Leveraging the 80/20 Rule to Drive Performance Improvement

By Brian Robertson and Zane Newitt

The 80/20 rule—also known as the Pareto Principle or the Law of the Vital Few—states that, for many business occurrences, 80 percent of the consequences or outcomes originate from 20 percent of the causes. The 80/20 rule is pervasive in the healthcare industry today and begins with the verity that 80 percent of health spending in the United States is caused by less than 20 percent of the population. From there, the 80/20 rule can be found in evidenced-based medicine, patient costs and utilization, supply chain, and revenue cycle operations.

A tremendous opportunity exists to leverage the power of the 80/20 rule to drive advanced performance improvement through *focused, data-driven decision making*. That's the good news. The challenge is in setting aside enough time in our busy schedules to focus on that critical 20 percent of our businesses that truly matters.

In this toolbox, our goal is to provide practical ways to use the 80/20 rule to take performance outcomes to the next level in the area of revenue cycle operations.

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1. The 80/20 Cash Flow Split

Summary: Revenue cycle leaders continue to place increasing focus on preregistration, point-of-service strategies, and patient access processes. However, there still remains a "back end" heaviness to revenue cycle management.

In general, 80 percent of cash is received from charges generated from the previous two months. The Pareto approach for cash flow is "keep new revenue new," preventing erosion before it occurs. For most providers, this may translate to even greater resource, business intelligence, and technology investments in preregistration, patient access, and health information management.

Report / Analytic Recommendation: Move beyond basic aging analysis and use informatics to develop an "Erosion by Reason" report. By flagging accounts that age due to denials, claims submission errors, or service documentation causes, a Pareto Principle chart can be developed to manage the 20 percent of delayed cash opportunity in accounts receivable.

2. 80% of Authorization Denials in 20% of Service Types (ED Admits)

Summary: Patient throughput, especially for patients whose care originates in the emergency department, can have a significant impact on denials and delayed cash. As a patient moves from department to department, the likelihood for systemic or human error to both initiate, monitor, and secure authorization (or validate and document visits where no documentation is required) increases. The preprocessing (preregistration) team may not be aware of an ED admit until well after the status change and bed assignment has occurred, creating high potential for denied days or a full denial of claim for no preauthorization.

Report / Analytic Recommendation: Today's progressive revenue cycle leaders require on demand business intelligence to both apply the Pareto Principle and reduce/prevent ED denials.

1. *ED Movement Analysis.* This daily report creates a picture of the prior day's ED Activity. Which patients were discharged to home? Transferred? In a holding unit? Admitted?
2. *Admits by Payer by Source.* Use this analysis to quickly vet ED admits who may not have been driven to a preprocessing representative for follow up. Even if a status change was not properly assigned in the host system, ED admits can be quickly and easily identified by both charge and physician information associated with the account.

Using the discipline of the above informatics on a daily basis will reveal trends that allow for application of the Pareto Principle as assignable causes are revealed .

3. 80% of CMS Withholds Tied to Less Than 20% of Assignable Causes

Summary: CMS withholds can be predicted and managed. Clean claims do, for the most part, mean cash for Medicare. Approximately 80 percent of CMS withholds occur from:

1. OCE edits—Usually spanning June and July
2. DRG weighting recalibration—Usually, but not always, in October
3. CMS budget adjustments—Usually, but not always, in September

Reporting / Analytic Recommendation: Here, a simple strategy should be incorporated whereby accounts that are on withhold (which can be identified within the CMS Fiscal Intermediary

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Common Working File) should be flagged and segmented out of the workflow. In this way, Medicare representatives' activities can be reallocated to touching only those accounts which can be resolved during the withhold.

4. 80% of Registration Errors Occur on Approximately 5–10% of Outpatient Population (Unscheduled)

Summary: Most outpatient-related errors (excluding the ED) occur when patients present at the hospital and require a complete registration. Volume, speed, customer service, and lack of patient education are all competing against the registrar when none of the critical data elements are secured prior to care.

By applying an additional 20 percent of patient access staffing to scheduling and/or preregistration, hospital leaders can expect an 80 percent reduction in registration errors for outpatients.

Reporting / Analytic Recommendation: Create a daily report to measure registration errors by level of preprocessing:

1. Fully preprocessed—Accounts with full financial securement and verified demographic information
2. Partially preprocessed—Accounts with some financial securement and verified demographic information
3. New Registrations—Accounts with no financial securement or verified demographic information (this would include the nonscheduled portion of the patient population)

The daily use of this report will reveal that new registrations (mainly nonscheduled outpatient visits) account for a preponderance of fatal errors. The report can be used to make data-driven decisions regarding resource reallocation or segmenting patients by level of preprocessing.

5. Coding Stratification and the 80/20 Rule (Prioritizing Medicare)

Summary: Segmentation and stratification strategies in HIM can benefit greatly from the Pareto Principle. In most cases, coders are evaluated based upon numbers of charts coded and prioritize based upon balance or alpha split, and not on accounts that convert to cash with the greatest rapidity. Moreover, as backlogs occur, coders tend to seek out self-pay patients, which require less documentation for final billing.

Using Pareto, coders should recognize that 70 percent of the most rapid returns occur on 25–35 percent of the Medicare payer mix. When backlogs due to staffing, process, or technology limitations occur, HIM should blitz Medicare to both stabilize and accelerate cash.

Report / Analytic Recommendation: Managing away the self-pay game in HIM is accomplished by two powerful key performance indicators:

Gross revenue to final billed ratio by major payer. This critical KPI measures the movement of accounts from unbilled to final billed against gross charges for the same calculation period. If front-end revenue cycle functions aren't moving accounts into the final billed accounts receivable ahead of the rate of new business, a cash shortfall can be predicted.

This becomes more powerful at the major payer level. Often, this ratio reveals that HIM staff are spending 80 percent of their time to finalize 20 percent of the charts (self pay) while Medicare final billed to gross revenue ratio trends at approximately 75 percent, well below the 101 percent needed to ensure rapid and steady cash conversion.

Unbilled beyond suspense days by payer. This KPI measures accounts that have aged beyond suspense and remain unbilled as a days-in-revenue calculation. Again, 80 percent of these accounts tend to reside within the Medicare receivable.

The daily measurement and management to these KPIs will normalize the flow of accounts to patient financial services and give them the opportunity, when a backlog does occur, to focus on payers with the greatest rapidity for cash. ■

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