The healthcare industry in general and medical groups specifically continue to see changes in every part of their business. Whether it is a declining local economy or federal healthcare reform, medical practices are feeling continuous pressure to perform. Medical practices want to deliver great care to their patients, and they accomplish that every day. Medical practices also want to be successful in the business side of medicine, and this becomes ever more difficult each day.

Medical practices need more cash at their bottom line, and most often they look for that cash in the billing and accounts receivable part of their business. In the last three articles in this series on office financial management, I have presented ways that medical practices can increase their cash at the bottom line. These recommendations have come from the medical practices that I have worked in and from other groups that have shared their stories with me. All of these are proven strategies that are implementable but a practice has to be careful not to make too many changes at one time—you want the changes to stick! Each medical practice knows its strengths and weaknesses and must prioritize where changes can be implemented that will create the greatest results for that individual practice.

In this installment, we continue that dialogue with a focus on charge capture and entry. Located in the middle of the revenue cycle, charge capture is a process that we have been doing since physician billing began. Charge capture is a critical function as it touches 100% of the medical practice’s patient encounters and can be greatly enhanced through the use of technology.

Have you billed for all services provided?

BY SARA M. LARCH, MSHA

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cost of their revenue cycle.

Before we explore charge capture basics, let’s first discuss several variables that will affect charge capture:

1) Is the medical practice receiving charges on paper, electronically, or both? Obviously, a medical practice wants to automate as much as possible and reduce or eliminate paper. In order to do that, a practice needs an electronic solution that will allow the physicians and other billable providers to capture charges all the time (24 x 365). Until the practice accomplishes that, it will have both paper and electronic processes, which creates some inefficiencies within the practice.

2) Is an electronic health record (EHR) system fully implemented and creating suggested charges? It has been documented that a medical practice’s charges will increase when an EHR system is fully implemented. Fully implemented means that all billable providers have access to the EHR or a portable device that syncs with the EHR wherever they provide patient care. If EHRs are off in the medical practice’s future, then other strategies need to be put into place to ensure that all charges are captured.

3) Does the medical practice have more than one location? If so, each location must designate one person responsible for charge capture.

4) Does the medical practice centralize its billing at a location separate from the practice locations or outsource to a billing vendor? If the answer to either is yes, then the medical practice needs to be very clear about who is responsible for charge capture, and all handoffs between the entities (paper or electronic) must be documented and audited regularly.

Based on the medical practice’s answers to the questions above, it will approach charge capture and the recommendations proposed in different ways. As we move through “the basics” and the “contemporary strategies” below, I will mention how these variables may affect the medical practice’s performance.

**Charge Capture: The Basics**

One person is responsible for ensuring all charges are captured at each location where services are provided. For every office location, a medical practice needs to designate one person responsible for ensuring charges captured. Other medical practices will compare on paper the appointment schedule versus the charge tickets completed each day. For inpatient services, surgery/delivery logs, operative notes, and other tools are compared to ensure all charges were captured.

Let’s take some time now to review an actual medical practice example and see how this can assist your medical practice. A large multispecialty physician practice decided to focus on charge capture for an extended time period. It quickly identified several types of services that were chronically not being billed, and it corrected those processes. The practice was aware of several physicians who routinely submitted charges late, and it decided to focus on timeliness of charge capture as delays usually resulted in missed charges. The medical practice asked the question, “Does every physician submit charges every day?” When no one could answer this question, the practice decided to track this for the next 30 days. This large practice (160 physicians) was using a combination of an electronic mobile charge device that the physicians captured charges in and paper charge tickets in some locations.

In order to track this, the team created a spreadsheet showing every physician every day, and tracked outpatient and inpatient charges separately. One staff member devoted time each day to note in the spreadsheet if any electronic charges were received that day and if any charge tickets were received that day. The intent was not to do a full charge audit—other staff and tools were working on that. The intent was to understand the timing of the charges.

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ChARGE CAPTURE

**Charge capture audits are performed daily, weekly, and monthly for all locations and each physician.**

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coming in. When they initially asked the question about whether they received charges from each physician each day, one of their executives responded, "Of course, we are—the physicians are working and getting paid every day!"

Unfortunately, that is not what the study revealed. The results showed that less than 50% of the physicians were turning in charges each day, and it was a different set of physicians each day. This meant that no physician was consistently turning in charges daily. Some physicians did consistently submit 100% of their office charges but their inpatient charges lagged. Can you answer the question about your physicians? If you found these delays, what would you do next?

After the first week, it was obvious that change was needed in this medical practice. E-mails went out to all physicians reminding them that the policy was to submit all charges daily. At the end of the second week, an individual e-mail went out to any physician who did not submit any charges for any three consecutive days, and the physician’s specialty chief was copied. Copying their boss was a motivator. All of a sudden, charges started pouring in to the billing office. The medical practice experienced a huge one-time increase in charges, and subsequently charges continued to be timely. The medical practice continues to audit this aspect of charge capture, and e-mails go out weekly to physicians as needed. Any physicians who do not respond in a timely fashion will have this issue escalated at the end of the month to the physician president, and it will be considered in the physician’s annual evaluation.

Charge lag is measured monthly and reported out to all physicians and staff. The traditional charge lag measures the number of days between the date of service and the date the charge is entered into the practice management system. This should be a regular report available in every practice management system. The report should include office/outpatient charge lag and inpatient charge lag at a minimum. The best practice for total charge entry lag is zero to two days. Office/outpatient charge lag is expected to be zero to one day.

An annual review of all charge capture tools is important. Schedule this review to take advantage of the annual CPT/ICD updates so that all charge capture tools are up to date at all times. Review all paper charge documents (tickets, audit tools, etc.). Review all electronic tools to ensure all physicians are listed correctly and that coding and documentation regulatory updates have been entered. This is a perfect example of how doing it right the first time can save many hours of rework! Put this on your medical practice calendar.

**FIGURE 1**

**Leading Charge Capture Indicators**

| Date of service to date of documentation: | 0 to 24 hours |
| Date of documentation to date of coding: | 0 to 48 hours |
| Date of coding to date of charge entry: | 0 to 48 hours |
| Date of charge entry to date of bill release: | 24 to 72 hours |
| Missing charges for services documented: | 0% |

(Adapted from Keegan DW, Woodcock EW, Larch SM. The Physician Billing Process: 12 Potholes to Avoid in the Road to Getting Paid, 2nd ed. Medical Group Management Association. 2008; 77.)

With EHRs, charge capture will be an outcome of what the physician has documented and not a separate function.

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**Charge Capture: Contemporary Strategies**

EHRs are implemented fully and available all hours of the day for charge capture. As more medical practices take advantage of this new technology, charge capture will be a part of the clinical encounter—an outcome of what the physician has documented and not a separate function. Some EHRs provide charge capture/coding support to physicians in their clinical workflow. In some cases, the charges are pushed to the practice management system, and in others the charges are pulled by the billing office.

Medical practices must review all charges before they are submitted. In the section on the basics, we focused on capturing the charges, but now we want to ramp up the quality. Each medical practice needs to ask itself what percentage of charges—paper or electronic—arrive in the billing office with all required data elements and what resources (staff/time) could be saved if all the charges were complete upon arrival.

A charge is not captured until it is complete, accurate, and entered. Charges that arrive incomplete should be categorized as pending or suspended. Most practice management systems will allow incomplete charges to be entered and then suspend that charge until the required fields are complete. Make sure that you are running a report each week showing the number of suspended charges so they get worked. Best practice medical groups use their practice management system to create as many charge/claim edits as possible to improve the number of clean claims that go out and the percentage of claims that get paid the first time by their payers.

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New charge lag measures should be reported monthly at a minimum. We already mentioned the traditional charge lag measure (date of service vs. date charge entered). Over time, in an effort to understand the reasons for charge lag, new, more discrete measures have been defined and used by many medical practices. Some practice management systems can track these and others require a custom report (Figure 1).

Medical practices are using algorithms to project expected services and creating a variance analysis to find missing charges. Usually using an add-on to the practice management system or working with an external vendor, medical practices are analyzing the charges that have been entered to identify potential missing charges. As an example, for a charge entered for an annual well-woman examination, expected additional services would be blood test, Pap smear, etc. If the medical practice has a laboratory, it would expect to bill for those services for that patient on the same date of service. This kind of exception or variance report will be used to validate whether the additional services were provided; and if so, why the charges were missed. This analysis is still new in medical practice industry, but something we should continue to learn more about.

**Conclusion**

Charge capture is a critical function in the medical practice’s revenue cycle. Managers need to focus on the timeliness and completeness of their charge capture processes. When their charge audits or charge lag reports indicate opportunities for improvement, they should consider whether one of the basics or one of the contemporary strategies discussed in this article can help them improve this part of their revenue cycle.

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