Revenue Cycle Training Handbook

Sharing the responsibility for financial success

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Introduction

The term "revenue cycle" has become a focus area for many organizations in their efforts to maintain financially solvent businesses. Hospital management teams are constantly hearing about the importance of the revenue cycle from external consulting firms that claim they can help improve it. Some facilities are even creating positions, such as director of revenue-cycle operations, and forming revenue-cycle management teams.

In the fast-paced world of healthcare, it can be difficult to explain exactly what the revenue cycle is and what impact each department has on this complex puzzle. The revenue cycle presents a significant challenge because if it isn't running efficiently, it can significantly alter a hospital's bottom line and its ability to secure financing for projects such as new building construction, service expansion, and technology improvements.

This handbook provides a quick, easy-to-understand overview of the revenue cycle for the departments and teams that contribute to the overall financial health of the institution. Keep in mind that each staff member has a direct impact on the whole.

Definition of the revenue cycle

Revenue is defined as financial income, and the cycle is the regularly repeating set of events that produces it. In a healthcare facility, all administrative and clinical functions that contribute to the capture, presentation, and collection of patient-service expenses comprise the revenue cycle. In other words, the minute a patient presents or is scheduled at a healthcare facility, the cycle begins. All events that take place from the time a patient enters the facility to the time the facility receives payment for the services rendered contribute to the revenue cycle.

Players in the revenue cycle

The departments that play major roles in the revenue cycle typically include the following:

- Admissions/access management
- Case management
- Charge capture
- Health information management (HIM)/medical records
- Unbilled management
- Business office/patient financial services
- Finance

- Compliance
- Information technology

Each player's role in the revenue cycle

Each player in the revenue cycle must ensure the cycle is efficient. If one part of the cycle runs poorly or without collaboration, the facility's revenue flow can suffer; the players should understand others' roles in addition to their own. The following is a brief description of each department's typical duties within the revenue cycle. Note that these duties vary by institution, depending on facility size and demographics. For example, in larger healthcare organizations, each function many be assigned to a different department. In smaller organizations, one department may perform several functions.

Admissions/access management

The access department collects fundamental patient-demographic information—a process also called registration and admitting. These data routinely consist of patient-identification elements, payment/guarantor data, service and provider assignments, and facility-specific data and protocols. Although this collection may seem easy, it can be complicated by factors such as unavailable information, confusion from the source of the information, and the necessity of rapid turnaround because of medical need. Demographic data collection can be further complicated by the centralization or decentralization of the process. Some facilities allocate the registration function to individuals as a primary duty, while others designate it as an added responsibility. Training and

consistency are often difficult in access management because of the sheer volume of personnel involved in the process. As difficult as it may be, however, data collection is critical to the overall outcome of receiving payment.

In addition to collecting basic and detailed demographic data, the following functions may be required of the access-management department:

Verification of eligibility—Insurance eligibility verification is typically completed during the collection of insurance information. It may not be a real-time process (i.e., performed as the patient is being registered for service), but the accuracy of the data collected is crucial. Also, a follow-up process to ensure that the facility will receive payment for services is necessary. Most facilities have electronic connections to high-usage carriers, such as state Medicaid programs, to ensure that a patient currently has coverage. Eligibility verification can be critical when providing routine or annual scheduled care as it relates to insurance payments v. employee self-pay requirements.

Precertification—Insurance carriers often require precertification of elective or nonemergent services before a patient receives care. For example, if a patient is coming in for surgery, the insurance company will require certain clinical information to justify the services. Once the facility has provided the necessary information and the carrier has verified the necessity of the service through established clinical guidelines, a precertification number is

issued. The capture and transmission of this number with the billing statement can be crucial to expediting payment. Further, retrospective certification is time consuming and can result in nonpayment. If a patient begins in the emergency room, the certification process tends to be completed through case management functions. Workers' compensation reporting and authorization may also be completed at the point of access.

Registration—In this context, registration refers to the act of selecting the type or class of account under which a patient is receiving care. The type or class is key to later decisions in the care process. For example, common patient types include inpatient and outpatient, with many subsets below the outpatient classification, such as observation, ambulatory or same-day surgery, and emergency room. This classification determines the schedule under which a facility will receive payment. Additionally, this classification determines what type of diagnostic and procedural codes need to be assigned. Registration also refers to the selection of service type; services are often linked with particular departments within a facility. The service type is key to cost report improvement and profitability analysis in the finance area.

Scheduling/bed assignment—Assigning a procedure in a certain room or unit allows a facility to maximize the quantity of services provided. For example, scheduling surgeries in a suite of rooms to ensure a certain volume maximizes a surgeon's time and other available resources, such as nursing support. The old economic principle of supply and demand is essential in assessing the success of a facility's scheduling and bed-assignment practices.

Collection of insurance information—As the volume of uninsured patients grows, the challenge of collecting insurance information increases. There are frequently several insurance carriers with similar names, different addresses, and different clinical-authorization requirements. If payment information is inaccurate, the correction and rework after the fact affects all players in the revenue cycle. Identifying a covered party by its identification number can be challenging as well. For example, under Medicare, widows sometimes use their deceased spouses' identification numbers (i.e., Social Security number) rather than their own.

Entering the correct insurance and carrier information at the point of access is important to all departments in a facility. Many carriers accept electronic transmissions of data for processing payments because it expedites payments to hospitals. However, the selection of the wrong carrier at the time of registration can bring this process to a halt.

Collection of admission diagnosis and orders—The access department collects crucial front-end clinical information, such as a reason for admission diagnosis. It may be recorded in a narrative form to be coded later. For the majority of outpatient services, such as laboratory tests and x-rays, a physician must provide the patient with an order for service. This order should be signed by the physician and presented at registration. The physician should have documented on the order the type of test to be run and a diagnosis or reason for the test. Linking an appropriate test to the

provided diagnosis can sometimes cause denials if the facility fails to prove the procedure was medically appropriate in the first place.

Issuance of advance beneficiary notices (ABN)—Closely linked to the diagnosis and test appropriateness is the need to issue ABNs. ABNs are required any time a patient registers for an outpatient service and the diagnosis does not match the requested test. They inform patients that the test is a noncovered service based on the clinical information, and that they may need to pay for the service directly out of pocket. Issuing ABNs is a regulatory requirement for all governmental programs such as Medicare and Medicaid.

Consents/notices—In addition to ABNs, access departments provide patients with common treatment consent(s). By signing the consent, the patient agrees to receive treatment, accept financial responsibility regardless of insurance processes, and release his or her clinical information for the purposes of payment. Some facilities include additional items in their consents. For example, a teaching hospital may use a general consent to notify patients about the use and participation of students in their care. More recently, a privacy notice has also been included in the documents required at the time of registration.

Collection of copays—Most insurance plans require a copay for medical services, such as $15 for an office visit. Depending on the facility, some access departments collect copays at the point of registration rather than issuing a statement or bill and collecting payment later. Doing so can expedite cash flow into a facility.

Case management/utilization review

Case management/utilization review directs the care services patients receive during more acute-level encounters (i.e., as inpatients). Evaluating the necessity, appropriateness, and efficiency of medical services and facilities is essential to receiving fair payment for service rendered. This department generally comprises nurses who are assessing the acuity of patients' conditions (i.e., how sick they are) based on clinical information such as lab tests, vitals, and physician documentation.

Documentation review—During patients' treatment in the hospital, nurses or case/care managers review clinical documentation about patients and their conditions that is contained in charts or on computer systems. Using the available information, they communicate with the patients' insurance companies regarding the length of stay, resource consumption, next steps for treatment, and referrals.

Provider interaction and education—In addition to reviewing existing documentation, care/case managers review charts and advise physicians on what documentation will help determine the appropriate level of reimbursement the organization should receive. Interaction and education can be directed by the facility or be part of a tool kit or system purchased from a consulting group. Documentation awareness can greatly improve coding.

Patient type/class changes—A patient receiving treatment will occasionally need a different level of care than originally anticipated or ordered. When this situation occurs, initiate a review

and new authorization process. The timeliness of this process and the supporting acuity documentation are key to a facility's success in receiving appropriate payment for the services rendered. Postdischarge or postbilling patient type changes can be a significant compliance risk and result in payment denials, underpayments, and reimbursement paybacks.

Concurrent diagnosis-related group (DRG) assignment/review—There is an everpresent need for facilities to evaluate the medical necessity of a patient's admission. Assigning a DRG is an important step in this evaluation. The DRG determines the amount of reimbursement a facility will receive for the services provided. Through this review, a hospital can compare the cost of the services provided with the amount of reimbursement. If the cost doesn't reasonably balance the reimbursement, it should be examined further.

Charge capture

Charge capture has a significant impact on a facility's revenue. Each department in the hospital that provides goods and services needs to properly document and record its charges. A charge-capture and compliance department must be aware of the following to ensure that a facility receives all the revenue it deserves:

Verification of correct patient—All charges must be applied to the correct patient account to avoid nonpayment from an insurance carrier, which could result in an additional expense to the facility from an insurance defense audit.

Verification of key service elements—Correct patient account number, service date, and bill type should be verified prior the charge-entry process. The service date must reflect the admission dates and the charges incurred, and the bill type on the claim form must reflect the type of service the patient received (e.g., OP—outpatient; IP—inpatient; OBS—observation patient).

Selection of date of service—Many patients have more than one admission date. During the charge-entry process, the staff responsible for charging must correctly identify and record the charges for each patient service date. Hospital staff must identify the correct date of service for the charges they enter. Charges placed on the wrong account could lead to incorrect billing and lost revenue.

Clinical documentation—Clinical documentation is a critical part of charge capture. If a supply, room accommodation, or service is not property documented by the staff providing the care, the hospital will not be able to collect payment for services rendered. If a charge on a patient account carries no corresponding clinical documentation in the medical record, the charge must be credited to the patient account; therefore, the charge becomes an overcharge. If a charge is not documented, the service was not given.

Linking to order entry—Physician orders are linked by the order-entry system to some departments within a facility (e.g., laboratory, radiology, etc.). These orders trigger an automatic charge to the patient account. If the physician's orders call for a certain item to be given each day, the charge will automatically be charged to the patient account through the order-entry link.

When a patient is discharged, charging staff must match the order-entry charge with the clinical documentation in the medical record to ensure the charge matches the documentation. If there is an order-entry charge on an account without supporting clinical documentation, the charge must be credited to the patient account.

Undercharges, overcharges, and late charges—Undercharges are for goods and services provided to a patient and not charged to the patient account. An overcharge could result when there are two charges to the patient account and only one item was documented in the medical record. This would be a duplicate charge. Most hospitals have a hold period after the discharge or service date during which staff enter all charges. If staff are not timely with submitting charges, a late charge will be added to the account and the patient-accounting staff must take action. Depending on the contract or rules governing the insurance company, the charge must either be submitted late (which causes delay in payment to the hospital) or written off, because no late charge can be submitted to the payer.

Data dictionary (charge description master)—The charge-description master, frequently referred to as the chargemaster or CDM, serves as a price list for the hospital. It contains descriptions of the goods and services, prices, and any special codes that are required for billing.

Audit process—Audit staff review the patient medical record and the itemized billing. They compare the documentation contained

in the medical record with the charges that have been applied to the account. Auditing the bill in this way allows the hospital to identify and correct systems and processes that prevent correct billing.

HIM/medical-records department

Processing-cycle order and reconciliation—The health information management (HIM)/medical-records department picks up all discharged records for inpatient, day-surgery, and emergency-department patients. It reconciles these records with the patient census to ensure that documentation or a record is received for each patient discharged that day. The HIM/medical-records department frequently enters records into tracking software so they can be located quickly. Doing so also ensures documentation and a history of a patient's care at the hospital.

Documentation timeliness—The HIM/medical-records department also reviews the record at the time of discharge to ensure that all necessary documentation requirements are met. For example, this department must ensure that an operative report is dictated for each procedure. Complete and timely documentation is as essential for accurate and compliant coding as it is for patient care.

Coding—Medical-record documentation is reviewed for each patient encounter to identify appropriate diagnosis and procedure codes. These numerical codes are assigned based on the healthcare provider documentation in the record and they are used in several ways. The codes are used to convert documentation into a standard

format to bill and receive reimbursement. They are used as an easy way to pull data for research, accreditation, and credentialing. The data they express are also used to justify medical necessity and evaluate healthcare practices and trends.

Transferring narrative descriptions of diseases, injuries, and medical procedures into numeric designations is completed using several common classifications:

- **ICD-9-CM codes**—*International Classification and Diseases, 9th Revision.* A statistical coding system that reports, compiles, and compares healthcare data using numeric and alphanumeric codes to assist in the evaluation, planning, delivery, reimbursement, and quantifying of medical care.

- **CPT codes (LEVEL I)**—*Current procedural terminology.* A classification of medical codes, developed and maintained by the American Medical Association. This five-digit, numeric coding system is used to report medical services and procedures performed by or under the direction of physicians, and it is updated annually.

- **HCPCS codes (LEVEL II)**—*Healthcare Common Procedure Coding System.* A national coding system that contains alphanumeric codes for physician and nonphysician services not included in the CPT coding system. HCPCS Level II codes cover ambulance services, durable medical equipment, orthotic and prosthetic devices, and more. These codes are updated annually.

Physician query process—When reviewing a record, a coder may need to ask a question of a physician to determine the most appropriate code. A query process allows physicians to add or clarify documentation when the clinical information in the patient record is unclear or incomplete. Because unclear or incomplete documentation may directly affect coding quality, diagnosis-related group (DRG) assignment, or the patient's bill, the type and frequency of queries can be analyzed to target problematic conditions that require attention.

Coding accuracy audits—As mentioned, code assignments that use various schemes and classification systems are required to translate clinical documentation into a claim. Coding accuracy is crucial to reimbursement, and coding guidelines are published from various official sources including Medicare (program memorandums and local medical review policies), fiscal intermediaries, insurance carriers, and the American Hospital Association (Coding Clinic). Education about and adherence to everchanging standards can be difficult without periodic review from both internal experts and external third parties. Depending on the encounter volume at a given facility and the results of prior audits, an organization may coordinate monthly, quarterly, or annual audits.

Requests for records/documentation (release of information)—The HIM/medical-records department must ensure that requests from insurance carriers/payers for additional information to support claim payment are processed in a timely manner. Medicare has specific guidelines for the timeframe in which an additional development request is satisfied (CMS Progressive Action Plan guide-

lines—PM AB-00-72 and program integrity manual Chapter 3, Section 5.3.3.). Additional development requests involve an intermediary gathering information from a provider while the claim is still active. Regardless of who the payer is, delays in providing requested information can unnecessarily prolong the time before a facility receives payment for services rendered. Facilities also can identify proactively those payers or diagnosis/procedure groups that will require additional clinical information, such as an operative report, and send this information with the original claim to expedite payment.

Unbilled management

Return to provider/denial management—Denial management refers an organization's multidisciplinary approach to minimizing claim denials by maximizing prevention and optimizing responses to payment denials. The program includes

- tracking and trending denials
- analyzing and improving associated processes (e.g., centralizing, appealing, contracting)
- identifying best practices for recovering denied revenue
- ensuring accurate reimbursement in a timely manner
- developing effective denial-prevention strategies

Response to business office/patient financial services (PFS) requests—At times, communication must be routed from the business office or PFS to the appropriate hospital ancillary department for review and modification. For example, if a patient's type is listed as outpatient day surgery and the patient's actual length

of stay is five days, this account would need to be routed back to case management/utilization review. Such communications may be prompted by an edit or other review mechanism used by the hospital. The hospital's response should be swift to avoid any potential lost revenue. Reporting mechanisms should be created to store, track, and monitor these types of accounts.

Edit correction (Outpatient Code Editor (OCE) and groupers)—Logic within the standard claims-processing system selects certain claims, evaluates or compares information on these claims with other accessible sources, and, depending on the evaluation, takes action on the claims, such as "pay in full," "pay in part," or "suspend for manual review."

Policy development based on corporate guidance—An organization should create policies based on corporate goals that represent the mission, vision, and/or values of an organization.

Data presentation—Data presentation is essential to decision making. Data must be regularly collected and presented to decision-making groups to track status, both current and over a set period of time.

Data analysis—Analysis must be conducted to ensure that data are meaningful. If data are not concise and significant, problems (and therefore resolutions) cannot be effective.

Write-off preparation—Policies should be created for write-offs. Consider the following when developing write-off policies:

- Days postdischarge
- Dollar amount
- Previous activities conducted toward problem resolution

Thresholds should be set using analyzed data for these considerations. When the thresholds have been met, write-offs should occur.

Additional documentation requests—Additional documentation may be requested to modify an account's unbilled status. This additional documentation may be requested to modify coding or to accompany a bill for payment purposes at the request of the insurance carrier.

Discharged not final billed—This occurs when the patient has been discharged from the facility, but the bill has been held as a result of system flags or holds triggered by a lack of diagnosis/procedure coding, insurance verification, audits, etc.

Medical necessity—Medicare can deny payment for services that do not meet the requirements of local coverage determinations (LCD). Medicare LCDs outline Medicare-coverage requirements. Medicare defines medical necessity as "reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." *42 U.S.C section 1395y(a)(1)(A).*

Technical denials—The meaning of this term varies among claims and payers. A technical denial is received for claims missing beneficiary demographic information, eligibility information, or

unique physician identification numbers. Some services are not paid and are considered technical denials even though they are often reasonable and important healthcare services. In the Medical Policy Section, these denials are described as "noncovered." They are not included in the benefit package specified by the law.

Managed-care denials—A coverage denial can occur either before or after the services are provided. This denial can be based on patient eligibility, physician or hospital network participation, and medical necessity.

Patient financial services (PFS)/business office

PFS, sometimes called patient accounts or the business office, is responsible for the submission and collection of all patient bills in a timely and compliant manner. Using a combination of software and specialized knowledge, PFS is the watchdog for all revenue-cycle processes that occur in the hospital.

Bill-hold settings—The hospital-billing system holds bills that are not ready to be submitted to an insurance company due to missing or incorrect information. The problem must be resolved before the account can move to the editing step of the process.

Generation and resolution of edits (front end, prebilling, and postbilling)—Once charges have been accumulated on a bill, software programs review the claims for potential problems, a process known as "scrubbing". An experienced biller reviews them to determine what actions must be taken before the account is

sent to a third-party payer. Additionally, all Medicare accounts are reviewed for special circumstances. When a Medicare beneficiary has been hospitalized as an inpatient, all of the inpatient records are reviewed to determine whether the patient had any related diagnostic services within three days of the admission. Those services must be combined on one bill and sent to Medicare. All Medicare outpatient bills are reviewed to determine whether Medicare will cover the services rendered for the patient's diagnosis. If the bill does not meet Medicare guidelines and no advance notification was given to the patient, the bill must be written off.

Every payer has specific guidelines dictated by its contract with the hospital. Medicaid and Medicare have guidelines dictated by state and federal laws. Every bill must be reviewed to ensure that all service and billing guidelines are met before the bill is submitted.

Billing generation and submission—After a bill has been scrubbed for errors, edits, and compliance with contract terms and laws, it is either mailed to the insurance company or submitted electronically to the payer. The bill format for paper bills, called a UB-92, is a one-page, codified format for bill submission that contains all the information required by the payer to process the bill. Charges, diagnoses, procedures, and patient-identifying information are contained on the form in a coded format.

Bills that are submitted electronically must now conform to guidelines established in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These guidelines require that electronic data be submitted in a format similar to the UB-92

designed for electronic transmission, known as an 837 data set. This 837 data set ensures uniformity of electronically transmitted data. Electronic transmission of billing information greatly reduces the time and labor required to submit bills.

Denials/return to providers—A payer can return a bill to the hospital for more work, if necessary. In the case of Medicare, if the patient's name and Medicare number are not an exact match to the Medicare card, the claim will be returned to the hospital for correction. Insurance companies often deny claims or return claims for more information.

Whenever a bill is returned to a hospital, PFS staff must work to determine whether there was a billing error or whether the patient must now be held responsible for the bill. While correcting the bill, PFS staff accumulate information that can be shared with other departments to determine whether process improvements will reduce the number of denied bills.

Appeals—A denial may require an appeal to the payer to reconsider payment on the claim. Appeals must always be in writing and according to the format required by the payer. The type of denial may require a clinician to prepare an explanation of the medical course of treatment. Once a hospital receives a denial, the payer will consider the claim closed and take no further action unless it receives an appeal from the hospital.

Posting (remits, payments)—A hospital receives payment for its services in two ways: Checks are mailed to the hospital or payments

are electronically transmitted. Like billing, if the payment is in the form of a check, no universal format exists. Every insurance company has its own format for payments. If a payer submits payments electronically, it must send the electronic data in a uniform format called an 835 data set. Electronic payments reduce the time it takes to apply the payments to the correct account and increase accuracy. When the payment is received, it is reviewed to determine whether the payer processed payment for the correct amount. This postpayment audit function ensures that the hospital will receive the entire amount due for the services provided.

Collections—It is frequently necessary to follow up with a payer when payment hasn't been received in a reasonable amount of time. Collectors can use Web-based tools to check on the status of claims. They may also have to call the insurance company to determine why the claim has not been paid.

Self pay—Any medical care that must be paid directly by the patient falls under the category of self pay. Generally, this represents amounts not covered by the payer, such as coinsurance or deductibles. Also, any patient without insurance coverage is considered a self-pay patient. The hospital works with self-pay patients to establish insurance coverage through Medicaid or charity programs when appropriate, or directly with the patient to obtain payment in full.

When a self-pay account remains unpaid, it is generally referred to a collection agency for phone follow-up to obtain payment for the services.

Finance

Finance-department functions can be a rich source of knowledge, support, and data contributions to the revenue-cycle team. Administrative and financial analysis, understanding, and support are key elements to a successful revenue-cycle team.

Case-mix analysis is a review of a facility's patients classified by disease, procedure, method of payment, or other characteristics at a given time, usually measured by counting or aggregating groups of patients sharing one or more characteristics. Analysis involves review of patient-volume data by groupings (diagnosis-related groups, or DRGs) and service-line comparisons, which are defined by DRG sets within the facility or database comparison group.

Case-mix analysis is used to determine changes in patient volumes in an attempt to understand what services are driving the hospital's case mix. Identification of emerging trends in these important "driver" services will allow the facility to prioritize the greatest opportunities to affect revenue. Finance areas produce the UB-92 driven data, which can explain the cause for change and, when shared with decision makers and clinical areas, can assist in understanding and affecting case mix. Underlying assumptions that the analysis is correct include data accuracy and adequate documentation to support complete coding and data capture.

Case-mix index is determined by adding the DRG case weights of the total cases for a specific time period and dividing the sum by

the total number of cases for that period. The major portion of any hospital's case mix is determined by the weights and volumes of DRGs that are equal to or exceed a relative weight of 1.5000. Comparing internal data from year to year and benchmarking against similar facilities allows a facility to evaluate trends and progress.

In evaluating and reconciling case-mix data, identify positive or negative changes for the period analyzed, consistency of changes, specific months, or trends evaluated. Identify the underlying cause of changes in case mix. The financial impact of these changes can be evaluated by use of the facility's blended rate to calculate contractuals. Medicare contractuals are defined as the difference between the hospital's estimated DRG payment and total charges per case. With exclusion of outliers, contractual review provides the greatest potential for improvement. Cases with the highest contractuals—excluding outliers—can represent significant revenue impact.

Accounts receivable (A/R) days are calculated values that are key to evaluating the status of the revenue-cycle processes. Acceptable A/R days hover in the low 50s. Calculation of A/R days is a factor of total A/R dollars by an average day of revenue (ADR). A/R days are an effective measure/indicator for monitoring and trending to evaluate revenue-cycle process improvement/change impact.

Decision-support systems provide a rich data source because they contain the patient's clinical and financial data as well as

detailed facility financial data. They allow for data mining and analysis at various levels of summary and comparison. The data can allow summary and detailed service line, detailed provider data, or individual patient data. Use of these data in comparison to state, systemwide, and other comparative databases can be useful in process review for best practice as well as for delays in process review and clinical resource management efforts.

Reports from clinical and facility data decision-support systems are tools that will assist in clinical and operational performance review compared with budgeted amounts for both revenues and expenses at all facility levels. Most systems have a variety of reports to allow performance evaluation. The degree of system integration between the clinical-information system, patient-accounting/claims-management system, contract-management system, and compliance-management systems solutions can affect the ability to track and monitor processes (e.g., insurance underpayments through variance collection reporting by grouping/service). Contract-management software that assesses the financial performance of payer contracts and business lines, combined with solid cost-accounting estimates, will take on greater importance as providers evaluate profitability related to business lines.

Budget—The budget area of the finance department is responsible for coordinating and consolidating capital- and operating-budget information and tracking it against the actual data as they become available during the year. The capital budget comprises

assets that have a useful life greater than one year and cost more than $5,000. The operating budget includes depreciation that is calculated using assets from the capital budget, as well as items such as revenue, employee costs, supplies, and travel that affect earnings on the profit and loss statement.

Financial planning—Financial planning analyzes potential hospital services and performs profitability and statistical reporting on existing operations. Financial planning maintains the financial decision-support system and can perform cost and reimbursement estimates for hospital management. Financial planning also performs all new hospital-service pricing with assistance from the cost center manager and PFS, and it regularly reviews existing prices to determine accuracy and market competitiveness.

General accounting—The general ledger is maintained. All cost-center, revenue, and expense-account numbers are assigned and distributed by accounting staff. General accounting accumulates the financial transactions of the hospital and prepares monthly financial statements for the hospital and affiliates. It also tracks the assets of the hospital, which include both investments and physical assets.

Evaluation of the flow of financial operations involves reviewing workflow efficiency of all the subprocesses related to the revenue cycle. Eliminating bottlenecks, identifying backlogs, and streamlining steps in the revenue-cycle flow calls for aggressive management optimize the whole cycle. Front-end problem solving is a must.

Compliance

The compliance department's mission addresses ethical processes, both in the provision of healthcare and in the operation of the business. Additionally, protecting information and personal integrity, providing education, and ensuring process and personnel accountability are frequently high-level goals. Within the revenue-cycle, compliance offers considerable guidance including—but not limited to—the following items:

Legal watchdog/regulatory experts—Compliance is typically the monitor of federal, state, and local guidelines related to business practices (including billing), care provision (including access and safety), and credentialing or educational requirements for practitioners. Any regulatory-related issues identified by team members as affecting the revenue cycle are reviewed and discussed collaboratively, but they also commonly require the endorsement of compliance leadership. An example would be the need to require a valid and authentic physician order for all services provided.

Administer coding accuracy reviews—Targeting and directing medical-review efforts on Medicare or other payer claims is key to balancing optimal reimbursement and regulatory compliance because this is where the greatest risk of inappropriate program payment exists. The goal is to reduce the number of noncovered claims or unnecessary services. Providers must know national Medicare coverage and billing guidelines and local coverage determinations, and they must determine whether the services

provided to the Medicare beneficiaries are covered. A review program typically includes at least the following points:

- Internal scheduled audits to identify educational needs or validate compliance with prior problem areas
- External contracted audits to ensure up-to-date third-party interpretation of complex regulations

Information technology

Information technology (IT) or information services (IS) departments are key to a revenue-cycle process because they typically are the owners of the systems in which data and information are stored. Extracting these data to conduct further analysis is crucial. Additionally, specialized reporting is often required to measure results.

The key functions performed by IT or IS include, but are not limited to,

- supporting various component systems for admission, discharge, and transfer activities, which collect and store registration information and assigned medical-record and account numbers
- supporting billing and abstracting systems that generate claims and apply edits for missing information, claim rules, and payment schemes
- providing decision-support applications that include the financial and encoder (grouper) systems
- generating requested reports based on source data from other

revenue-cycle departments
- updating code sets and tables in a timely manner to ensure data quality and comparability

Conclusion

Not every hospital employee has an impact on the care rendered to patients. However, everyone does bear some responsibility for the facility's well being. An effective revenue cycle requires strong, consistent efforts from every department, regardless of its primary functions. If one link in the chain breaks, the likelihood of the hospital receiving adequate and timely payment decreases significantly. So whether you maintain the computer systems, balance the checkbook, or are in charge of the entire operation, stay focused on your role to help your hospital maintain its bottom-line goals.