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# **End Stage Renal Dialysis Services:** Strategies for Increasing Revenue and Efficiencies

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# End Stage Renal Dialysis Services: Strategies for Increasing Revenue and Efficiencies

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## Dialysis Providers Face Mounting Pressures

Over 400,000 Americans suffer from kidney failure (End Stage Renal Disease, or ESRD) and require either kidney dialysis or a transplant to live. Since 1973, when Congress approved legislation for the Medicare ESRD program, the number of hospitals and clinics offering dialysis treatments increased substantially to accommodate the only federal program that finances a disease specific service for Americans on virtually a universal basis.

For most freestanding clinics, this service has become a cash cow. For-profit facilities can invest the money to build newer, more comfortable surroundings for dialysis treatment and charge appropriately for ESRD services.

For hospitals, however, income from dialysis services is regulated and depends on Medicare funding which is, according to many, not keeping up with inflation. To make matters more difficult, many hospitals – such as Grady Memorial near Atlanta, Georgia – must deal with an influx of the uninsured such as illegal immigrants.

As a result, cash strapped hospitals that usually are operating in the “red” have little to invest in elaborate surroundings and must concentrate, instead, on providing the highest quality of care with available resources.

Turning ESRD hospital departments into a money-maker is not realistic for most hospitals – much like with the Emergency Department. Yet, any and all improvements in ESRD processes and service delivery that result in cost savings and increased cash flow would help a hospital reach break-even or, at least, reach a modest level of income that would enable facility or staff-related improvements.

The following white paper outlines areas within the ESRD revenue cycle and operations that are often dysfunctional, which lead to incomplete billing and reimbursement and in the end, unclaimed revenue. The paper will also provide strategies for improving each area for increased cash flow and overall fiscal health.

## Improving ESRD Operations

From errors in charge capture to billing and collection to a breakdown in communication between people and processes, there are many factors that negatively impact ESRD departments and their ability to make money.

Though ESRD is not viewed as a money-maker, many directors, COOs and CFOs would be surprised at the costs that can be recouped and the potential revenue that can be realized when key processes and procedures are assessed and then corrected relative to ESRD-specific services.

In many hospitals, there are clear indications that something might be wrong with ESRD operations, but few financial and clinical managers have the time or experience to comprehensively assess what might be wrong.

The most obvious indicator that something is awry with ESRD operations is when hospitals experience poor financial performance in their dialysis centers. However, poor financial performance is not an eventuality for ESRD services and management should consider fixing specific problems that impact the revenue cycle.

Your hospital might need an ESRD revenue cycle review if you notice the following breakdowns:

- 1. Inadequate documentation and charge capture functions**

This might lead, for example, to dialysis related drug charges not being applied appropriately to patient accounts, which can be one example of a breakdown in the revenue cycle. The inability to properly document and charge each service will ultimately impact a facility's ability to track revenue and collect proper payments.

- 2. Invalid or obsolete insurance information**

A review of procedures is necessary to make sure insurance information is up-to-date and patients can be charged quickly and efficiently. Ensuring 100 percent insurance verification and integrity and having an effective insurance authorization process are key factors in successful ESRD operations.

**3. Inefficient billing and reimbursement**

Disputes with payers over primary and secondary billing slow down the revenue cycle. Accounts receivable usually suffer from the breakdown in four key areas – timely claim submission, resolving Medicare suspense issues, outsourcing balances and reviewing credit balances. Secondary billing is usually not standardized and the delay from the time of payment or denial to secondary billing is usually inefficient and not comprehensive.

**4. Denials due to missing medical records or coding error**

A lack of clear medical record documentation can impact the ability to collect 100 percent of net patient service revenue. Also, the dialysis chargemaster should undergo a yearly review so that pharmaceutical drugs, for example, are accurately captured and submitted accurately— if not, they will negatively impact reimbursement.

**5. Breakdown in IT system or internal communications**

Inherent system problems, defunct business processes or the inability of staff to communicate effectively is like a virus in the ESRD system. It must be found and fixed for ESRD operations to operate smoothly and effectively.

**6. Insufficient back-end collections**

Accelerating the rate at which accounts are adjudicated and closed, or discovering if a hospital qualifies for other back-end payments, such as the high percentage renal add-on payment, can significantly increase cash flow.

While finding opportunities for enhanced cash flow and net revenue are certainly main motivators for hospitals, other important benefits accrue from identifying and correcting ESRD operational problems, such as increased ESRD staff productivity, improved patient and employee satisfaction, and resolution of any compliance issues.

## **Comprehensively Assess ESRD Services**

The first step to any comprehensive or specific ESRD revenue cycle fix is to undergo an audit, or a review that examines current ESRD processes and finds the breakdowns and areas that are negatively impacting overall net patient service revenue, delays in billing and collections, and overall operations efficiency.

Assessing ESRD services at any hospital involves reviewing the charge-capture, billing and collections areas. A review should cover the dialysis-related charge capture processes for pharmacy, laboratory, ancillary, treatment, medication and Epoetin services for the centers and home dialysis patients, as well as the registration process for the dialysis patients.

Further, an audit of the medical records, corresponding UB92 and explanation of benefits are also conducted to determine if all documented services from the medical record are being captured and billed. Payments to the facility are compared to the contracted and/or expected amounts, and denials should be categorized by type.

In order to get a full assessment, management personnel in the finance departments and dialysis department, as well as other key staff, should be interviewed as to current procedures, and reviewers should get a hands-on look at the facility and the forms used for charge capture and other processes.

## **Correcting Common ESRD Operational and Revenue Cycle Problems**

As discussed above, there are six main problem areas that commonly cause a breakdown in the revenue cycle and keep hospitals in the red. This white paper will describe some strategies to solve ESRD operational and revenue cycle issues and highlight the financial impact of remedying ESRD problems.

These solutions below are not the only ones that would be appropriate for a hospital, but show examples that could lead to cost, compliance and operational improvements.

### **Inadequate documentation and charge capture functions**

Drug charge capture, documentation and reconciliation must be as thorough as possible. At a minimum, a daily reconciliation process should be implemented so that it can be determined that all dispensed drugs are accounted for, and the charge logs should be designed to capture as much information about the patient and the specific drug, as possible.

Regarding Erythropoietin (EPO) charges specifically, a monitoring system should be established so that daily EPO usage is monitored and reconciled to the charge entry function. The amount of EPO in the refrigerator each day should be reconciled to the EPO that is documented as having been removed which, in turn, should be reconciled to the charges documented in the center's system. This may require the development of new reports to facilitate this process. For treatment charges, there should be individual charge capture forms for daily treatments. These forms should be patient specific and would be reconciled daily to the schedule.

Lost charges are also an issue for the billing of EPO for home dialysis patients. Rather than accumulating charges manually until month end, charge postings should occur on a daily basis, or as the EPO is dispensed, and should be documented by the pharmacy staff.

Or, in some cases, the best way to ensure 100 percent charge capture and documentation is to implement a system that allows clinical staff to enter drugs administered to the patient at the bedside terminals, as well as treatments. This data could then be used for both clinical documentation and charge purposes.

*Potential financial impact. Comprehensive charge capture and documentation is the cornerstone of improving the revenue cycle. With daily charge reconciliation, a medical center can realize increased reimbursements, decrease turnaround times for collections, and improve overall cash flow.*

## **Invalid or obsolete insurance information**

Patient registration is a critical step in the revenue cycle, and a financial counselor should be on hand and versed on how to advise patients with regard to Medicare and/or insurance coverage and follow up to ensure that patients take the necessary steps to secure coverage when appropriate.

The task of monitoring and updating patient insurance information should be part of the financial counselor role and hospitals should institute a policy stating that the insurance information be provided to patients upon their initial visit (i.e. Medicare coordination of benefits period, the need to update insurance information regularly, etc).

Also, when providing ongoing services to recurring patients, it is often overlooked that patient demographic and insurance data does not remain static. Medical Centers should incorporate a requirement that patients complete an insurance update form at least two times per year. This form would be provided during a scheduled patient encounter and would request that changes be provided about their insurance coverage.

*Potential financial impact. Properly recording insurance information at the time of service can increase cash flow by 15 days and reduce unnecessary denials and rework, while also providing patients an added benefit and level of quality service.*

## **Inefficient billing and reimbursement**

Accounts receivable usually suffers from breakdowns in four key areas: untimely claim submission, resolving Medicare RTP issues, outsourcing balances over 180 days and reviewing credit balances.

There are four recommended steps that will immediately result in increased cash flow and also resolve outstanding accounts and improve the aged accounts receivable.

- 1. Identify & resubmit all claims with no activity**

Most commercial and managed care plans have timely filing periods that range from 60 days to one year. Medicare requires accounts to be received within 18 months from the date of service. Considering time constraints with all payers, it becomes critical for claims to be submitted accurately and timely, and efforts must be made to review if these accounts are in the payer's processing cycle. Those not in the cycle should be submitted.

- 2. Resolve Medicare (Suspense) issues**

Maintaining and correcting the Medicare accounts in a timely manner will ensure that they continue the processing cycle. Accounts remain in suspense for approximately 45 days. Within that timeframe, the provider can make any corrections to the account. If the provider fails to correct the account within 45 days, it is dropped from the Medicare system and must be resubmitted for reconsideration. When a number of claims are submitted simultaneously, the RTP can also be used as an indicator to determine the accuracy of the data on the claims. Errors received can be corrected on the claims but should also be addressed at the source (e.g. chargemaster) to eliminate future errors.

**3. Outsource balances over 180 days**

Following-up on account balances over 180 days requires extensive and aggressive efforts. Timely filing will be a critical factor for many of these accounts. Since collections on these accounts will be difficult at best, medical centers are served best by outsourcing this population to a firm that can handle it specifically.

**4. Review credit balances**

Credit balances will undervalue the overall accounts receivable. Medicare regulations contain strict requirements with regard to credit balance reporting. Efforts must be made to ensure that Medicare credit balances are identified and reported accordingly. A formal policy and procedure must be designed and followed to ensure that all credit balances, Medicare and non-Medicare, are handled appropriately.

When it comes to secondary billing, procedures are usually not standardized and the delay from the time of denial to secondary billing is usually inefficient and not comprehensive. Secondary billing should occur within fifteen days of payment receipt or denial, and this function should be integrally tied to the daily processing of EOBs.

*Potential financial impact. Resolving accounts receivable issues can quickly decrease open receivables by as much as 75 percent for claims over 365 days.*

## **Denials due to missing medical records or coding error**

In order to secure full reimbursement for any medication or service provided, the facility must ensure that every billable service is properly coded and submitted with the corresponding HCPCS or CPT code, service units and diagnosis code(s). Routine audits on a yearly basis will help monitor the accuracy of the items coded and submitted. The audit should entail a review of the documented charges, the billed charges, and when applicable, the reimbursement amounts.

For example, many reviews will find pharmaceutical drugs inaccurately captured on the UB92. These drugs are reimbursed separately since they are not included in the composite rate. If these items are not submitted accurately, they will negatively impact reimbursement.

*Potential financial impact. Implementing strategies to correct revenue code and HCPCS/CPT errors, chargemaster issues and electronic submission errors can improve accuracy by up to 150 percent.*

## **Breakdown in IT or internal communications**

Finding an IT solution specifically designed for the financial and clinical management of ESRD patients is always a good idea. There are a number of solutions on the market, but hospitals should consider the following when evaluating a system:

- Reporting Functions
- Clinical and Financial Capabilities
- Compliance Monitoring
- On-line Tutorials
- System Compatibility

Another problem is disparate systems not “talking” to one another. If purchasing a new, integrated solution is not possible, consider the development of an interface between billing systems and between separate clinical and billing software. And, it’s important that measures are taken to ensure that information flows to the UB92 for final billing. This eliminates duplication in work and billing errors.

*Potential financial impact: Disconnects in charge capture software between hospital and dialysis billing systems can amount to thousands of charges not reaching the final bills. After implementing corrective measures, a Medical Center can realize increased reimbursements and improved overall cash flow.*

ESRD operational improvements should always be accompanied by a “re-engineering” of how people and processes interact. One way to improve internal communications and ensure success in any ESRD improvements is by establishing a task force.

By establishing a task force, a Medical Center fosters an environment of teamwork, which is an integral component of a successful outcome. The task force must realize that individually none of the items can be resolved without full cooperation between departments, since every area impacts each other. It is recommended that the task force initially meet on a monthly basis and transition to quarterly, once the majority issues are resolved. A work plan should also be utilized to foster accountability.

Other long-term benefits of this task force include the establishment of clear lines of open and effective communication between each member and the individual departments, and a sense of partnership over the Dialysis billing.

### **Insufficient back-end collections**

By going after receivables that have been delayed and remain open, a medical center can increase cash flow and reduce open accounts – this type of cash acceleration initiative can reflect a return on investment within 60-90 days.

One area of opportunity for medical centers is the recouping of up to \$200,000 a year by pursuing Medicare’s “high percentage renal add on payment.” If a medical center has a high percentage – 10 percent or above – of inpatient renal charges, then they can obtain information and submit a claim. This can be determined during an audit, as described above.

*Potential financial impact: Pursuing claims that are considered untimely and uncollectible can increase cash flow up to and over \$250,000.*

### **Summary**

Lack of clear medical record documentation, missing charges, invalid or obsolete HCPCS/value codes/modifiers, incomplete insurance information and breakdowns in IT and internal communications are just a few areas that impact a medical center’s ability to collect 100 percent of net patient service revenue.

ESRD reviews that look at the full revenue cycle and reimbursement are key to identifying a number of opportunities at today’s medical centers to improve overall ESRD revenue, meet compliance requirements and achieve overall operational efficiencies.

Medical centers that viewed ESRD as only a money drain will be surprised at various strategies for not only breaking even but also making ESRD financially healthy – enabling them to increase quality of care through facility, clinical and customer satisfaction enhancements.

**For further information on how BESLER Consulting can help you please call, 1.877.4BESLER or visit [www.beslerconsulting.com](http://www.beslerconsulting.com).**