maximizing patient care revenue throughout a major HIS conversion

Teamwork and planning help organizations keep patient care revenue flowing during implementation of a new health information system.

Each year, Black Book Rankings polls about 4,000 hospitals to determine how satisfied they are with their electronic health records (EHRs). For several years, the research firm has found that a growing number of hospitals are choosing to upgrade their existing EHRs or convert to new ones. As of November 2014, more than 4,300 hospitals had attested to meaningful use under the Centers for Medicare & Medicaid Services’ EHR incentive programs. A major goal of an upgrade or conversion is improved billing processes. However, patient revenue often suffers during the early stages of a conversion to a new EHR—or, for that matter to any new health information system (HIS), which also includes computerized provider order entry (CPOE) systems and patient financial systems.

“One of the biggest concerns with a major HIS conversion is making sure you don’t miss any revenue and that you’re able to bill for all services appropriately,” says Janice Ridling, vice president of revenue management at Baptist Hospital Health System (BHHS) in Birmingham, Ala. Baptist implemented a new EHR in April 2013.

To ensure that revenue cycle performance doesn’t suffer during a system conversion, a hospital needs a four-part plan: appointment of a point person who will focus on revenue preservation, risk mitigation through preconversion revenue cycle cleanup, a staff augmentation plan aligned with key phases in the conversion, and a strategy for handling legacy accounts.
receivable (A/R) postconversion. A comprehensive strategy involves seamless teamwork by hospital leaders, revenue cycle staff, IT staff, clinicians, and coders.

**The Challenge**

When a hospital converts or upgrades to a new HIS, the initial focus naturally is on getting the EHR, CPOE, or other system running efficiently to support care improvement initiatives. Helping clinicians adjust to the new workflow can be time consuming.

After the care improvement elements of the new HIS are up and running, focus typically turns to implementing advanced technology aimed at supporting improved revenue cycle processes. The new solutions focus on improving hospital revenue cycle performance by eliminating redundant processes and driving down cost-to-collect through efficiencies. Again, in the long term, the upgrade is designed to help revenue, but the lag between implementation of the system and the focus on revenue cycle processes can hit the bottom line. Moreover, complications can arise at any step in the process, further affecting revenue.

What’s needed is a plan to prevent complications. Mastering the new system is difficult enough without the additional problems of increased A/R days and less cash on hand.

**Assigning a Point Person**

In addition to an overall project manager, every EHR implementation should have a revenue cycle point person who can make the conversion (and the accompanying revenue cycle issues) his or her top priority for a year or more. Often organizations add project leadership to an individual’s other responsibilities, which can affect the success of the implementation. Investing in additional resources to backfill key revenue cycle leadership positions during the conversion process can make a significant difference in the outcome.

“When we embarked on our EHR conversion, I was the collections manager at our hospital, so we backfilled that position and one other so I could become the project leader for hospital billing and revenue integrity during the conversion,” says Darrin Everitt, assistant director of patient financial services at University of Texas Southwestern Medical Center in Dallas. “This new role allowed me to take the in-depth courses offered by the EHR vendor. In truth, most EHR vendors are technical wizards, but they often have limited knowledge of hospital operations. So I was able to work with them closely to fine-tune things like clinical workflow and billing.”

With a team leader in place, it becomes easier to calm fears about what might happen to the revenue cycle during a conversion (e.g., big increase in A/R days, dwindling cash). Such fears became widespread with respect to the ICD-10 transition, particularly before the implementation deadline was delayed until October of this year, with industry pundits predicting that revenue cycle performance would worsen for six months to a year following the adoption of the new coding standard. Similarly, a conversion can cause a dip in revenue cycle performance if an organization does not take proactive steps to get key metrics back on track quickly. Having a strong team leader not only allays staff anxieties during this process, but also gives them the direction needed to set the stage for greater revenue and productivity in the new system.

**Preconversion Strategy**

The main revenue cycle objectives during the preconversion period are to create a plan, correct problems in the existing system, and clean up the backlog. This approach both ensures that the data being used to populate the new system are accurate and gives the revenue cycle a short-term boost, putting the hospital in a better financial position to absorb any problems.

A major conversion provides a great opportunity to integrate multiple clinical documentation and revenue cycle functions. Most new systems are designed to better capture clinical documentation, which likely will produce more accurate information for the revenue cycle if the hospital
has the requisite planning and interdepartmental cooperation during the conversion. It may be tempting for a hospital to completely re-engineer its billing and business office structure, but leaders should consider how much change the organization can absorb all at once and determine an appropriate strategy to implement new structures with the technology.

Preconversion issues generally fall into four categories.

**Charge capture.** A complete chargemaster review should be performed 12 months prior to conversion to help ensure the database is clean and complete before it is loaded into the new system. A complete charge capture audit should be performed next, not only to achieve short-term revenue optimization, but also to ensure that current issues do not make their way into the new system. The charge audit should be repeated six months before the system is scheduled to go live to ensure that new issues have not arisen during the process. Because many new systems can charge by documentation, an accurate chargemaster and charge capture process are critical to providing the information necessary to ensure the new system is configured properly.

**Accounts receivable (A/R) workdown.** Prior to conversion, it’s important to clean up the old system’s credit balance accounts and any A/R older than 90 days. Because of the billing risk associated with a system conversion, A/R should be as clean and as low as possible. One strategy is to bring in temporary staff to work the A/R and to free up key A/R personnel to participate in process mapping and system testing.

This is an ideal time to map out the A/R management process and structure to ensure the organization makes effective use of the many added features newer EHRs typically offer to automate revenue cycle functions. A clear understanding of the current process helps ensure that the right automation is in place at go-live and that a plan is identified to implement some features after go-live. The design and validation team should selectively review and test those features to determine the first phase of functionality implementation. Changing one variable and measuring the results is easier than changing everything simultaneously and then wondering what went wrong.

**Cleaning up the coding backlog.** The postponement of ICD-10 implementation until Oct. 1, 2015 provides organizations some latitude in addressing coding backlogs. Additional coding resources now available due to the ICD-10 delay should focus on “clearing the decks” before implementation of a new EHR. Even with careful planning by the hospital and EHR vendor, most organizations experience some hold on billing after go-live. A billing hold often is necessary to complete testing and comprehensive quality reviews of claims in the live environment. Ensuring that the discharged—not-final-billed report is as low as possible prior to go-live can accelerate cash flow and allow the health information management department to focus on other issues that arise during go-live.

**Testing.** In addition to unit testing, integrated testing should be completed to ensure technology and processes throughout the organization work together optimally after implementation of the new system. “We had a very sophisticated testing process prior to our EHR go-live,” says BHHS’s Ridling. “We took 48 accounts from our old system and emulated everything in the new one, all the way to posting cash. During the testing, we identified 100 issues that got corrected prior to go-live. Can you imagine going live and having all those issues hit with thousands of accounts, not just 48 test ones?”

**Staff Augmentation Plan**
Two areas in particular—revenue integrity and coding—will require heightened attention during a major HIS upgrade or conversion and are likely to push available staff resources to their limit. Many organizations find that flexible staffing approaches such as hiring temporary help (e.g., to allow internal staff to be reassigned to the conversion effort) or seeking outside support to
address these areas helps mitigate risk and capture additional revenue.

Revenue integrity. Charge capture is one of the areas that pose the greatest risks during a system conversion. Our experience shows that hospitals can miss as much as 6 percent of revenue if the systems are not set up properly. A go-live charge audit process helps ensure that all appropriate charges are captured, systemic and chargemaster issues are caught and fixed immediately, and areas requiring staff education are identified. A strong charge audit process ensures that all services provided are accurately reflected on the claim and determines the reasons behind any inaccuracies that are found. Based on that information, the organization can then implement a plan for improving processes to avoid missing charges in the future. Given the scope of this effort, hospitals typically require additional resources to perform such audits.

Coding. The first 90 days after go-live can put a real burden on a hospital’s coding staff because they have to learn the new system and deal with any unexpected problems. It’s important to have the flexibility to temporarily assign additional coding personnel to help handle the load. Coding resource suppliers should be apprised of the conversion and need for additional coders well in advance to ensure coders are made available.

Postconversion Strategy

The postconversion stage can be demanding because of the need to capture maximum revenue while implementing new policies and procedures.

Several issues should be points of emphasis once the new system is running.

Revenue capture. One to two weeks after going live with a new EHR, many hospitals bring in additional resources to begin comprehensive charge audits and documentation review. This process usually takes four to eight weeks, and in some cases a bit longer. As previously noted, a hospital can experience a significant revenue loss during the EHR conversion if no charge audits are performed during this period. It can be helpful to bring in external charge auditors for a few weeks after go-live to help ensure that the charging is accurate and to apprise finance leaders of issues that need attention. It is also beneficial to engage these same experts six months after go-live to conduct a retrospective audit to identify and fix any lingering problems. Periodic charge audits also help keep the new system running at peak performance.

Staff education. The results of the charge audits should be used to educate staff. The postconversion period is the perfect time to train clinical directors. The charge auditors should help staff look at the hospital’s entire electronic system holistically, not just the new components. This perspective helps ensure that all appropriate charges get on the bill correctly.

Some hospitals move to an EHR from a paper-based system that does not include a

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Guidelines for the Clinical Review Team

Few hospitals have sufficient numbers of internal staff who are fully adept at implementing electronic health record systems. So many will be inclined to bring in an outside clinical review team—often with the combined expertise of nurse auditors, technology specialists, documentation experts, and experienced coders—during a conversion. In such circumstances, it is important that hospitals clearly define expectations and guidelines for the team. A hospital should establish the following basic guidelines regarding what it expects of the clinical review team:

> Look for things that are missing from itemized statements (either because of issues with documentation or lack of adherence to typical charging practices).
> Review and refine clinical documentation.
> Apply effective, well-tested processes across the full range of revenue cycle activities—including charge capture, insurance defense, charge hold/prebill, and stop-loss/carve-out—and educate staff on how to sustain those processes going forward.
> Offer technical guidance (e.g., helping the hospital determine its best choice for housing legacy accounts receivable).
> Provide legal/regulatory training spanning topics such as IRS 501(r) changes for not-for-profit hospitals and expanded HIPAA privacy and security rules, which now apply to a hospital’s many business associates.
reconciliation process to ensure that all charges
were captured properly. Moving to an electronic
system allows the hospital to establish a
standard reconciliation process at the clinical
department level.

Legacy A/R. The two components to address
regarding legacy A/R are the workdown process
and the workdown platform. Often after imple-
mentation, attention and focus shift to the new
system and the issues that may arise. Hospitals
should develop a plan to ensure the legacy A/R is
worked in a timely manner and that cash flow
remains consistent, which, again, may require a
staffing augmentation plan, including consider-
ation of possible outsourcing options.

Regarding its legacy A/R platform, a hospital has
three choices: convert the old data to the new
format, which can be complicated and expensive;
maintain the legacy platform, which also can be
expensive due to software and hardware mainte-
nance fees; or implement a data warehouse
solution, which is far less expensive.

Increasingly, hospitals are turning to web-based
data warehouse solutions that are less costly and
can immediately boost productivity. These
solutions extract data from the old system and
give it the “look and feel” of the new system for
faster workdown.

The newest data warehouse tools allow hospitals
to extract data from any EHR system (regardless
of vendor) and dynamically work those accounts,
posting payments and updating accounts on
screens that emulate the new EHR. In addition,
master tables (e.g., chargemaster, financial
classes, payer codes) are stored for reference.
Many data warehouse solutions use a web-based
architecture, but none of the data runs over the
Internet. To meet the highest HIPAA standards,
data get shared via a secure virtual private
network tunnel.

Reporting. Healthcare professionals are inundated
by reports, so reporting on an IT conversion
should be limited and focused. Nonetheless, it is
especially important for hospital leaders to
develop a report to track key performance
indicators during a conversion, including how
much additional revenue was generated (or
saved) via charge audits, improved documenta-
tion, staff training, and technology solutions. A
dashboard format of performance indicators that
trends metrics through the go-live period should
be created and maintained by the implementation
revenue integrity team and patient financial
services team. These reports should be designed
with finance and IT to ensure the new system can
produce the data for tracking.

Not a “One and Done” Process
Many U.S. hospitals will likely experience EHR
conversions or upgrades in the next few years.
When these happen, the facility’s revenue cycle
performance can either go into a short-term
tailspin or quickly stabilize and improve as the
new system matures. Any hospital can achieve the
latter outcome if it is willing to craft a revenue
cycle strategy that begins long before go-live and
continues until postconversion problems are
eliminated and best practices are in place. ●

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