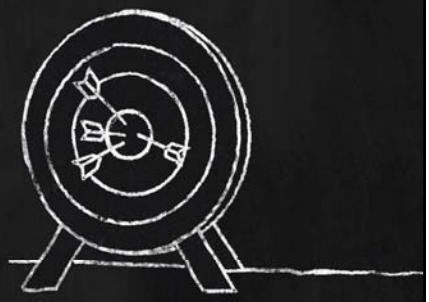
Critical Access Hospital and Rural Health Clinic Conference

Build Your Way to a Healthy Revenue Cycle

May 4, 2017



WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

AGENDA

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

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HEALTH CARE PRACTICE

Denial Management and Underpayments

Denial Management

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

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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 error or clerical error. Common denials include:
  - Missing modifiers
  - Insurance coverage issues
  - DOFR disputes between medical group and health plan
  - 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.

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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. A few components are:

- The denials should come into work queues or be assigned to staff depending on the current workflow processes in place.
- 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 and identifying responsible staff dependent on denial type.

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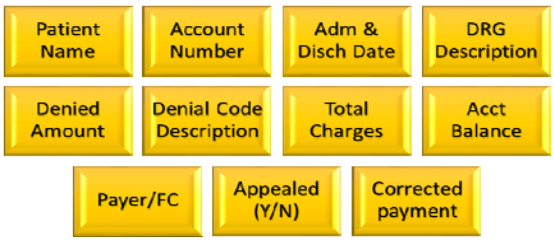
Denial Management

- 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:



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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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Denial Management

Following are denial examples:

- Division of financial responsibility between the medical group and the payor
- Medical coverage
- Inappropriate use of denials by payors
  - Medicare Advantage payors denying entire claim for using unspecified diagnosis code

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Underpayments

Underpayments

Most critical access hospitals either do not have contract management software or lack the staff necessary to maintain this type of system. This is an area where revenue can suffer.

Contract Negotiations

- Should not be done in a silo. It is important to understand patient population profile, payor, and market dynamics of your area.
- Create a strong internal communication system for your contract negotiator.
- Ensure contract terms are clear and concise.
  - 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. Below are some suggestions:

- Look for denial trends, e.g., chest x-ray in ED suddenly being denied by a single payor.
- 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.
- Any other payors that are reimbursed either on an inpatient per diem or a percentage of billed charges can be added to the Medicare report.

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Underpayments

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

- Important to load the appropriate weights into your encoder as well as billing system and compare your payment to what the encoder estimated and fee schedules you will need to rely on for your denial management program.
  - Need to ensure that weights are updated appropriately on an annual or quarterly basis if needed.

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Underpayments

Following are some underpayment denials:

- Line item denials
- Authorizations, maximum limits
- E&M levels
- Nursery levels

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Questions?

Claims Review Program

"Embryo to Grave"

Claims Review – "Embryo to Grave"

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

- Hospitals are required to have a Quality Assurance Performance Improvement (QAPI) plan.

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Claims Review – "Embryo to Grave"

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

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Claims Review – "Embryo to Grave"

- To build the program, we recommend you start with a team. The team would consist, at minimum, of the following:
  - Revenue Cycle Director
  - Patient Access Director
  - HIM Director
  - Patient Financial Services Director
  - Utilization or Case Management Director
- 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.

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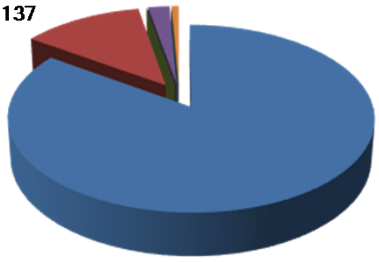
Claims Review – "Embryo to Grave"

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"

- When choosing the claims to review, select:
  - No more than 30 claims per quarter.
  - Zero balance claims from the previous quarter.
- In order to identify trends, we suggest that inpatient, OP surgery, and ED claims be reviewed every quarter and other ancillary departments be 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, you should 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 a basis as possible 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 names and will be responsible for auditing 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 to submit it to QAPI and any other committees designated. We suggest the Revenue Cycle Committee.
- A policy and procedure for this process must be developed.
- Longer term improvements identified should 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 of a successful RCC include:

- 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, provide a safe environment for staff to communicate.
- Review monthly MedLearn bulletins, Medicaid bulletins, and monitor other payor 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)

- 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

Owner	Metric	Best Practice
CM	Observation appropriateness - all	95%
CM	30 day readmits (all diagnoses)	<18%
CM	% needs assessments completed in 2 days	95%
HIM	% of charts reviews resulting in a query	20%
HIM	Query response rates	98%
HIM	Coder Productivity - ED (initial)	36-40/day
HIM	Coder Productivity - OutPt (initial)	150-230/day
HIM	Coder Productivity - InPt (initial)	23-26/day
HIM	ED Coding Accuracy	95%
HIM	OutPt Coding Accuracy	95%
HIM	InPt Coding Accuracy	95%
HIM	Days in Discharged, Not Final Coded (DNFC)	4
HIM	Delinquency / Deficiency Rate	< 5%
HIM- Denials	Administrative/Technical Denials ($)	<1.5%
HIM- Denials	Clinical Denials ($)	<1.5%
HIM- Denials	Average clinical denials follow-up success rate	95%
Patient Access	Denial rate for decentralized registrations	1-2%
Patient Access	Denial rate for centralized registrations	1-2%
Patient Access	Admission Error Ratio	< 1 - 2% error
Patient Access	Total POS collections for the month	$580,000
Patient Access	Average POS collections as a % of goal	100%
Patient Access	POS collections as a % of total Self Pay collections at PFS	
Patient Access	% collected compared to potential	N/A
Patient Access	Associated rate of pts qualifying for sponsored programs	
Patient Access	# of "status change" requests without an order	N/A
PFS - Billing	Total Discharged, Not Final Billed (DNFB)	5
PFS - AR	Days in AR (gross)	< 52 Days
PFS - AR	AR >60 as a % of billed AR	75%
PFS - AR	AR >90 as a % of billed AR	15%
PFS - AR	AR >120 as a % of billed AR	10%
PFS - Bad Debt	Bad Debt as a % of gross	<4%
PFS - Billing	Discharged, Coded, Not Final Billed (DCNFB)	5
PFS - Billing	Clean Claims Pass Rate	> 95%
PFS - Collections	Cash Collections as a % of Goal	100%
PFS - Collections	Collections agency success rates	
PFS - Collections	% of self-pay accounts with no collections (payments)	
PFS - Credits	Days in Credit Balance AR (gross)	
PFS - Credits	$s in Credit Balance AR	
PFS - Denials	Denials due to timely filing	
PFS - Denials	Average underpayments follow-up success rate	
Rev Integrity	Late charges as a % of total charges (includes corrected charges)	<2%

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Questions?

Healthy Chargemaster

Healthy Chargemaster

- Charge Description Masters (CDMs) have evolved from a tool to manage inventory with a minor role in billing to a tool primarily organized to support the creation of clean claims.
- Some health information systems still use the chargemaster as a 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 to order entry systems and ancillary systems increase the potential for clean 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 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 a RCC so that all parties understand, know the changes, and all systems are updated (not just the CDM), and changes are communicated.

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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

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Healthy Chargemaster

Develop a process for new service items. This would include a form with the following parameters:

Demographic and requesting department data

To: CDM Coordinator	
Date Requested:	
Requestor Name:	
Dept Name/Nbr:	
Phone Number:	
Email Address:	
Effective Date:	

Medical Supplies - Instructions for Completion

*A. In the **"Comments"** section below, please note any special instructions for processing your request.*

*B. In the **"Charge Master Description"** box below (max 30 characters) describe the item.*

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.

	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:	

Healthy Chargemaster

- Ensure an open line of communication with Patient Financial Services.
- Participate in Revenue Cycle Committee and denial 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 hospital's QAPI.
- 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?
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Thank you!
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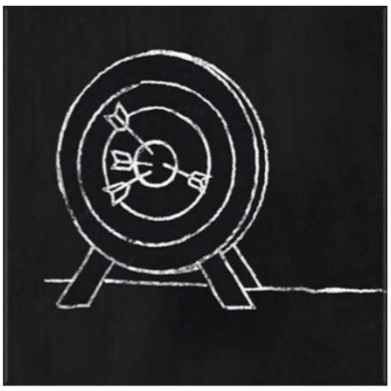

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