cash flow. The downside is that a cashier and mechanism for paying with credit or debit cards is required in the radiology department or in the patient access department.

Conversely, although billing after the fact can be more convenient for both the hospital and patient, it frequently becomes more difficult to collect payment as time passes and bad debt can consequently rise. If a hospital bills for the copay after the claim is filed, a radiologist administrator may want to seek information from the finance department about the collection rate of radiology copays. If the amount of bad debt is significant or rising, it may make financial sense to shift to an up front payment policy, even when the additional cost of a cashier is accounted for. Regardless of whether payment is made before or after the service, it is important that a consistent and rigorous copay policy be adopted and detailed records kept regarding slow payments and bad debt.

**Pre-authorization**

As is the case with ABNs, failure to obtain insurance pre-authorization letters can result in expensive financial hits to the hospital and radiology department. The problem can result from a disconnect between the referring physician, the managed care contracting department, and the radiology department. Because responsibility for obtaining pre-authorization for a particular exam lies with the referring physician, radiology department staff should ask patients at the time of scheduling whether they were given a pre-authorization letter or number by their doctor. If the answer is “no” or “I don’t know,” the radiology scheduler should instruct the patient to contact their physician and reschedule the exam after they’ve secured pre-authorization. Care should also be taken to ensure that the pre-authorizations contain the exact exam, date of service, and provider. However, obtaining pre-authorization does not guarantee payment from the insurance provider.

Obtaining an up-to-date list of the carriers and specific procedures that require pre-authorization from the hospital’s managed care director or department is another way radiology administrators can limit the likelihood of pre-authorization denials. All administrative staff should be required to check during each step of the scheduling and registration process to determine if specific exams require pre-authorization.

**Managed Care Contracts**

Maintaining solid communication with the hospital’s managed care department can be beneficial in a number of ways. For example, the managed care department can help ensure, through regular audits or contract management software, that carriers are reimbursing for services at the contractually agreed upon rates. It is not unheard of for reimbursements that are below the contracted amount to remain undetected for months or even years due to a lack of communication between managed care administrators and the hospital department.

Separately, the radiology administrator should keep managed care negotiators informed about emerging technologies or procedures that are in use or under consideration by radiologists. This will help ensure that the new procedure or technology is included for reimbursement when existing contracts are renegotiated or new ones developed. Administrators should also work closely with negotiators to establish equitable carve out rates for high cost procedures. The managed care staff should not be expected to understand the costs associated with interventional radiology procedures or PET scans. Most commercial payors are open to renegotiating to include new technologies in existing contracts, since many newer imaging procedures (although not inexpensive) are replacing much more costly and invasive surgeries and procedures.

**Charge Description Master**

The Charge Description Master (CDM), or chargemaster, is a comprehensive listing of items and services that can be billed to a patient, payor, or healthcare provider. Because the CDM contains the procedure, CPT, and revenue codes that dictate how much the hospital will be paid for its services, it is the backbone of the reimbursement process. Consequently, it is critical that chargemaster pricing and coding information be kept current and up-to-date.
Making sure that all radiology services produce payable claims is the central objective of revenue cycle management. A reconciliation of procedures-to-charges is one of the best ways to confirm that an accurate number of claims have been generated.

Responsibility for maintaining the chargemaster can vary among hospital organizations. Frequently, it is the duty of individual departments to update their section of the chargemaster with the appropriate payor codes. Because CMS makes modifications in Medicare coding on a quarterly basis, it is vital that the new codes be entered into the system and old ones disabled as soon as the information becomes available. Failure to do so can result in both lost revenue and compliance difficulties.

It is important to remember that CMS no longer offers the 90 day grace period that previously allowed institutions to use old or deleted CPT codes for the first quarter of each fiscal year. If possible, arrange to meet with the department or individual responsible for CDM updating in mid-December of each year so that all parties are aware of the changes that must be implemented by January 1.

Even when responsibility for updating the chargemaster falls to the finance department or some other hospital entity, the radiology administrator should double check to make sure that the appropriate, radiology related information is accurate and up-to-date. Additionally, it is important the CDM be updated as new procedures are performed in the department or outdated procedures discontinued.

Interfaces between the hospital’s information system (HIS) and the radiology information system (RIS) should be checked on a quarterly basis. If the table for the CDM resides in the RIS, testing should take place so as to make certain the correct codes are crossing over to the HIS.

Another important step is to review the procedure descriptions in the CDM to make sure the same descriptions come up on the ordering screens of both the RIS and HIS. The descriptions should be easily understood by the registrars and the inpatient clerical staff to ensure that the correct orders are received by the department. For example, the difference between an MR scan of the chest and a CT of the chest should be clear to anyone with responsibility for entering orders into either system.

The bottom line: Maintaining an accurate and up-to-date CDM will help to ensure the accuracy of your claims.

Accurate and Timely Charge Capture

Making sure that all radiology services produce payable claims is the central objective of revenue cycle management. A reconciliation of procedures-to-charges is one of the best ways to confirm that an accurate number of claims have been generated. The process should be conducted frequently, preferably once a week. Reconciliation will help identify whether procedures are being dropped. It may also reveal instances or patterns in which charges are not entered in a timely fashion. Causes of dropped and late claims vary. The radiographer may have been distracted or the data entry clerk overwhelmed. Frequently, referring physicians fail to provide accurate diagnosis codes or do not send them in a timely manner. Regardless of the reason for the omission or delay, administrators must isolate the problem and work with the responsible party to minimize the likelihood of it happening again.

Because coders may need to review the entire dictated report to identify the elements required for accurate procedure and diagnosis coding, radiology administrators should work with physicians to develop a fast and reliable system for conveying dictated notes. Radiologists should also be educated about the importance of signing their reports on a timely basis. Unsigned reports can have a dramatic impact on the revenue cycle and cause a ripple effect involving patient and physician satisfaction, as well. A report signing policy should be developed for radiologist vacation coverage that clearly defines who is responsible for signing reports dictated by a radiologist on their final day of work before vacation.

On a separate track, regularly scheduled referring physician in-services focusing on appropriate diagnosis codes can produce major improvements across the system.

Length of Stay

It is important to understand that the radiology department can have a significant impact on the inpatient revenue cycle as it relates to length of stay (LOS). In fact, if a representative of the radiology department is not currently on a committee devoted to shortening LOS, that will probably change soon. Any delay in testing that keeps a patient in the hospital for additional days must be avoided. Open slots for patients who are awaiting discharge should be built into the daily schedule of all modalities so that testing can be completed on a timely basis. In addition, the cost of providing weekend service must be weighed against the loss of income for denied days. In many cases, the insurer may not reimburse the hospital for weekend days if the patient’s discharge depends on test results and a test ordered late Friday is not completed until Monday.

Administrators should regularly communicate to staff and physicians about the importance of timely completion of tests and results reporting and the impact delays can have on LOS.
Interventional Coding

Because of the component nature of interventional radiology coding, the modality presents radiology administrators with significant challenges in making sure that coding is accurate, compliant, and complete. Most radiology codes are so-called hard coded into the CDM. This means that the CPT codes are listed in the CDM along with the description of the procedure and the code that identifies that charge. When the charge is “picked” to be submitted on the UB, the correct CPT code is automatically assigned to the charge. However, interventional radiology coding is a labor intensive process that typically requires skilled, “hands on” coders capable of interpreting medical records and understanding the nuances of the specialty. Although many smaller hospitals outsource their interventional radiology procedures, the specialty can represent a significant book of business for tertiary and academic medical centers. Radiology administrators in larger institutions, therefore, will benefit by working to attract and retain qualified interventional coders.

Because of the complexity of the coding and the relatively high level of reimbursement typically seen with interventional radiology, ensuring efficiency and accuracy across this modality is critical. Consideration should be given to adding the surgical codes to the CDM, so that the coding associated with each procedure is automatically dropped to a patient’s bill.

As in all areas of revenue cycle management, education remains the key to accurate interventional radiology coding. When providing educational sessions, it is productive to have all of the staff that “touches” the interventional coding process—physicians, residents, nurses, radiographers, and information management (medical records)—present so that everyone hears the same information at the same time.

Charge Capture Audit

The charge capture audit can be a useful safeguard for periodically assessing the department’s efficacy in producing appropriate claims for radiology services. The process is typically executed once per quarter and is designed to review, in detail, the progression of procedures across all modalities from chart to billing. Generally, a sampling of between 5–10% of charges across each modality are assessed on a quarterly basis. The audit involves physically comparing the initial order, the final report, and the UB-92 (or the hospital’s concurrent UB-92s) with the detailed internal bill produced by the billing application. It is important to confirm that what was ordered was actually performed and that the charges dropped initially in the detailed bill are correct and moved to the final UB.

It is not uncommon for charges to be deleted by the hospital billing application during the “scrubbing” process. Scrubbing is an automated or manual analysis of the detailed bill designed to identify or correct procedural or coding errors prior to conversion to a UB-92. It is therefore important to make sure that the “scrubber” has the correct coding initiative (CCI) edits and that nothing is being deleted incorrectly. During this process, the CDM can be indirectly checked by determining whether the correct CPT and revenue codes are also on the final UB.

Compliance Audit

Another important audit that radiology administrators should regularly conduct involves comparing the CPT codes the physicians are billing for their professional services with what the hospital is billing for its global services on the same procedure or exam. This can be accomplished by evaluating a sampling of 1500 forms (the document used by physicians to bill for their charges) against the hospital’s concurrent UB-92s. Because the Department of Health and Human Services Office of Inspector General has indicated that they intend to more closely scrutinize consistency between hospital and physician charges, radiology administrators should make conducting these audits a priority to avoid compliance problems and potential sanctions. Additionally, the process should provide useful information about coding compliance.

Denial Management

Reducing the possibility of claim rejections and denials by addressing root problems like inaccurate demographic data, ABN and pre-certification deficiencies, and improper diagnostic coding ahead of time—this is the best strategy for successfully managing the radiology revenue cycle. It is nonetheless important to develop a comprehensive back-end system that can identify and resolve denials that do occur. This process is not only valuable for revenue recovery, but will also highlight the existing vulnerabilities that allowed the denials to occur in the first place.

Although denial management is typically handled through the billing department, it is important to remember that denial management is everyone’s responsibility. Thus, open communication between the billing department and radiology staff is necessary to ensure that problems are resolved quickly and efficiently. Administrators should instruct staff to be responsive to inquiries about claims and prioritize requests for information from the billing department.

Some of the most frequent causes of denials are bad demographic information and lack of medical necessity. Another common issue is coding bundling edits. To better understand why denials are occurring, radiology administrators should assess denials by type and then look for underlying causes in each category. For example, are most medical necessity denials the result of inaccurate diagnostic information provided by the referring physician? If so, is there a particular physician that is responsible for a disproportionate share of denials?

Payors typically utilize standardized rejection codes to identify the reasons for the denials. This makes tracking and measuring both the type and quantity of denials a relatively simple process.
When it comes to resolving the underlying problems that lead to denials, administrators should initially concentrate on those denials that are costing the department the most money. High charge, high volume procedures that are being denied must be the first priority when it comes to denial management.

The Sum of the Parts

In today’s unforgiving healthcare climate, hospitals can no longer afford to take a compartmentalized approach to departmental financial management. Gone are the days when denials or bad debt were someone else’s problem. Instead, hospital personnel must strive to integrate key systems and procedures in order to ensure full and appropriate payment for services rendered. By viewing the radiology payment process as a series of interconnected, mutually dependent steps, radiology administrators will be in a position to quickly identify and resolve vulnerabilities.

Along with improving financial results, fully understanding the revenue cycle will also enhance customer service by allowing the organization to more quickly address patient questions or concerns. And just as important, the radiology administrator will benefit from the confidence and satisfaction that comes with leading a complex organization that is performing at an optimal level.

Resources for Key Performance Indicators

- HFMA Resource Library
- Revenue Cycle Improvement (includes sample indicators and improvement strategies) (www.hfma.org/library/revenue)
- Hospital Accounts Receivable Analysis
- Aspen Publishers (www.aspenpublishers.com)
- AHA Hospital Statistics
- American Hospital Association
- Health Forum (www.healthforum.com)
- Almanac of Hospital Financial and Operating Indicators
- Ingenix (www.ingenixonline.com)

Elizabeth DeBlock, a member of AHRA, has over 25 years of experience in radiology. After a career in acute care, beginning as a staff radiographer in 1976 and culminating in a position as Vice President of Clinical Services at Saint Barnabas Medical Center, Livingston, NJ, Ms. DeBlock now works as an Operations Manager with Medical Management Professionals, Inc. MMP provides billing, coding, and collection services as well as full practice management services to hospital based physicians, including radiologists. She may be contacted at edeblock@cbizmmp.com
AHRA Home-Study Resources

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Questions

Instructions: Choose the answer that is most correct.

1. Substandard financial performance in the radiology department may be caused by lack of coordination between and/or among:
   a. The patient financial services department
   b. The managed care contracting department
   c. The patient’s physicians
   d. All of the above

2. Advantages of using a comprehensive revenue cycle model include:
   a. Reducing denials
   b. Improving customer service
   c. Boosting bottom line results
   d. All of the above

3. Who are the primary participants involved in the revenue cycle?
   a. Radiology managers, hospital administrators, and vendors
   b. Technologists, physicians, and administrators
   c. Patients, providers, and payors
   d. None of the above

4. Why are radiology departments particularly vulnerable to revenue loss?
   a. High volume
   b. Low reimbursement
   c. Poor management
   d. Both a and b

5. Robust financial information systems capable of interfacing with institutional clinical systems help ensure the transfer of:
   a. Acceptable diagnostic images
   b. Accurate demographic information
   c. Appropriate financial records
   d. Multiple modality studies

6. Optimal revenue cycle management allows personnel to:
   a. Code for services completely and accurately
   b. Receive appropriate payment for the patient stay
   c. Track, document, and report services provided to the patient
   d. All of the above

7. Which of the following are useful for determining where, when, and how erroneous information is entering the system?
   a. Periodic audits of the patient access department
   b. Regular training of hospital registrars
   c. Both a and b
   d. None of the above
8. Name the document required by the CMS to inform patients that a particular procedure or service may not be covered by Medicare.
   a. Advanced Beneficiary Notice
   b. Altered Benefits Notation
   c. Authorized Billing News
   d. None of the above

9. What are some of the reasons why a hospital might not obtain ABNs prior to service being rendered?
   a. May result in a negative public perception
   b. May result in a negative patient response
   c. Both a and b
   d. None of the above

10. If a hospital fails to systematically obtain ABNs, what is the primary result?
    a. Major financial write-offs for the hospital
    b. CMS review of the radiology department
    c. Loss of accreditation
    d. None of the above

11. To increase the likelihood of collecting the patient copay and to accelerate cash flow, it may be wise to:
    a. Refuse credit cards for copay
    b. Collect the copay at the time of service
    c. Bill the patient for the copay within 90 days
    d. Bill for the copay after the claim is filed

12. Who is responsible for obtaining insurance pre-authorization letters?
    a. The patient
    b. The referring physician
    c. The radiology manager
    d. The hospital registrar

13. Who can help ensure that carriers are reimbursing for services at the contractually agreed upon rates?
    a. The radiology department
    b. The hospital’s managed care department
    c. The hospital administrator
    d. The referring physician

14. What is the document that lists the items and services that can be billed to a patient, payor, or healthcare provider?
    a. The Charge Description Master
    b. The Claims Discussion Master
    c. The Corporation Digest Master
    d. None of the above

15. How often does the CMS make modifications in Medicare coding?
    a. Annually
    b. Quarterly
    c. Monthly
    d. Daily

16. What is the best way to confirm that an accurate number of claims have been generated?
    a. An up-to-date financial report
    b. A monthly financial record of examinations performed
    c. A reconciliation of procedures-to-charges
    d. None of the above

17. How can the radiology department help to shorten the patient’s length of stay?
    a. Build open slots into the daily schedule of all modalities for patients who are awaiting discharge
    b. Provide outpatient services for patients who are awaiting discharge
    c. Schedule all in-patients during morning hours only
    d. None of the above

18. What is the purpose of a charge capture audit?
    a. To review the progression of procedures across all modalities from chart to billing
    b. To provide a manual analysis of the detailed bill
    c. To determine if the correct CPT code has been applied
    d. None of the above

19. A compliance audit compares the CPT code the physician is billing for his/her professional services with:
    a. The CPT code the radiology administrator has applied to the procedure
    b. The CPT code the hospital is billing for its global services on the same procedure
    c. The CPT code required by the CMS
    d. None of the above

20. Issues related to claim rejections and denials include:
    a. Bad demographic information
    b. Lack of medical necessity
    c. Coding bundling edits
    d. All of the above
ANSWER SHEET

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