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Revenue Cycle:
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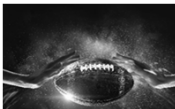


Building a Revenue Integrity Program

Friday, January 18th, 2019
Gillette Stadium Clubhouse

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Senior Manager
Baker Newman Noyes

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This presentation is for general education purposes only.

The information contained in these materials is not intended to be, and is not legal or business advice.

The laws, regulations and policies pertaining to the subject matter of this presentation are open to interpretation.

The regulations and guidance for claims submission and plan coverage vary by payer and state, and the methodology described may or may not be pertinent in all circumstances.

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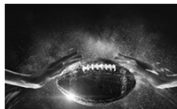


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What is Revenue Integrity?

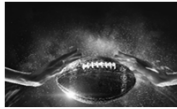
- Merriam-Webster's definition of integrity~ noun
 1. Firm adherence to a code of especially moral or artistic values: **Incorruptibility**
 2. An unimpaired condition: **Soundness**
 3. The quality or state of being complete or undivided: **Completeness**



What is Revenue Integrity in Healthcare?

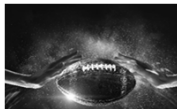
- Means something different to each organization
- Recent HFMA article: "Revenue integrity is the internal process or function ensuring that revenue is accurate in coding, appropriate in charge capture, contains reasonable pricing for services that are being provided, and complies with laws and regulations."





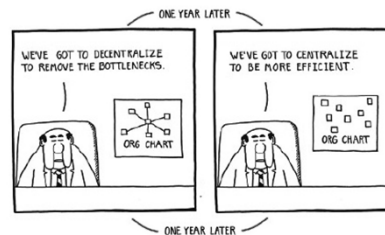
Securing Revenue?

- Healthcare organizations are having a harder time now more than ever to ensure that their revenue is captured appropriately and will not be challenged down the road.
- What is your organization doing to secure their revenue?



Decentralized or Centralized?

- No correct answer: Determine what is correct for your organization
- At a minimum, one person should coordinate
 - Understanding of billing
 - Fundamentals of department operations
 - System interfaces and charge flow
 - Clinical knowledge (if possible)
 - Acts as the bridge between clinical and financial



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Possible Components of Revenue Integrity Team

- Charge capture
- Charge/documentation reconciliation
- Denial management
- Underpayment analysis
- Price definability and strategy
- Chargemaster maintenance
- Documentation Improvement
- Charge audits
- Coding audits
- A/R management
- Late charge reductions

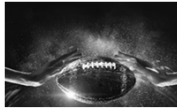


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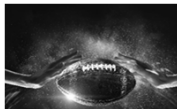


Charge Capture



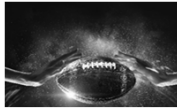
Charge Capture

- Make sure all reportable charges are on the claim!
- What processes and reconciliation processes do you have to ensure charge capture?

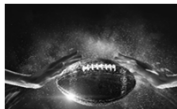
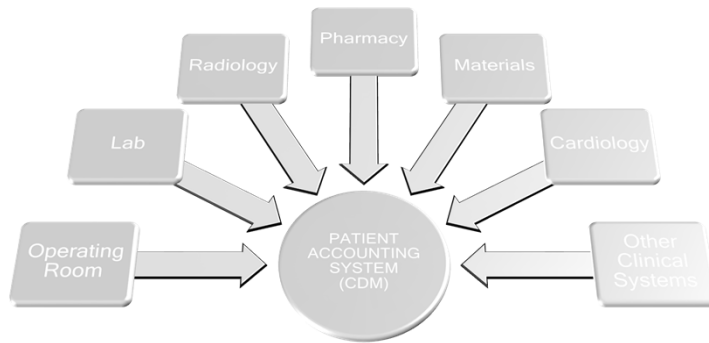


Department Charge Capture

- Assign a revenue steward in each revenue generating department
 - Department subject matter expert who understands the operations of the department
 - Responsible for reconciling charges daily
 - Primary billing contact
- Make sure there are back-up stewards identified. This function should not stop because someone is out on vacation

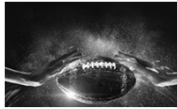


Ancillary Programs



CDM Mapping Multiple Ancillary Systems

- When charges are being entered from ancillary systems, they have to be maintained in BOTH systems
 - Patient Accounting System
 - Ancillary System
- Communication is key between the ancillary department, applications analyst who maintains the software and the person/team who oversees the CDM
- Charges can very easily be missed when communication breaks down



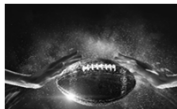
Charge Entry

- There are MANY ways that charges can be entered into a patient's record
 - Often charges are entered in an automated fashion
 - Orders into ancillary systems often create charges
 - Paper charge slips?



KEY POINT!

- Clinical users often do not realize, as they are documenting, that charges are (OR ARE NOT) being created in the background!



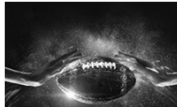
Common Areas of Opportunity/Compliance

- Operating Room
 - Is someone reconciling supplies charged for?
 - Does someone review the operative report for supporting content?
 - Who is informed if the procedure changed from what was booked?
 - Are common CPT code ranges authorized?
- Emergency Room/Urgent Care
 - Are all procedures and chargeable supplies charged for?
 - Facility E/M fee correctly leveled?
 - Critical care?
 - Trauma activation: Are you a licensed trauma center?



Common Areas of Opportunity/Compliance (cont)

- Lab
 - Column 1/column 2 NCCI edits: Are charges being combined appropriately?
 - Reference labs: Timely billed / correct CPT codes
- Physical/Occupational/Speech Therapy
 - Appropriate use of status modifiers
 - Are units supported with documentation (time based codes)?
- HBO: Medical Necessity



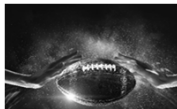
Common Areas of Opportunity/Compliance (cont)

- Materials Management
 - Non-PO items
 - Pyxis: Nursing assigning to "floor"
 - How often are prices adjusted for purchase price?
 - Chargeability threshold? Is it costing you more to track items than the net revenue it's worth?
- Drugs
 - UNITS, UNITS, and did we mention UNITS?
 - Charge on chart vs. charge on dispense?
 - How often are prices adjusted for purchase price?
 - Quarterly HCPC's updates: J-code values often make zero clinical sense
 - Correct NDC



Pharmacy Waste

- Medicare allows for the charging of waste
 - Medicare Claims Processing Manual chapter 17, section 40 Discarded Drugs and Biologicals: “Modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological.”
- Example: Cancer patient on Avastin® (Bevacizumab)
 - Vial: 1,000 mg; patient dosed 950mg
 - Avastin’s® HCPCS: J9035; billed per 10mg
 - In this scenario, we would bill the following:
 - J9035 x 95 (95 billing units x 10mg per unit = 950mg dosed)
 - J9035JW x 5 (5 billing units x 10mg per unit = 50mg wasted)



Common Areas of Opportunity/ Compliance (cont)

- Documentation Improvement
 - Note cloning: PROHIBITED
 - Can each note stand on it’s own?
 - Devil is in the details
- “Incident to Billing”
 - Proper documentation for who performed the initial service?
 - Assurance that follow-up care only?
 - Documentation for where the physician providing general supervision is physically located during the visit?
 - Documentation that the physician is still actively involved?
 - POS correct?

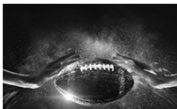


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Charge Reconciling

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Charge Reconciliation

- Why is charge reconciliation so important?
- Systems are so automated now that, without a review of charges, it is very easy to unintentionally make an error or lose revenue
 - Example: Lab Director submits a new test that will be performed. CDM Analyst gets the charge built and the Lab Analyst also builds the test so it can be ordered. The Lab System Analyst forgets to place the CDM number in the field that would make it chargeable.
 - In this example, everything was built, but no charges crossed because the charge was not mapped.





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Charge Description Master

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Types of Charges

- Flat Rate Charges: Majority of CDM
 - Diagnostic and therapeutic
- Time Based
 - Surgical/recovery time, Observation
- Supplies: Gray area for what is considered chargeable
- Pharmaceuticals
- Statistical: Zero dollar charges for tracking purposes only
- Exploding Charges: CDM that automatically generates other CDMs



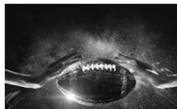
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Routine vs. Nonroutine Supplies

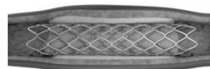


- Routine Supplies: Not separately billable
 - Items are considered floor stock and should not be individually charged
 - Considered to be part of the procedure or Room and Board
 - Organization should have a policy on what they consider nonchargeable and routine
 - Supplies that are customarily used or considered an “integral part” during the course of treatment are considered routine
 - Considerations
 - Should there be a cost dollar threshold? \$5 / \$10 / \$20? Financial analysis should be performed to see what makes sense. Charging for inexpensive items could cost more than not charging for them
 - Items like IV tubing, gauze, gloves, needles, bed pans, patient convenience items should NOT be charged



Routine vs. Nonroutine Supplies (cont)

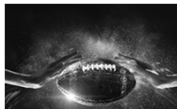
- Nonroutine Supplies: Billable to the patient
 - Can you answer “yes” to the following questions
 1. Is the item medically necessary and specifically ordered by a physician?
 2. Is the item used specifically for and by the patient?
 3. Is the item not commonly furnished as part of a medical procedure or treatment?
 4. Is the item not commonly available for patient use in the medical department or setting?
 5. Is the item documented within the medical record that it was used?





Hard Coding vs. Soft Coding

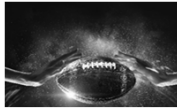
- Hard Coding: CPT® codes are housed directly in the CDM as part of the charge
 - These are CPT® codes that get entered directly on an outpatient claim and can go out the door without coding intervention
 - If not set up correctly, these can cause over/under payments
- Soft Coding: Coding will enter the CPT® code generally through an abstraction process



Pricing

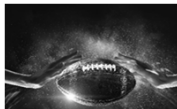
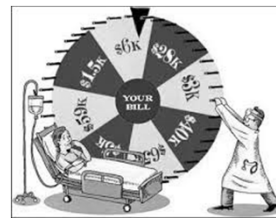
- Is your price defensible?
- Is your price consistent?
 - Does a left hip cost the same as a right hip x-ray?
- Is your price logical?
 - How does the price of CT Scan without contrast compare to a CT Scan with contrast?
- How does the price compare to fee schedules?
 - Are you leaving money on the table?





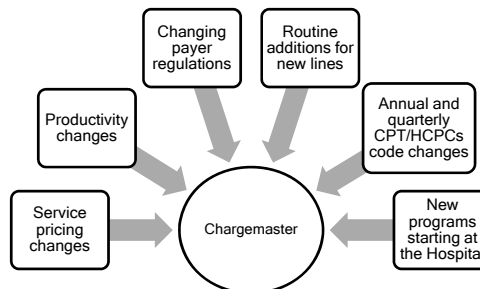
Pricing (cont)

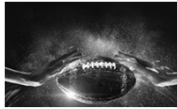
- Are prices related to costs?
 - Medicare paper based manual section 2202.4: “Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.”
- Organizations should have a policy as to how prices are set



Chargemaster Maintenance

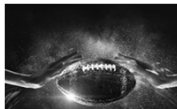
- Maintenance of the Chargemaster
 - Keeping the Chargemaster up-to-date is a major challenge for any healthcare organization, with many internal and external factors impacting the process





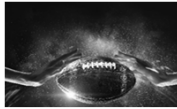
Chargemaster Maintenance (cont)

- Process for Maintenance
 - Centralized
 - Finance, PFS, HIM and Compliance
 - Review, approve and accept (manage the document)
 - Clinical managers
 - New services / updated services
 - Inactive / obsolete services
 - Decentralized
 - Clinical managers “own” their department Chargemaster



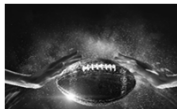
CDM Team Responsibilities

- Quarterly updates
- Annual review
 - Codes released in the Fall to be effective at beginning of year
 - Prime opportunity for annual review
 - Deleted charges: Is there a replacement?
 - New charges: Is that service being performed?
 - Revised Services: Does the way the service is being performed still meet the criteria for the code?
 - Good time to review charge reconciliation procedures
 - Utilization review: Delete items not used during the past 3 years
- Stay abreast of changes
 - Contract
 - Regulatory
 - Clinical



Change Requests

- Are there controls in place?
 - Limited number of individuals should have access to change the master file
 - Separation of duties: Person entering the charges should not have access to change the charges
 - Change request process
 - Form
 - Sign-off from department head, CDM analyst, applications analyst and others if needed
- Is there a policy or procedure?



Biggest Areas of Opportunity

- No charge for the service
- Charges are too high or too low
- Improper revenue or procedure codes
- Obsolete charges
- Pricing inconsistency
- Inadequate charge descriptions
- Miscellaneous charge codes
- Mark-up policies for drugs and supplies



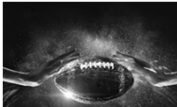
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Coding

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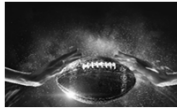


Where Does the Coding Take Place?

- Procedure
 - Most OP CPT coding happens as a function of charge entry from the CDM
 - OP surgical/procedure CPT coding often abstracted through coding
 - IP procedure ICD-10-PCS coding will happen through coding
- Diagnosis
 - Majority abstracted through coding
 - Computer-assisted coding (derived from documentation or orders)
 - Physician pass-through (physician selects as part of encounter)

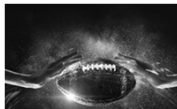


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Accuracy

- ICD-10-CM is not that old!
- How accurate is coding?
 - Does your compliance program have an internal audit program?
 - External audit?
- Are coders supported for continuous education?
- Are there accuracy and productivity standards?



Medical Record Completion

- Medical record completion can be one of the largest lags that inhibits coding to be able to code the chart
- What are the timeframes for record completion?
- Are hospital by-laws for record completion enforced?
- How does the organization track incomplete documentation?



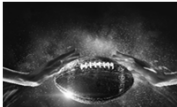
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Claim Generation

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Claim Scrubber

- Most organizations have a claim scrubber
- Application where staff will modify claims to ensure faster payment
- Best practice is to have coding work any edits that require looking into documentation
 - Column 1/Column 2 edits
 - Medically Unlikely Edits (MUE)
 - Medicare and other specific insurance edits
 - CPT[®] mismatch



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Selected Billing Requirements

Up-to-Date and Current


- CMS Transmittals and Change Requests
- Formalize process

LCD and NCD compliance


- Written Policies and Procedures governing coverage of services
- Documentation requirements

Coding

- Coding accuracy
- CPT/HCPC
 - Hard/Soft coded
- Modifiers
- Who is assigning?


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Change Management

Hospitals participating in the Medicare program are challenged by the complexity and design of the Federal Program

- Developing a solid knowledge base
 - Currently there are 21 on-line manuals that exist on the CMS website providing information that establishes a foundation for hospitals in managing their compliance with the Medicare program
 - Five manuals are core in applicability to your responsibilities
 - Eligibility
 - Benefits
 - Claims
 - Medicare Secondary Payer
 - Coverage policies


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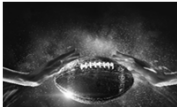


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Denial Management

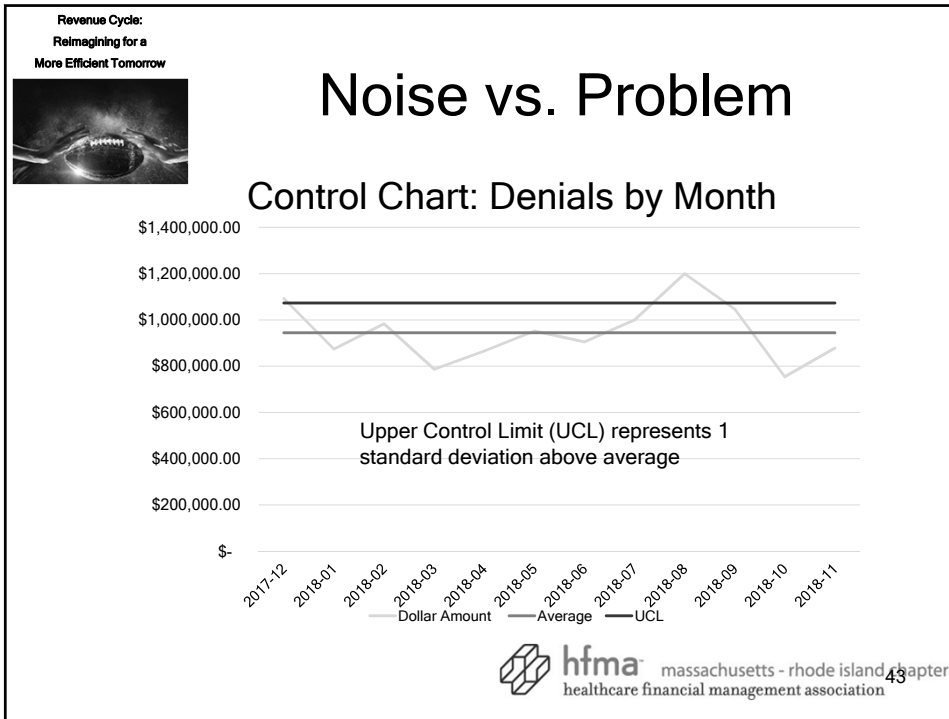
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Denial Management

- Denial reporting is an excellent way to hone in on what areas need focus
 - Documentation improvement
 - Authorization
 - Medical necessity
 - Non-covered services
 - Registration errors
- Creating dashboards for departments to track progress or identify issues early





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Control Charts: Reaction Plan

- Control charts provide the ability to react utilizing data vs. emotion
- Internal constraints can be set
 - Examples:
 - If more than 2 months are increasing, root cause analysis will occur
 - If a data point goes above UCL, a formal corrective action plan will be created with weekly check points
 - If 2 data points are above UCL: Every denial is reviewed, with weekly reports to CFO
 - Etc...

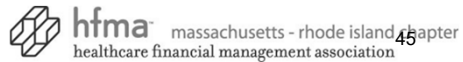
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Denial Management (cont)

- Appeals
 - Who is doing them
 - How many levels are available
- An experienced RN can provide clinical knowledge when appealing a claim to justify why a service was performed
- Often these days, just sending in an appeal form will trigger an automatic denial

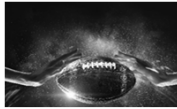


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Payment Analysis



Payment Analysis

- Contracts from providers are complex and are highly variable
- Some plans may calculate payment manually
- Payment review will often pay off!
 - Computer software
 - Manual review (internal / external)
- Follow-up is key!



Selecting the Correct Insurance

- An Organization's payer master can be complex
 - Understand what the most common insurances in the area are
 - There should be continuous communication with patient access staff, when modified
- Selecting the wrong payer could lead to reporting errors
 - Is the correct A/R rep following up on the claim?
 - Is the contract management system calculating expected reimbursement correctly?





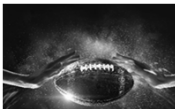
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Self Auditing Programs

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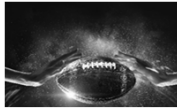
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Audit

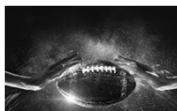
- The best way to identify opportunities is to create an audit plan
- Relationships should be complementary, not adversarial
- Best practice
 - Create calendar of departments to audit
 - Randomly select sample of claims (30 ideally)
 - Compare final paid claim to documentation that supports charges
 - Create report and discuss with stakeholders
 - Develop corrective action plans





Benefits of Routine Monitoring/Identification of Compliance Risks

- Educated / informed staff
- Prevent problems
 - Government audits and large pay-backs
- Mitigates problems at an early stage in development
- Can reduce possible penalties if and when problems are found
- Can influence the government's decision to prosecute or levy penalties and sanctions
- Promotes comprehensive and ongoing review of hospital billing practices
 - Supports work quality and efficiencies



Areas of Vulnerability

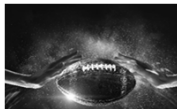
- What to review....
 - OIG Workplan high utilization / high dollar services
 - Hospital concerns / trouble spots
 - Incorrect coding resulting in overpayments
 - » CPT/HCPCS/ICD-10
 - » CPT/HCPCS modifiers
 - Incorrect claim preparation and submission
 - » Noncompliance with CMS instructions
 - » Complexity of billing instructions
 - New Medicare benefit categories
 - Non-covered services billed as covered
 - » LCDs/NCDs
 - » Statutory exclusions





Compliance Program Design (cont)

- Medicare related reviews/probes in Region 1 of late have included:
 - Inpatient short stays: 2 midnight rule!
 - Inpatient same-day discharges and readmissions (UB Condition code B4)
 - Inpatient claims billed with high severity DRG codes, 96 hour vents, sepsis, malnutrition
 - Inpatient claims paid in excess of charges: Outliers
 - Outpatient claims billed with/without appropriate reimbursement-related modifiers
 - Outpatient claims billed during inpatient stays: 3 day window
 - Outpatient evaluation and management services billed with surgical procedures: Modifier 25 reporting
 - Outpatient dental services: Lack of clarity
 - Physician critical care billing: Documentation not supporting
 - Untimed therapy (excessive units): Undocumented
 - Inpatient psych: Medical necessity
 - "Incident to" billing unsupported by documentation



Medical Devices: Warranty and Replacement

ISSUE

- Inpatient and outpatient claims for replacement of medical devices must comply with Medicare billing regulations
 - Medicare is not responsible for the full cost of the medical devices when partial or full credits are applicable
 - Recalls
 - Warranties

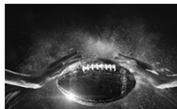
CONSIDER

- Hospital process associated with identifying patients who are receiving medical devices as a results of warranty or recall issues
 - Collaboration and communication between PFS, HIM, OR and central supplies
 - Modifier FD with Value code 49 and/or 50
- Test current processes
 - Review claim submissions for appropriate coding and modifier reporting



Advanced Beneficiary Notices (ABN)

- An ABN is a written notice (CMS R-131) given to a traditional Medicare patient before medical items or services are provided, when the Medicare provider believes the services are not covered
 - Informs the patient that Medicare will not pay
 - Allows the patient to make an informed consumer decision
 - Allows the patient to better participate in health care decisions
- Form must be verbally reviewed with the patient or his/her representative
- Form must be signed, and the original notice retained



Changes / Errors

- Keep a central repository/log of all changes to the CDM
 - Knowing why a change was made or who wanted it changed is important for future reference
- Keep a central repository of any errors uncovered
 - What was the error?
 - How was it discovered?
 - How fast was it corrected?
 - Did any amounts billed have to be refunded?
 - Reasoning behind why corrected claims did or did not have to be filed

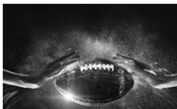


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Revenue Integrity Key Performance Indicators (KPI's)

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Revenue Integrity KPI's

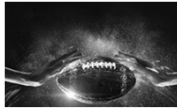
- HFMA's MAP Keys provides that the following are KPI's that are associated with revenue integrity
 - Days in total discharge not final billed (DNFB)
 - Late charges as a percent of total charges
 - Denial write-offs as a percent of net revenue





Days in Total Discharges Not Final Billed (DNFB)

- Purpose: Trending indicator of claims generation process
- Value: Provides indicator of revenue cycle performance and can identify performance issues impacting cash flow
- Calculation:
$$\frac{\text{Gross dollars in AR (not final billed)}}{\text{Average daily gross revenue}}$$



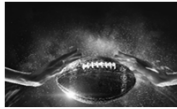
Late Charges as Percent of Total Charges

- Purpose: Measurement of revenue capture efficiency
- Value: Identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance and accelerate cash flow
- Calculation:
$$\frac{\text{Charges with post date greater than 3 days from service date}}{\text{Total gross charges}}$$



Denial Write-Offs as a Percent of Net Revenue

- Purpose: Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount
- Value: Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
- Calculation:
$$\frac{\text{Net dollars written off as denials}}{\text{Average monthly net revenue}}$$



Questions??



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