Critical Access Hospital and Rural Health Clinic Conference

Build Your Way to a Healthy Revenue Cycle

September 14, 2017

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

AGENDA

- Denial Management
- Underpayments
- Claims Review – "Embryo to Grave"
- Revenue Cycle Committee
- A Healthy Chargemaster

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Denial Management and Underpayments

Denial Management

- The goal of denial management is to manage denials on the front end by billing accurate and timely claims.
- A good denial management program can lead your facility to a path of compliant claims where the denials are payor errors versus facility errors.

Denial Management

We are finding that more and more claims are denied by the payors for erroneous reasons. This is adding more complexity to the denial management process.

- Technical denials – Are most commonly processed by patient accounting, coding, or registration areas and are usually the result of a preventable or clerical error. Common denials include:
  - Qualifying visit codes/Missing modifiers
  - Insurance coverage issues
  - Timely filing
  - No authorization
- Most of these denials can be corrected without filing an appeal and are preventable.

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Denial Management

Clinical denials – Are reviewed first by HIM for potential code assignment and escalated if necessary to an RN or clinician.

- Common denials include medical necessity, which often requires an appeal that should be prepared by a clinician.
  - Provider documentation issues.
  - Incorrect assignment of diagnosis and/or procedure codes.

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Denial Management

Workflow

The workflow for denial management and reporting is largely based on the health information system and its capabilities. Below are a few components:

- The denials should come into work queues or be assigned to staff dependent on skill and the resources of the health information system.
- Processes for getting denials to other departments, e.g., HIM, Admissions, and clinical staff, need to be developed, implemented, and documented in policy.
- Processes and procedures for working denials, including time frames, identification of responsible staff dependent on denial type, should be implemented and documented.

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Denial Management

- Reporting, Process Improvement, and Monitoring
  - Reporting will need to be developed based on the health information system's capabilities.
  - Reporting will be used for determining trends, monitoring improvements, and reporting to the various departments and committees.
- Report development – Recommended data parameters:

Patient Name	Account Number	Adm & Dsch Date	Patient Type
Financial Class	Total Charges	Denial Code	Denial Description
Denied Amount	Appealed (Y/N)	Adjusted Payment	Account Balance

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Denial Management

Team Development

The charter of the team is to:

- Review denial reports
- Look for trends
- Perform root cause analysis on preventable denials
- Make necessary policy and procedure changes
- Monitor progress
- Report improvements

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Underpayments

Underpayments

Most CAHs and RHCs either do not have contract management software or lack the staff necessary to maintain this type of system.

Contract Negotiations

- Contract negotiations should not be done in a silo.
  - Know your patient population profile, payers, market dynamics, and internal struggles with contract terms
- Create a strong internal communication system for your contract negotiator.
  - Bidirectional feedback
- Contract terms should be clear and concise, and revenue cycle staff should be educated on executed payer contracts.
  - Timely filing, appeals, payment methodologies

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Underpayments

Identifying Underpayments

For those facilities with no contract management system, identifying underpayments can be a much larger task and will rely on a combination of people, process, and technology.

- Look for denial trends, e.g., chest x-ray in ED suddenly being denied by a payer.
- Since CAHs are reimbursed on an inpatient per diem and an outpatient percentage of Medicare, put a process in place to ensure all Medicare reimbursement is accurate. A monthly report can easily be developed to accommodate this.
- RHCs need strong reconciliation processes in place for ensuring that payment has been received for Managed Medicaid.

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Underpayments

Identifying Underpayments (Continued)

- Any other payers that are reimbursed either on an inpatient per diem or a percentage of billed charges can be added to the Medicare report.

Payers that reimburse on fee schedules, MS-DRG and/or APR DRGs

- Important for CAHs to load the appropriate weights into their encoder and compare payments to what the encoder estimated.
  - Need to ensure that weights are updated appropriately on an annual or quarterly basis if needed.
- With fee schedules, you will need to rely on your denial management program whether from a contract management system or a report developed internally.

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Underpayments

Following are some underpayment denials:

- Line item denials
- Authorizations
- Charge capture
- E&M levels

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Questions?

Claims Review Program

"Embryo to Grave"

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Claims Review – "Embryo to Grave"

In the health care industry today there are so many rules and regulations facilities must follow in order to stay complaint; it is overwhelming!

- Hospitals are required to have a Quality Assurance Performance Improvement (QAPI) plan.
- RHCs are required to have an annual program review.

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Claims Review – "Embryo to Grave"

- Our "Embryo to Grave" program meets several departments' QAPI and program evaluation initiatives and also serves to address other concerns such as:
  - New regulations
  - Charge capture
  - Over and underpayments
  - Billing compliance issues
  - Admission compliance issues
  - Documentation issues
  - Coding issues
  - Chargemaster issues

Claims Review – "Embryo to Grave"

- To build the program, we recommend you start with a team. The team would consist of the following, at a minimum:
  - Revenue Cycle Director
  - Patient Access Director
  - HIM Director
  - Patient Financial Services Director
  - Utilization or Case Management
- Next, you would build a worksheet based on the items that you want to review. The graph on the next slide has suggestions for the different areas. We suggest you consider the following but remember that this project is based on QAPI as well and should incorporate known problems specific to your hospital.
  - The spreadsheet can be changed based on your QAPI or a new regulation you want to monitor in a specific area.

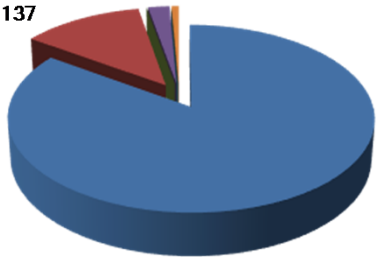
Claims Review – "Embryo to Grave"

Your spreadsheets should be built with simple dropdown menus.

- Example: Documentation area – Build data parameters where every field can be measured with a menu of key values that can produce simple pie charts or graphs for reporting.

Revenue Code Findings

Revenue code supported	85%	116
Recommend more specific	12%	17
Supports a different code	2%	3
S/B routine supply	1%	1
Total	**100%**	**137**



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Claims Review – "Embryo to Grave"

- Choosing your claims to review:
  - No more than 30 claims per quarter
  - Zero balance claims from the previous quarter
- In order to identify trends, we suggest that Inpatients, OP surgery, and ED claims are reviewed every quarter and other ancillary departments are reviewed on a rotating system based on the services your hospital provides.
  - Always keep in mind, if there is a regulation change that you want to monitor, consider adding it to the mix.
  - Example: CPT code changes - 73550 Femur two view was replaced with 73551 Femur one view and 73552 Femur minimum of two views on 12/31/15.
  - Accounts need to be chosen on as random as possible a basis in order to keep out any bias.

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Claims Review – "Embryo to Grave"

- Once the accounts for the quarter have been chosen, each area will be supplied with the initial spreadsheet filled in with the patient name, encounter/account number, and date of service. Each department would have someone assigned to fill and analyze their portion of the spreadsheet.
- The spreadsheet should be a shared file in order for the various departments to audit independent from one another in their own time.
- A time frame for completion must be established and respected.
- Responsibility must be assigned to compile the data and provide it to QAPI and any other committees designated. We suggest the Revenue Cycle Committee.

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Claims Review – "Embryo to Grave"

- A policy and procedure for this process must be developed.
- Longer term improvements identified would be handled as part of the QAPI process.
  - Easy or short-term improvements would be reported in QAPI but may be monitored through a key performance indicator (KPI) in the Revenue Cycle Committee.

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Questions?

Revenue Cycle Committee

Revenue Cycle Committee

Revenue Cycle Committee (RCC)

Communication is key in hospitals today, and RCCs have become necessary. The key components to a successful RCC include the following:

- Keep the committee small with permanent staff from the revenue cycle areas and invite other hospital representatives as the agenda indicates.
- Manage by Key Performance Indicators (KPIs).
- Roundtable every meeting and provide a safe environment for staff to communicate.
- Review monthly Med Learn bulletins, Medicaid bulletins, and monitor other payer websites and correspondence for changes on the horizon.
- Develop subcommittees for issues and projects that are complicated and need attention; then update the RCC on progress and decisions made.

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Revenue Cycle Committee

Revenue Cycle Committee (RCC) (continued)

- Consider incorporating the denial management team.
  - Discuss and plan for new legislation and reimbursement models:
    - HHS HCCs
    - American Health Care Act
    - Provider-Based Clinics

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Revenue Cycle Committee

- List of common KPIs

Patient Access	Best Practice	KPI formula
Inpatient Admission Error Ratio	1.0%	Inpatient registration errors/Total inpatient charts
Outpatient Registration Error Ratio	1.0%	Outpatient registration errors/Total outpatient charts
Total POS collections for the month	TBD	Total cash collected at time of service (POS)
Average POS collections as a % of goal	TBD	POS collections/POS collection goal
% collected compared to potential	90%	POS collections/POS collection potential (this is based on monies that were eligible for collection at POS)
# of pts qualifying for sponsored programs	TBD	How many patients were converted from self-pay to a sponsored program.
Utilization Management	**Best Practice**	**KPI formula**
Observation appropriateness	95%	Incorrect Observation admissions/Total Observation admits
30 day readmits (all diagnoses)	10%	How many inpatient admissions were readmitted within 30 days
Overall rate of appeals overturned	TBD	Successful appeals/Appeals written
Health Information Management	**Best Practice**	**KPI formula**
% of charts reviews resulting in a query	20%	Queried charts/Total admissions
Query response rates	98%	Number of query responses/Queries sent
Coder Productivity - Outpatient	20 per hour	# of inpatient accounts coded per day by coder
Coder Productivity - Inpatient (initial)	3 per hour	# of inpatient accounts coded per day per coder
IP Coding Accuracy	97%	Coding errors/# of outpatient admissions
Days in Discharged, Not Final Coded (DNFC)	4	Discharged but not coded claim $$/Average daily revenue
Deficiency Rate	10%	# of charts with deficiencies/Total charts

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Revenue Cycle Committee

- List of common KPIs (Continued)

Denials	Best Practice	KPI formula
Overall Denial rate as a % of gross revenue	3%	Denial $$/Gross revenue
Overall rate of appeals overturned	60%	Successful appeals/Appeals written
Average admin denials follow-up success rate	98%	Overturned admin denials/Total admin denials
Average under payments follow-up success rate	98%	Overturned underpayments/Total underpayments
Patient Financial Services	**Best Practice**	**KPI formula**
Total Discharged, Not Final Billed (DNFB)	5	Discharged but billed $$/Average daily revenue
Average Clean Claims Pass Rate	TBD	Claims passed through billing without touching/Total claims
Average Rejection Rate	2.0%	Payers rejected claims/Total claims submitted to Payers
Days in AR (Net)	40	Average daily revenue/Total Net AR
AR >90 as a % of billed AR	20%	Percent of AR over 90 days/Total AR
$s in Credit Balance AR	TBD	Dollar value of credit balances
Days in Credit Balance AR (gross)	<1	Credit balances/Average daily revenue
# Late Charge Encounters	TBD	# of accounts that incur late charges
Bad Debt as a % of gross	4%	Bad debt write-offs/Gross AR
Charity as a % of gross	3%	Charity care write-offs/Gross AR
Cash Collections as a % of Goal	100%	Collections/Collections goal
Collections agency success rates	TBD	Cash collected from agency/Agency inventory
% of self-pay accounts with no collections	10%	Number of self-pay accounts with no payments/Total self pay accounts
$ value of self-pay accounts with no collections	$0	$ value of self-pay accounts with no collections

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Questions?

Healthy Chargemaster

Healthy Chargemaster

- The Charge Description Master (CDM) has evolved from a tool to manage inventory with a minor role in billing to one primarily organized to support the creation of clean claims.
- Some health information systems still use the chargemaster as an item master that contains charge codes, billing codes, inventory items, and statistical monitoring items.
  - Maintaining a CDM that supports all these functions increases its complexity and often is not in sync with the functions provided by the billing system vendor.
  - Often interfaces with order entry systems and ancillary systems, which increases the potential for **incorrect** charge information to flow to the patient bill.

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Healthy Chargemaster

- Suggestions:
  - Identify the CPT/HCPCS changes you will need to make when they are announced in October for the January 1 effective date each year.
  - Review and discuss major revisions with impacted clinical departments.
    - Deletions, revisions, additions
  - Review high volume services to assess how current charges compare with proposed payment Medicare/Medicaid reimbursement amounts.
  - Review mark-up strategies for continued relevance.
  - Review supplies and other items charged separately to assess whether they should continue to be charged separately or incorporated into another service.
    - Ensure that this has been done through a committee like an RCC so that all parties understand and know the changes and all systems are updated, not just the CDM, and communicated **to stakeholders**.

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Healthy Chargemaster

You must consider the following when updating CPT/HCPCS:

- Ancillary ordering systems for departments like lab, radiology, pharmacy, PT, clinics, etc.
- Physician order forms with pre-printed CPT codes
- Superbills/charge tickets
- Order sets in the electronic medical record
- Interface with the clinical side of practice management systems

Healthy Chargemaster

Develop a process for new services and separately chargeable items. This would include a form with the following parameters:

Demographic and requesting department data

To: CDM Coordinator	Medical Supplies - Instructions for Completion
Date Requested:	*A. In the **"Comments"** section below, please note any special instructions for processing your request.*
Requestor Name:	*B. In the **"Charge Master Description"** box below (max 30 characters), describe the item.*
Dept Name/Nbr:	
Phone Number:	*C. If the item described is a kit or a bundled supply (not pre-packed), you must document the cost of each item contained in the kit.*
Email Address:	
Effective Date:	

	Requesting Department to Complete									EA
	A=ADD C=CHANGE D=DELETE	Vendor Name	Vendor Item Number	Vendor HCPCS No:	Materials Management #	Indicate (S/N) Sterile = S Non-Sterile = N	Implantable Yes (Y) No (N)	Disposable Yes (Y) No (N)	Medical Supply Cost	Unit
1	A=ADD	Synthes	390.005		000012025	Sterile = S	Yes (Y)	No (N)	827.00	EA

Healthy Chargemaster

CDM Coordinator data, reviewers, and approvals:

CDM COORDINATOR						
Item #	UB04 Rev Code	CDM Description '(Limit to 30 Characters)	HCPCS Code *(If applicable)*	CDM Use Only		
			NA	Mark-up	Calculated Charge	Dept Budget
12025		Combination Clamp, Large	NA	3	2,481.00	

Reviewer/Date	Notes	Additional Information Request:
CDM Coordinator		
Entry into System		
Dept Notification		
Update Order Entry/Form		
Send to Order Entry		

Approved date: _____

Approved By: _____

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Healthy Chargemaster

- Ensure an open line of communication with Patient Financial Services.
- Participate in Revenue Cycle committee like RCC and Denials Management.

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Conclusion

- Institute a robust denial management program that also addresses underpayments
- Develop an "Embryo to Grave" quarterly claims review process tied to your facility's QAPI or annual evaluation
- Develop a functional Revenue Cycle Committee
- Maintain your CDM

You will be on your way to a healthy revenue cycle!

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Questions?

Thank you!

Today's Presenters:

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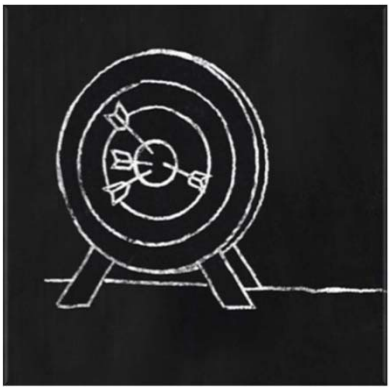

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