Do Lost Charges Matter?

Looking back a few decades, patient financial executives found themselves very concerned about lost charges. Yet today, most patient finance executives no longer believe that lost charges constitute any real concern. Has the lost charge problem been solved, or is it simply that charges no longer matter?

The rate of lost charges that never make it to billing has held steady at about three to five percent for the past twenty years. The problem of lost charges has not diminished, but the concern has.

The causes of lost charges are rather obvious.
Nurses administer medications and note them on the patient chart, but they postpone completing the charge document until the shift becomes less hectic. It never becomes less hectic. Ancillary departments fail to correctly transmit their charges to the billing department in a timely manner. Operating room technicians cannot find the appropriate hardware description in the charge master, so they skip the entry. These types of incidents are daily occurrences in nearly every hospital.

Can lost charges be eliminated?
Almost every hospital has lost charges. A very small number of facilities experience exceptionally low percentages of charge loss. In those facilities, a team dedicated to the improvement of charging integrity keeps the rate of charge loss below one percent. This involves the ongoing training of everyone responsible for the preparation of charge entries, regular quality control audits on charging compliance, and constant systems improvements to the various components of the charge capture systems. Although a rather expensive endeavor, it effectively reduces lost charges at those facilities.

What about overcharges?
Insurers have long complained that hospitals tend to overcharge patients more than they undercharge. The reality is that the majority of hospitals will have more undercharges than overcharges. In fact, the overcharging rate averages only 0.5% to 1% compared to the normal 2% to 5% for lost charges and undercharges. Common sense dictates that it is far easier to neglect posting a legitimate charge than it is to incorrectly post an illegitimate charge. The only exception is seen in pharmacy departments, especially those that employ an order-entry charging system. In such systems, the medication is charged to the patient as soon as it is dispensed by the pharmacy. If the order is rescinded or the medication not administered to the patient, someone must actively cancel the patient charge, otherwise an overcharge situation occurs.

Do lost charges still matter?
Lost charges have not gone away, but the concern about them has greatly diminished in the minds of most patient financial managers. There has been a general trend away from charge-based billing for the past several decades. Governmental payers and some commercial insurers now use the diagnosis based DRG payment methodology. Other

commercial carriers prefer per-diem contracts that bundle most charges into flat daily rates. In these situations, charges do not directly affect the rate of payment.

Certain hospitals have remained somewhat immune from this trend. In the rural, less populated parts of the country, where managed care has sparse penetration, a significant portion of the payer mix remains charge based. The same holds true for hospitals near popular resort destinations that attract many out-of-network patients. It is also true for some community hospitals without local competition where they have used their unique bargaining power to secure charge-based payment contracts from their major payers.

Even in urban hospitals with a high penetration of managed care, parts of their payer mix is still based on charges. Besides the indemnity insurers and out-of-network patients, some managed care contracts might be based on a percent of charges. Even the per-diem and DRG based contracts can have stop-loss provisions or exclusions that revert to charge-based payment calculations, and many of the outpatient services can be fee based or charge based. Most implants are paid on a cost or a charge basis. Lost charges may not matter as much as they used to, but they still matter in some situations.

The recovery of lost charges

Charges that are lost and never billed cannot possibly be paid. It definitely benefits a hospital to insure that at least on all charge-based accounts, the lost charges are found and billed. Lost charge recovery can be done on a concurrent or on a retrospective basis. There are advantages and disadvantages to each approach.

Concurrent Lost Charge Recovery

Some patient financial services executives prefer a concurrent approach to the recovery of lost charges. They would like to find the missing charges before the initial billing, so they can send a "clean bill" to the payer. That way, they do not have to submit late charge billings, and all co-pays are automatically billed under their existing system. Hospitals conducting concurrent lost charge reviews have seen good success.

The concurrent approach has some drawbacks. First of all, the review must be completed rather quickly after the initial bill is produced. Otherwise, the process would hold up the mailing of the bill and would extend the "days in receivable". Often times, as many as forty percent of all new billing records are incomplete or unavailable for review within the first 72 hours after initial billing. Those incomplete and missing records typically cannot be completed without holding up the billing and must be reviewed on a retrospective basis at a later time. Nearly fifty percent of the lost charges discovered in a concurrent review are actually late charges that would likely appear automatically within a few weeks after billing. Those late charges must be intercepted and cancelled to prevent duplicate billing.

Retrospective Lost Charge Recovery

In a retrospective lost charge recovery project, one typically examines all of the paid charge-based bills at least 90 days and up to one year after the initial billing. On these accounts, the medical records are complete, all late charges have been posted and the

account is virtually dead. Any additional charges discovered, billed and collected on those accounts is truly "found money". There can be a bit of additional work in billing the found charges on a late-charge bill and following up with the payer to insure collection of the extra revenue.

The recovery process

Both retrospective and concurrent lost charge recovery begin in the same manner. One must identify the charge-based billings. That typically includes all indemnity insurers, all out-of network commercial accounts, all percent-of-charge contractual accounts, and all pass-thru charges and charge-based outliers on per-diem or case-rate accounts. To do that, you need to examine the financial classifications, the managed care contract terms, and even the manner in which prior accounts in the same plan were paid. Outpatient services such as charge-based ambulatory surgery, dialysis, chemotherapy and high priced cardiac and radiology procedures should be included in the review. Because of the low average bill size, it is usually not cost effective to include the ED accounts.

To complete the audit portion of the lost charge recovery project, hospitals should use registered nurses with in-hospital, acute-care experience. Although it is possible for lesser qualified analysts to perform this function, they typically do not have the working knowledge of the complex procedures and sophisticated medications used in hospital operating rooms or in many modern acute-care functions.

For successful completion of the lost charge audit, a reviewer needs access to a copy of the detailed bill, the medical record pertaining to that bill, and the charge master that was in effect at the time of original billing. The audit process includes verifying that all items and services documented in the medical record have been included in the bill. Any items that were omitted from the original bill must be priced from the appropriate charge master and then included in an amended late-charge bill.

Results of a lost charge recovery program

If you maintain a concurrent lost charge recovery program, you can be confident that you are sending out a "clean bill" the first time, but you will not be able to review all of the bills without holding up the mailing of some accounts.

If you conduct a retrospective lost charge recovery project, you will late bill all of your omitted charges and will collect approximately 80% of the total. You will also get an analysis of the unbilled charges categorized by department and by item. This will allow you to determine the major sources of your charge losses and will assist you in eliminating them.

What is the cost?

If you do it internally, you must dedicate an appropriate number of trained auditors to perform the recovery function on an on-going basis. A nurse reviewer can usually complete ten to twenty in-patient bills per day, and approximately twenty to forty out-patient bills per day. Such a program can be quite cost effective as long as your team maintains a good level of productivity and quality.

If you outsource a concurrent review, you must typically pay a per-hour rate for a staff of dedicated auditors. It is not wise to pay contingency fees for a concurrent review as the results will normally include a lot of late charges that were never actually lost. This solution can also be very cost effective as long as the vendor's staff maintains a good level of productivity and quality.

Retrospective lost charge recovery programs are typically conducted on a performance-based contingency fee. You pay the outsource vendor a percentage of the money recovered after it has been received. There is little risk to the hospital in this approach.

Finally, before choosing a vendor, ask them to run a sample group of charts. If they find an error rate of less than 2%, your hospitals falls within the norms and would not require a retrospective review.

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