

INTRODUCTION

KWS conducted an operational assessment of the Patient Financial Services (PFS) Billing Department at the direction of Sample Medical Center (SMC). During the course of the Billing Department Operational Assessment, we conducted one-on-one interviews with the Billing Manager and various members of the Billing staff. Additional information was obtained by observing the staff and manager under normal working conditions, and through review of billing reports.

The goal of this assessment is to provide SMC with an overview of primary operational issues that SMC needs to resolve in order to improve the management and productivity of the department that in turn would result in improved receivables. Within this report, we believe the key issues were identified; and if resolved, will allow SMC to increase cash collections, reduce expenses and improve the bottom line of the facility.

This report represents an appraisal of the current status of the Billing department, and presents our recommendations for improvement.

Throughout the review, KWS received exceptional cooperation from management, staff and other hospital personnel. In addition, we were given access to essential operational and financial information required to complete our analysis.

Finally, we would like to thank Mrs. Smith and Mrs. Johnson in particular for their participation in setting up appointments, providing workspace, and obtaining data essential to this review.

SUMMARY OF RECOMMENDATIONS

We believe the following seven (7) action items offer the most potential for significant financial and operational impact. Implementation of these items will also lay the necessary groundwork for future incremental improvements.

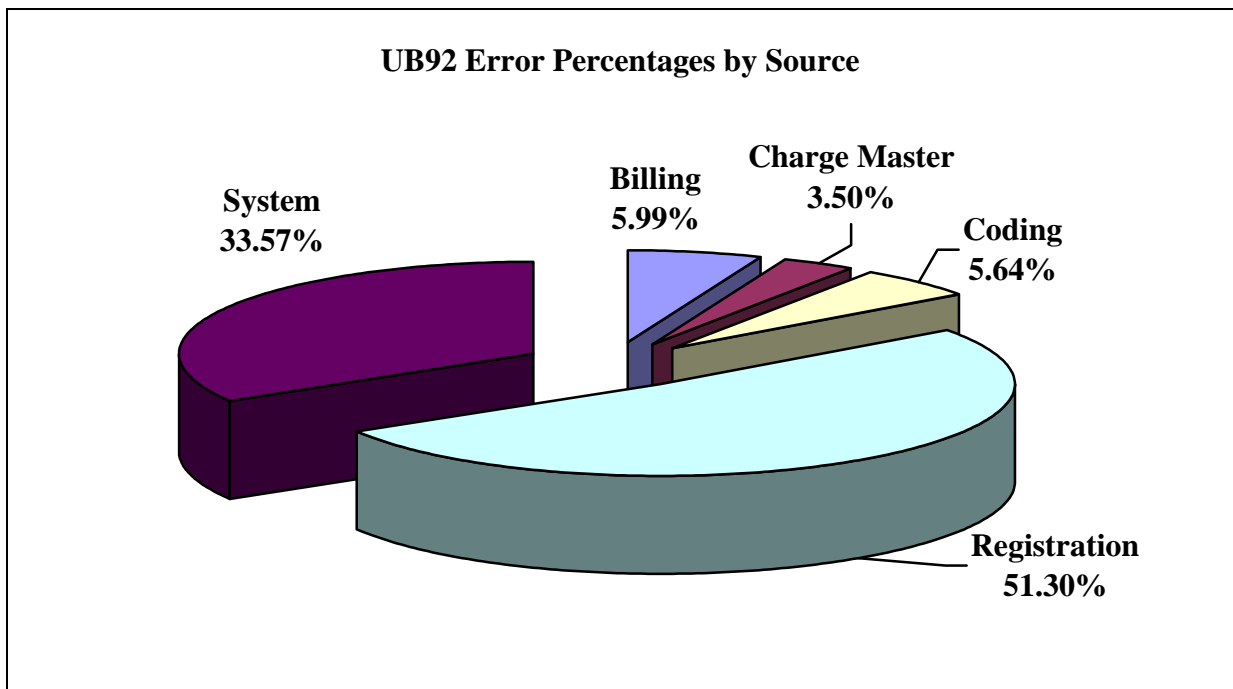
- Conduct operational assessment of all point-of-registration areas to improve the quality of data collection
- Conduct a Charge Description Master (CDM) review to ensure all charges are being captured and all regulatory payer requirements are met
- Maximize the efficiency and quality of SMC claim data generation with resultant improvements in billing efficiencies, reduction of payer denials and accelerated cash flow
- Implement pre-billing function to minimize payer denials
- Develop and improve performance standards and monitoring tools for the Billing staff
- Develop system reports to assist management with the creation of accurate unbilled inventory monitoring and benchmark reporting

LONG-TERM RECOMMENDATIONS:

- Establish a formal on-going training program for department staff in order to improve skill level

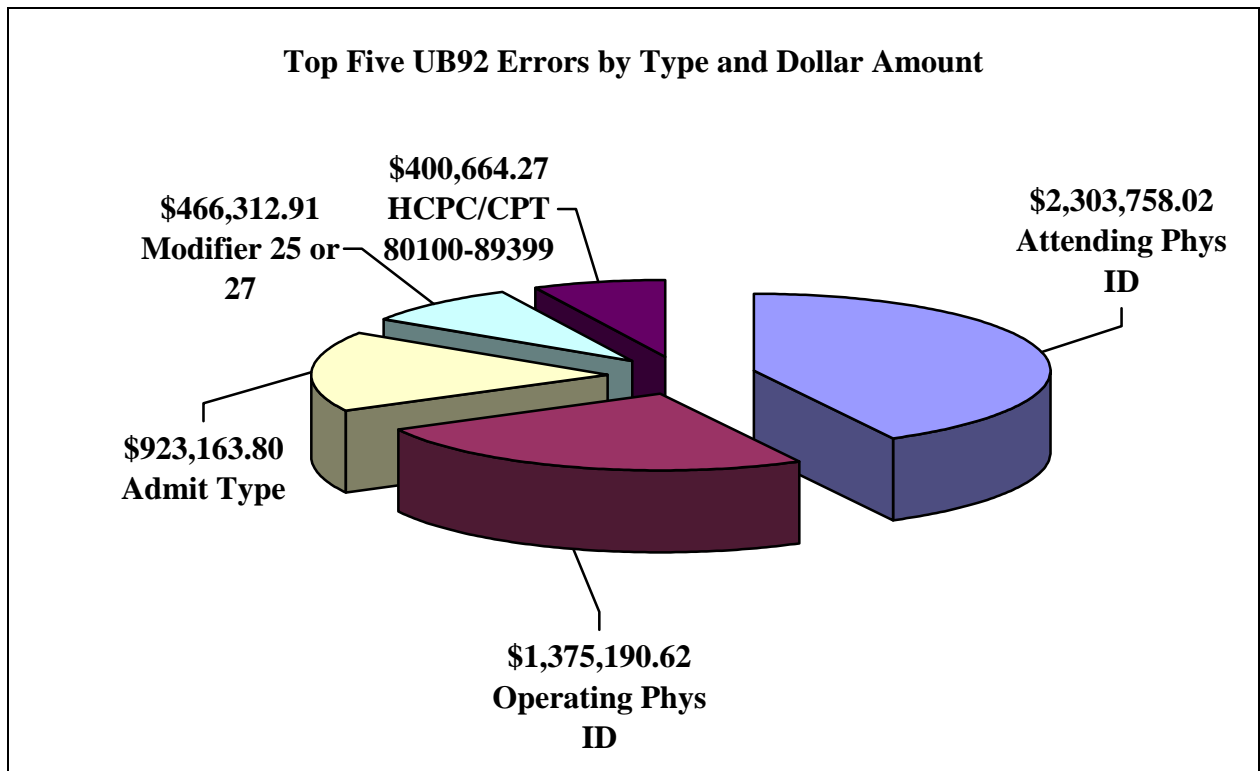
The following details the number of errors by source and related percentages:

Error Source	Error Count	% of Total Errors
Billing	51	5.99%
Charge Master	30	3.50%
Coding	48	5.64%
Registration	437	51.30%
System	286	33.57%
Total	852	



The following details the top five (5) types of errors by source, highest to lowest dollar amount, and percentage of overall rejected claim value:

Error Type	Error Source	Error Amount	% of Total Errors
When the Attending Physician's Name is present, a valid Attending Physician ID Number is required.	Registration	\$2,303,758.02	17.53%
When the Operating Physician's Name is present, a valid Operating Physician ID Number is required.	Registration	\$1,375,190.62	10.46%
Admission type missing.	System	\$923,163.80	7.02%
Modifier 25 or 2 may be required.	Coding	\$466,312.91	3.55%
When the units are greater than one for HCPCS/CPT-4 Codes 80100-89399, review for medical necessity.	Coding	\$400,664.27	3.05%
Total		\$5,469,089.62	

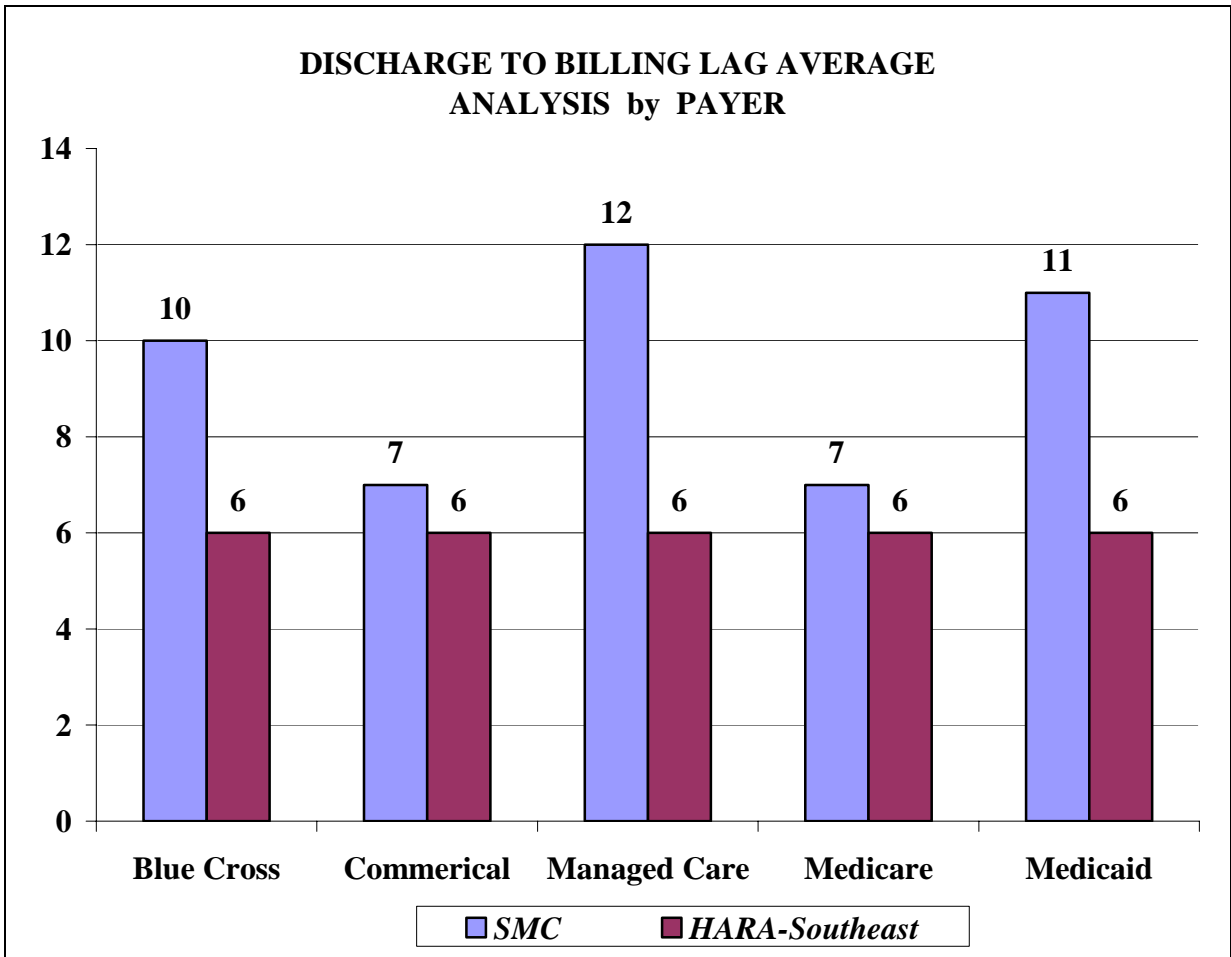


The overall results of the claims analysis indicate that the billing staff is doing a tremendous amount of work prior to sending the claims to the payers.

SECTION 2: BILLING LAG ANALYSKWS

Our review also included a billing lag analysis of thirty (30) random accounts representing multiple account types and major payers to measure the elapsed number of days between discharge and billing. During the review, it became apparent that a significant amount of time elapsed between the discharged date and the final bill date.

Client’s average billing lag (discharged to billing date) for reviewed payers compares unfavorably with HARA’s 2nd quarter 2003 southeast region’s average of six (6) days for Medicare and other payers.



SECTION 3: MONTHLY CLAIM VOLUME ANALYSKWS

The January 2004, Billing Transmission reports were reviewed to identify the typical volume of claims processed in the department.

The review indicated that approximately 34% of the claims required manual intervention due to Errors or being placed on “Hold” pending additional information. The review also indicated that 11% of the claims processed by the department are billed manually via paper.

