The Academy
The Health Management Academy

QUICK-HITTING SURVEY
MEDICAL GROUP REVENUE CYCLE

Executive Summary

Methodology

In May 2017, The Health Management Academy conducted a quick hitting survey of 26 Leading Health Systems regarding medical group revenue cycles. With a 62% response rate, the 16 responding Medical Group presidents represent health systems with an average Net Patient Revenue of $3.0 billion that own or operate 185 hospitals with almost 36,000 beds and approximately 1.7 million admissions annually.

Key Findings

- Most (75%) responding health systems report having an internal department for revenue cycle billing, coding and provider education.
- Of those that utilize an internal department or a combination (88%), half (50%) are organized as a health system function.
- A majority (62%) of responding health systems provide on-site coding assistance to providers .

Results

Most (75%) responding health systems report having an internal department for revenue cycle billing, coding and provider education (Figure 1). Those that reported other (12.5%) indicated utilizing a combination of a third-party vendor as well as having an internal department. One executive specified billing, coding, and provider education were handled internally and bed debt was handled through an outside vendor.

Of those that utilize an internal department or a combination (88%), half (50%) are organized as a health system function, while 21% are organized as a medical group function (Figure 2). All health systems that indicated other structures (29%) reported these functions were a combination of health system and medical group functions.

Half (50%) of responding health systems indicated billers and coders are centralized, rather than located at the practice sights. The remaining health systems (50%) indicated a combination approach to centralization of billers and coders. Three health system executives reported billers and/or coders are located within practices with central management, while two health systems indicated that billers are centralized while

FIGURE 1. DOES YOUR ORGANIZATION HAVE AN INTERNAL DEPARTMENT OR UTILIZE A THIRD-PARTY VENDOR FOR REVENUE CYCLE BILLING, CODING, AND PROVIDER EDUCATION?

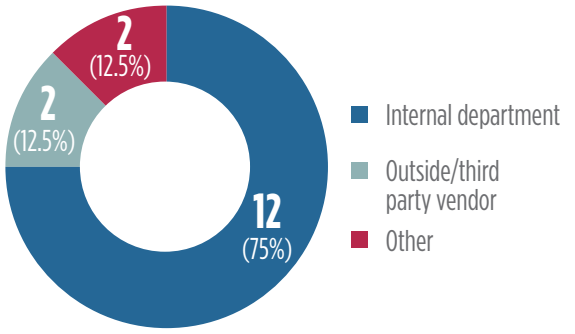
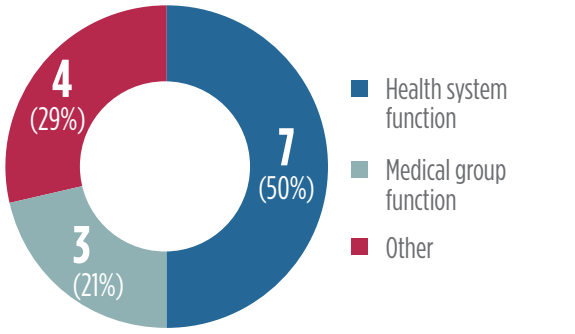


FIGURE 2. IF INTERNAL, IS THIS A SYSTEM FUNCTION OR MEDICAL GROUP FUNCTION?



coders are at the practice site. Health systems also reported billers and/or coders being centralized at the hospital or medical group level, rather than the system level.

Health systems utilize a variety of standard reports to track performance for revenue cycle. A majority (53%) of responding health systems reported using A/R metrics, commonly days in A/R. Health systems also reported using reports such as KPI reports, denial rates, collection ratios, bed debt, charge lags, hold times, and payer mix, among others. A full list of reports utilized by responding health systems can be found in the Appendix (A1).

Most health systems reported an average cycle time for coding/billing compliance audit, review, and education for providers of 6 months (25%), 1 year (33%), or between 1 – 2 years (17%). Two health system executives indicated a varied cycle time with one Medical Group leader commenting, **"Upon initial employment cycle depends on risk level with initial review."**

A majority (62%) of responding health systems provide on-site coding assistance to providers, while approximately one-fifth (19%) do not (Figure 3). Two health systems indicated assistance varies, with one specifying coding assistance is available for certain specialists but not for primary care physicians. Another health system executive noted coding assistance is a centralized function.

FIGURE 3. DOES YOUR ORGANIZATION PROVIDE ON SITE CODING ASSISTANCE TO PROVIDERS?

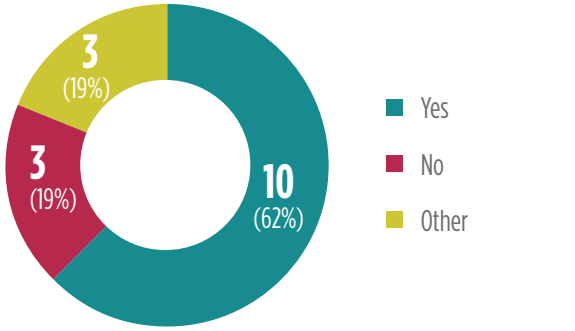
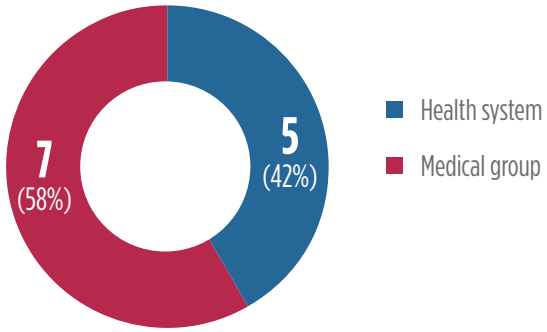


FIGURE 4. IF YES, WHO IS RESPONSIBLE FOR THE EXPENSE/COST?



For those health systems that do provide on-site coding assistance, over half (58%) indicated the Medical Group is responsible for expenses and costs (Figure 4).

Appendix

A1. What standard reports are being reviewed and used to track performance for revenue cycle?

- Traditional reports: days in A/R, CDAR, claims denied, claims on hold, inflow/outflow
- Days in A/R, ageing by payer, self-pay, bad debt percentages – all tracked by location or site
- Roll up and practice level KPI reports
- Benchmarked reports showing distribution of E/M codes
- NPR, NPR/wRVU, Payer Mix, A/R and A/R Days, Collection ratios, wRVUs, visits, procedures, write-offs, bad debt
- Monthly performance review. Internal KPI's TOS Collection, A/R days, Charge Lags, Bad Debt, Denial Rates, Hold times prior to billing
- Monthly dashboard of key performance measures
- Days in AR, Denials, Collections, POS collection rate
- Aging, subsequent receipts, actual versus expected collections, A/R days & denial/ recovery percentages
- Our own KPI report
- Dashboard with standard A/R metrics
- Typical A/R reports and trending
- End of Month, Exchange Reports & Optimal Practice Dashboard
- Denial rates, First pass collection, Days in AR, Timely filing