

# Hospital News<sup>TM</sup>

C H I C A G O

JULY 2003

Chicago's Monthly Health Care Newspaper

## Key to a Healthy Revenue Cycle? Registration Accuracy

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When reviewing the revenue cycle, healthcare administrators often focus on days in accounts receivable or average daily revenue. These statistics are easily collected and commonly accepted as indicators of overall facility stability. However, often overlooked is another easily obtained statistic representing a fundamental component of the billing process – registration accuracy.

Information gathered at registration is the driver for the entire revenue cycle. Inaccurate or incorrectly entered information inevitably slows down the entire billing and collection process. For example, an incorrect insurance carrier delays payment. A birth date or middle initial transcribed improperly could result in payment delay or possible denial. Obtaining correct registration data provides Patient Accounting with accurate information, permitting timely and clean claims processing.

The first step to ensuring accurate registration data is to establish a Quality Review Team. This group will be staffed with data quality auditors who review registration data. The auditors must thoroughly understand the registration process so they have credibility with the line staff, without which the review process will not work. Auditors are dedicated full-time to this team, perhaps on a rotating basis. Team leadership should include the Directors of Patient Access and Patient Accounts, as well as managers from each area. This team determines what registration data is reviewed, how data is collected, and how information accuracy is reported to the appropriate managers.

The easiest way to determine data to be reviewed is to start with information already captured by the registration system. For example, the UB-92 universal billing form – critical to processing a claim – is created with data from registration. Therefore,

all information on that form should be part of the review process. In addition to verifying patient demographic and financial data, the review could also check processes like completing additional paperwork for Medicare patients.

Once the team and review data is established, the real work begins. Since patient information is summarized on the face sheet, these forms can be the foundation of the review process. The Review Team should work like an assembly line. All face sheets and accompanying documents are collected by the Quality Team on a daily basis and sorted by registrar. The predetermined data elements are audited and accuracy statistics are collected for each registrar. The audit results are transferred to a spreadsheet, coded by registrar and department to facilitate tracking by employee and point of entry.

After an initial review period where baseline statistics are collected, the Quality Review Team sets accuracy goals for the institution, including milestones and longer-term stretch goals. The Team regularly provides managers with statistics on registration personnel who are held accountable for maintaining an acceptable accuracy rate. If this percentage is not reached and maintained, proper disciplinary action should be taken. Conversely, employees with superior data quality should be rewarded to reinforce the process. Managers should also use these statistics to uncover areas for retraining. In addition, each registrar could be required to correct their errors and retrain themselves as part of their personal development. Regardless, misentered data must be corrected so the billing process can proceed.

Initially, registration information for every patient should be reviewed before Patient Accounts produces a bill. If the system produces a bill 4 days after date of service or discharge, the Review Team soon will face a mountain of paperwork to audit

and a time crunch as well. After current registration accuracy is documented, the number of patient sheets audited and/or the list of data elements under review can be reduced to streamline the process.

Although quality review seems like a lot of work and a diversion of valuable human capital, the return on a relatively minimal investment can be tremendous. For example, a 15% overall registration error rate translates into a 15% billing error rate. If there are 100 registrations per day, this equates to over 5,000 bills per year requiring individual clean up for claims to be paid. Over time, a work backlog in Patient Accounts builds while days in A/R increase dramatically, perhaps leading to the need for outside assistance. However, by dedicating several staff to serve on a Quality Review Team, the error rate can improve dramatically in just a matter of months.

The Quality Review Team can be a marvelous asset to your institution. Patient Access will have hard data to support staff development. Patient Accounting will receive clean data, allowing more time for processing claims than correcting them. The overall health of the hospital will benefit with reduction in patient complaints stemming from improper billing and increased in cash collections.



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