AHIMA Distance Education

HIM in the Revenue Cycle: What You Need to Know to Talk to Your CFO

Audio Seminar/Webinar

February 5, 2009

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Faculty

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At The End of this Seminar You Should be able to:

- **Identify how HIM can contribute to the effective performance of most, if not all, revenue cycle components**
- **Share benchmarks**
- **Talk the talk – effectively communicate with your CFO about revenue cycle strategies**
- **Promote yourself as the revenue cycle administrator**

1

Seminar Objective

$160,000

Chief Revenue Officer

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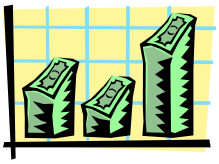
What is the Revenue Cycle?

- **All events that take place in the patient care process that permits the organization to receive payment for the services rendered.**
- **Reliant upon data**



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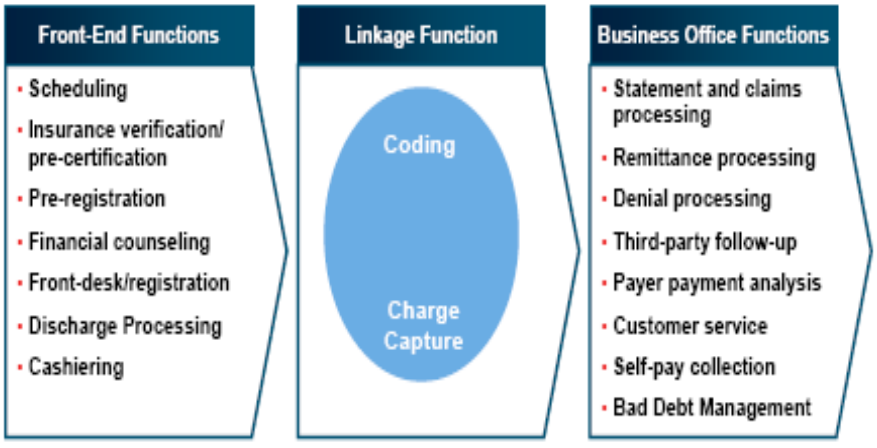
Importance of Data on the Revenue Cycle Events



Source: Cotton 2008

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Notes/Comments/Questions

Your Revenue Cycle Activities Should be a Team Effort

- **Be collaborative**
- **Create systems that:**
  - **Consistently captures all entitled reimbursement**
  - **Timely**
  - **Legitimately**
    - **With no bad press or public relations**

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Talking the Talk

- **Using the correct term**
- **Recognize the environmental drivers**
- **Focus on the Revenue Cycle and what HIM can contribute**

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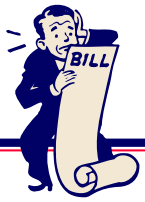
Revenue vs. Cash



- **Revenue**
  - **What we charge**
    - **At time of service**
  - **Contractuals**
    - **The discounts we anticipate/negotiate with payers**
    - **At the time of billing or at the time the claim is paid**

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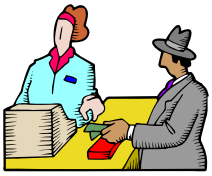
Revenue vs. Cash

- **Revenue**
  - **Not cash**
  - **Income**
- **Cash**
  - **What we get paid**
  - **Asset**
- **Income = The difference between <u>Revenue</u> and Expenses**
  - **Income ≠ Cash**



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Unbilled vs. Discharged Not Final Billed (DNFB)

- **UNBILLED – all charges that have not been billed**
  - **In-house – not yet discharged AND**
  - **Discharged Not Final Billed (DNFB)**
- **DNFB**
  - **Unbilled for someone who has been discharged**
  - **Unbilled after suspense**
- **DNFB – a component of unbilled**

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DNFB – Discharged – not final billed

- **Are NOT Accounts Receivable**
  - **If it's due to be received, then it's a receivable**
  - **It can't be due if it hasn't been billed**
- **Are typically stated in Gross Revenue**
  - **Not net because haven't been "billed"**
- **Due to a variety of reasons**

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Accounts Receivable (A/R)

- **Once billed it may be:**
  - **Net (less) of contractuals**
    - **Net Accounts Receivable**
  - **Include contractuals**
    - **Gross Accounts Receivable**
    - **Adjust at time of payment**

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Accounts Receivable (A/R)

- **Accounts Receivable**
  - **What's been billed and not paid/denied/settled**
- **A/R not paid (<u>but pursued</u>)**
  - **Bad debt**
    - **Write off to bad debt (uncollectable or provision for bad debt)**

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Contractual Allowances & Uncollectibles

- **Revenues (in thousands):**
  - **Patient services income $9,500**
  - **Less allowances & uncollectibles (1,950)**
  - **Net revenue from patient services $7,550**
  - **Non-patient service income 100**

Source: Dunn, R. Finance Principles for the HIM Professional 2E 2008 **13**

A/R Days or Days of Revenue in Coding

- **Days in Accounts Receivables (A/R Days) serve as a measure for Patient Financial Services**
  - **Count from date coding released account assuming hold has been met**
- **Days in Revenue or Days in Revenue Outstanding (DRO) serve as a measure for Health Information Management**
  - **Count from date of discharge**

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Net vs. Gross Revenue

- **HIM**
  - **Always gross**
  - **Billed Revenue BEFORE contractual allowances**
  - **Metric: Days in Revenue Outstanding-DRO**
- **PFS**
  - **Gross or Net**
  - **Depends on when contractual is taken**
  - **Metric: Days in Accounts Receivable-A/R Days**

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Calculating A/R days and DRO

- **Need to know:**
  - **Gross revenue for a period**
  - **Whether contractual allowances are taken at time of billing or time of payment**
  - **Net revenue for a period**
  - **Balance in Accounts Receivable**
  - **Balance in Unbilled/DNFB for HIM**

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Calculating A/R days and DRO

- **A/R Days-Gross (when contractuals are taken at time of payment)**
  - **Gross Revenue for the period ÷ Days in period = Average daily gross revenue**
  - **Balance in Accounts Receivable ÷ Average daily gross revenue**
- **A/R Days-Net (when contractuals are taken at time of billing)**
  - **Net Revenue for the period ÷ Days in period = Average daily net revenue**
  - **Balance in Accounts Receivable ÷ Average daily net revenue**

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Calculating A/R days and DRO

- **Days of Revenue Outstanding**
  - **Gross Revenue for the period ÷ Days in period = Average daily gross revenue**
  - **Balance in HIM Unbilled or DNFB ÷ Average daily gross revenue**

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Example

- **$59 Million (Net) in A/R**
- **Contractuals and Uncollectibles average: 10%**
- **Average $30 Million in Gross Revenues/Mo.**
- **$5 Million in DNFB for HIM and PFS**
  - **$4 Million in DNFB for Coding**
- **April**

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Example

- **Average Daily Gross Revenue:**
  - **$30 million÷30 days (April) = $1 million**
- **Average Daily Net Revenue:**
  - **$30 million - $3 million (10% contractuals) = $27 million÷30 days (April) = $900,000**
- **DRO: $4 million÷$1 million = 4 days**
- **Days in A/R: $59 million÷$900,000 = 65.6 days**

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Monitoring-Controlling DNFB and A/R

- **Monitor the components**
  - **Discharge date to code date (HIM)**
  - **Code date to bill date (PFS)**
  - **Bill date to collection date (primary payer) (PFS)**
  - **Primary pay date to bill date of secondary payer (PFS)**
  - **Collecting self-pay portions (PFS)**
  - **Posting payments**

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Monitoring-Controlling DNFB and A/R

- **Monitor the components**
  - **Discharge date to code date (HIM)**
    - **What is holding up coding?**
      - Records not available
      - Documentation missing
      - Transcription delay
      - Other processes holding up coder's access to the record
      - Work schedule

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Monitoring

- **Controlling DNFB and A/R**
  - **Monitor the components**
    - **Discharge date to code date (HIM)**
    - **Code date to bill date (PFS)**
      - Should be 1 day: Clean Claim
      - What is rejecting?

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Monitoring

- **Controlling DNFB and A/R**
  - **Monitor the components**
    - **Discharge date to code date (HIM)**
    - **Code date to bill date (PFS)**
    - **Bill date to collection date (primary payer) (PFS)**
      - Contract management timetable
      - Monitor the payer's claims suspension systems

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Monitoring-Controlling DNFB and A/R

- **Monitor the components**
  - **Discharge date to code date (HIM)**
  - **Code date to bill date (PFS)**
  - **Bill date to collection date (primary payer) (PFS)**
  - **Primary pay date to bill date of secondary payer (PFS)**
    - **Monitor remittance processing**
    - **Set up system triggers**
    - **Same monitoring as primary**

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Monitoring-Controlling DNFB and A/R

- **Monitor the components**
  - **Discharge date to code date (HIM)**
  - **Code date to bill date (PFS)**
  - **Bill date to collection date (primary payer) (PFS)**
  - **Primary pay date to bill date of secondary payer (PFS)**
  - **Collecting self-pay portions (PFS)**
    - **Initiate at time of scheduling**
    - **Education**
    - **Make patient feel welcomed**
    - **Work schedule**

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Monitoring-Controlling DNFB and A/R

- **Monitor the components**
  - **Discharge date to code date (HIM)**
  - **Code date to bill date (PFS)**
  - **Bill date to collection date (primary payer) (PFS)**
  - **Primary pay date to bill date of secondary payer (PFS)**
  - **Collecting self-pay portions (PFS)**
  - **Posting payments**
    - **Timely**
    - **Staffing schedule**

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Cost of DNFB

Figure 11.6

Age Period	# of Accounts	$ Value of the Accounts
1 day	14	$ 89,505.40
2 days	15	$ 95,898.70
3 days	8	$ 47,949.30
4 days	4	$ 23,974.65
5 days	3	$ 17,981.70
6 days	3	$ 13,576.75
7 days	2	$ 9,051.00
8 days	0	$0
9 days	0	$0
10 days	1	$ 4,525.50
> 10 days	3	$ 13,156.50
Total	**53**	**$315,619.50**

Figure 11.7

0.05 (interest rate) ÷ 365 = 0.0001369/interest/day
The account has aged 10 days = 10 x 0.0001369 = 0.001369
$4,525.50 (value of the aged account) x 0.001369 = $6.20

Source: Dunn 2E

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DNFB and A/R Impacts the Budget

- **Different types of budget**
  - **Operating Budget**
    - **Predicts when revenue will be posted**
    - **Ties expenses to predicted revenue**
  - **Cash Budget**
    - **Predicts when cash will come in**
  - **Capital Budget**
    - **Predicts when new items will be purchased**

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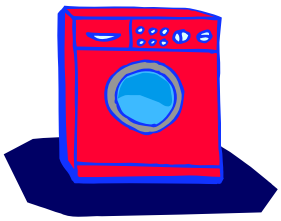
DNFB and A/R Impacts the Budget

- **Cash budget**
  - **Prediction of when cash will arrive**
  - **Tied to date of REVENUE posting and LOS**



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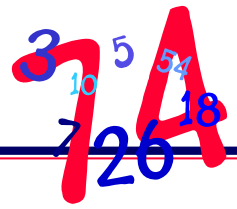
Cash Budget



- **Based on Days lag**
  - **Average length of stay**
  - **Suspense (Hold) Period**
    - **Late charges**
  - **Days from discharge to code**
  - **Days from code to bill**
  - **Days from bill 1st time to pay**
  - **Days from bill 2nd time to pay**
- **Cash going out the door before it comes in**

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Charity vs. Bad Debt - Revenue Cycle Obligations

- **Bad Debt – A claim was issued, payment was expected (and pursued), payment was not received**
  - **"Bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim."**

    P&P Board Statement 15-HFMA

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Charity vs. Bad Debt - Revenue Cycle Obligations

- **Charity – The cancellation of a claim if determined at time of service or a reduction of a claim made by the provider**
  - **"Charity care is provided to a patient with demonstrated inability to pay."**
    P&P Board Statement 15-HFMA

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Charity vs. Bad Debt - Revenue Cycle Obligations

- **Bad Debt – A claim was issued, payment was expected (and pursued), payment was not received**
- **Charity – The cancellation of a claim if determined at time of service or a reduction of a claim made by the provider**
  - **Payment for the charity component was never expected**
  - **Not revenue**
  - **Policy**

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Charity Applications

- **Usually managed by PFS**
  - **Access and Social Work may identify and initiate request/application**
- **~≤3% of gross patient revenues[1]**
  - **Same metric for Bad Debt and Charity write off**
- **Revenue cycle team should review and approve the Charity Policies**

[1]Hammer, David C. HFMA July 2007

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Charity ≠ Revenue; Charity ≠ Bad Debt

- **Revenue = Charges**
- **47 million lack insurance[3]**
- **Charity**
- **Bad Debt ≠ Charity**
- **25 million lack adequate insurance[3]**

[3]US News and World Report 6/10/08

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Underinsured/Uninsured

- **Recognizing the implications**
  - **Lost interest**
  - **Less capital**
  - **Less cash**
  - **Public relations**
- **HIM**
  - **Timely ROI and Coding**
  - **Educating Access and Physician Offices on Medical Necessity**
  - **Educating on front-end status assignment**

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Bad Debt

- **Seeing a shift from back-end to front-end initiatives**
- **Developing financial and clinical databases**
- **Technology for scheduling and collections**

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Write Offs or Uncollectibles

- **Write Off = Action that recognizes a loss or worthlessness of an amount due**
  - **Common categories for write-offs**
    - **Bad debt**
    - **Non-Eligibility**
    - **Not medically necessary (provider fault)**
    - **Denials**
    - **Contractuals**
    - **Small balances**
  - **Capture the cause/source of the write-offs**

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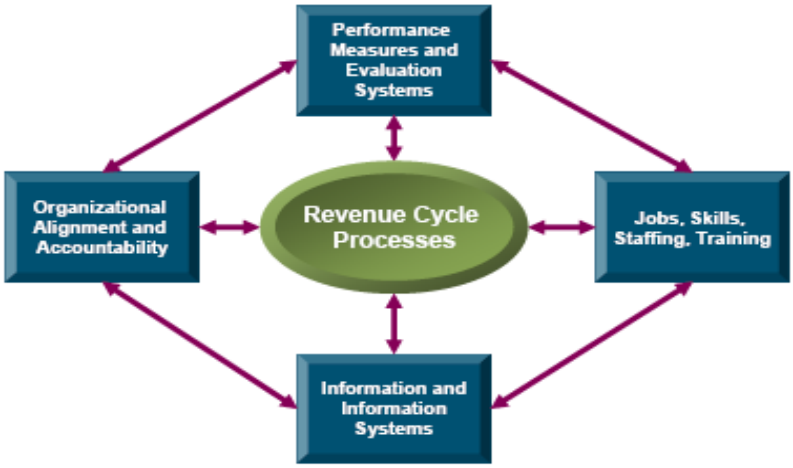
Revenue Cycle



Source: Cotton 2008

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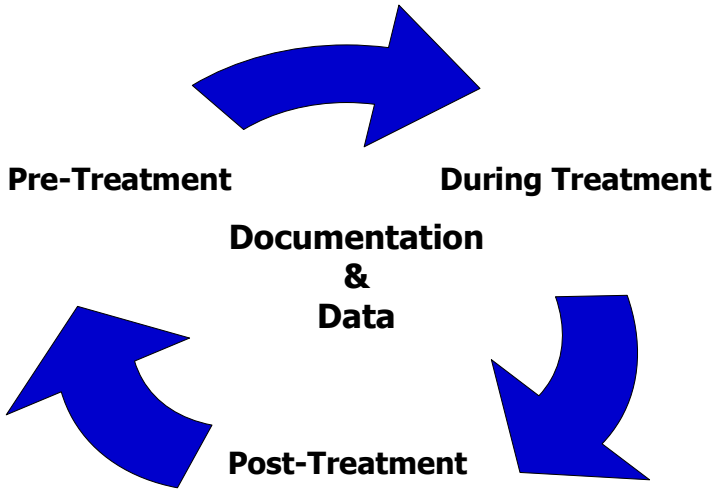
Revenue Cycle – Timing



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Revenue Cycle Oversight

- **Doesn't exist?**
  - **Grab First Base**

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Revenue Cycle Oversight

- **Knowing if You've Succeeded**
- **Must establish, monitor and trend**
  - **Performance indicators (metrics)**
  - **Ongoing basis**
  - **Regularly communicated to the entire management team and all phases of the cycle**

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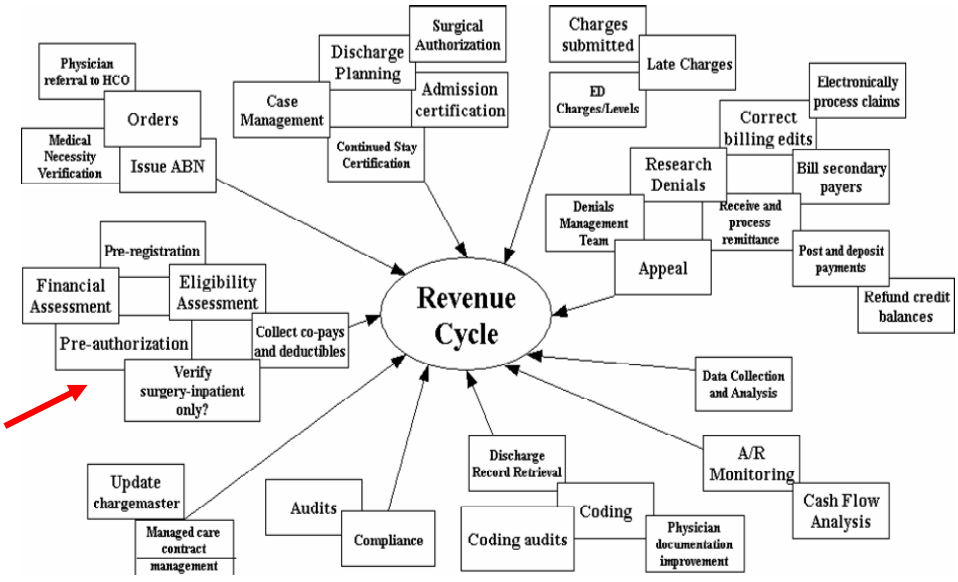
Spokes of the Cycle



Created by Rose T. Dunn 2006

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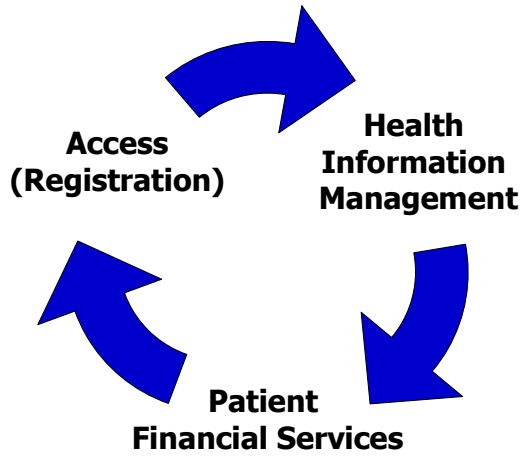
Drivers of the Revenue Cycle



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Other Key Players of the Revenue Cycle

- **Case management**
- **Charge capture-Patient Care Services**
- **Decision support**
- **Finance and accounting**
- **Compliance**
- **Information technology**

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Dissecting the Spokes

- **Ask? Where are:**
  - **Revenue opportunities?**
  - **Cash opportunities?**
  - **How to get it sooner?**
    - **Ways to decrease DNFB and A/R?**
  - **Improve entitled reimbursement?**
- **What role can/should HIM play?**

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Access (Registration/Admitting) Spoke

- **Scheduling**
  - **Inpatient Only**
- **Pre-registration**
  - **Insurance and eligibility verification**
- **Case Management**
  - **Pre-certification**
  - **LOS approval**
  - **Discharge planning**
- **Registration**
  - **Collection of admission diagnosis**
  - **Collection of orders**
  - **Obtaining consents, releases, Notice of Privacy Practices**
  - **Issuing ABNs**
  - **Collection of Co-Pays**

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Metrics

- Overall pre-registration of scheduled patients
- Overall insurance verification rate of pre-registered patients
- Deposit request rate for co-pays and deductibles
- Insurance verification rate of unscheduled inpatient admissions and high dollar outpatients within 1 business day
- >95% all factors

(Source: HFM Toolbox Sept. 2004 & HFMA Self-Assessment Tools)

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Access

- Data that drives the process
  - Patient address
    - Bad Mail
  - Guarantor/Insurer
    - Insurance card
  - Contact numbers
  - Advance directive
  - Patient type
  - Service category
    - Payment methodology
  - Admission/service diagnosis
    - Orders
    - ABNs
  - Consents
  - Collection of co-pays and/or payment alternatives (credit cards)
  - Primary language
  - Unit number

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How HIM can assist Access

- **Common Concerns**
  - Duplicate numbers
  - Name misspelling and address inaccuracies
- **Fixes-Education**
  - ✔ by DOB and SSN
  - ✔ view patient ID-driver license, etc.
  - Review every time

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How HIM can assist Access

- **Common Concerns**
  - Assuming nothing has changed
  - Wrong insurer info
  - Not obtaining pre-certification
- **Fixes-Education**
  - Review every time
  - Copy insurance card and verifying eligibility (electronic)
  - Verify each admission with payer and know if service is covered BEFORE providing it

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How HIM can assist Access

- **Common Concerns**
  - Incomplete or no orders for outpatient services
  - Not obtaining ABNs
  - Lost consents, copies of insurance cards, other paperwork
  - Servicing patients who lack eligibility
- **Fixes-Other**
  - Establish rule—no service without complete order
  - Provide easy to use software and training
  - Install desktop scanners or tablet technology
  - Install eligibility ✔-ing software

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How HIM can assist Access

- **Common Concerns**
  - Decentralized registration-inconsistent processes and multiple management structures
  - Quick Registrations
- **Fixes-Other**
  - Centralize management
  - Standardize:
    - Forms
    - Policies
    - Training
    - Equipment
  - Disconnect quick registration or monitor usage

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Metrics

Inpatient admissions error	<3%
Outpatient registration error	<3%
Average interview duration	<10 min.
ABNs and MSPQs obtained when required	100%
Duplicate numbers created as % of total registrations	<1%

(Source: HFM Toolbox Sept. 2004 & HFMA Self-Assessment Tools)

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HIM's Role – Access Management

- **Education:**
  - **Access and Physician Office Staff:**
    - **Complete Order**
    - **Acceptable Diagnosis**
    - **Coding basics**
    - **ABN issues**
      - Software-common vs. technical terms
      - Compliance
      - EMTALA
    - **Medical terminology and basic coding**

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HIM's Role – Access Management

- **Technology selection and implementation**
  - **ABN Software Selection**
  - **ABN Enforcement**
    - **Workflow changes**
      - Coder in scheduling
      - Coder reviews orders
- **Assume responsibility for Registration**

Data Driven/ Data Quality

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HIM's Role – Access Management

- **Medical Record Number-verification**
  - **Ties all clinical Information**
  - **Waste**
  - **Accounting of Disclosures**

- **Patient Type-verification**
  - **Service should have been as an inpatient**
  - **Inpatient vs. Observation**
  - **72 hour/3-day crossover**

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Case Management/Utilization Review & Discharge Planning Collaboration

- **Utilization Review**
  - **Validation of service assignment**
  - **Validation of patient type**
  - **Documentation intervention→education**
- **Discharge Planning**
  - **LOS data and criteria selection**
    - **Disease management info**
  - **Documentation intervention→education**

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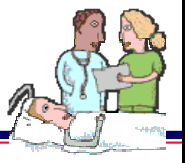
Case Management/Utilization Review & Discharge Planning



- **Social Work**
  - **Updating sources of services**
  - **Documentation intervention→education**

Get outside of the HIM box

60

Case Management's Spoke

- **Major impact on revenue cycle**
  - **Pre-certification**
  - **Gaining LOS approvals**
  - **Documentation improvement**
  - **Discharge planning**
  - **Clinical denials**
  - **Developing clinical pathways and outcomes data**
  - **Interaction with Medical Staff**
  - **LOS**

61

Metrics

Physician pre-certification double-checked rate	**100%**
Payer acceptance of clinical treatment plan	**95% acceptance**
Clinical denials overturn rate	**95%**

Do it right the 1st time --> Eliminate variations

(Source: HFM Toolbox Sept. 2004 & HFMA Self-Assessment Tools)

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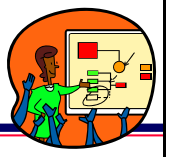
HIM's Role – Case Management



- **Education and Clinical Documentation Improvement**
  - **MDs, Nursing, CM, and UR**
    - **Nursing, CM, and UR to see the "clues"**
    - **Encouraging documentation of pre-existing (POA) conditions or complications that developed during stay**

Collaboration

63

HIM's Role – Case Management

- **Education**
  - **Identifying CCs and documentation that can improve DRG coding**
  - **How to assign a working DRG**
  - **Getting to specifics**

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Patient Care's Spoke

- **Providing services and treatment**
- **Facilitating orders**
- **Documenting what has been done**
- **Leading the patient safety and infection control initiatives**
- **Being attentive to patients and their families**
- **Capturing charges**

65

HIM's Role – Patient Care

- **Identifying misplaced documentation**
- **Reducing documentation efforts- Streamlining templates and forms**
- **More time for Patient Care and Documentation**
- **Guidance on compliance issues – Late entries**

[2]Studer 1/30/09

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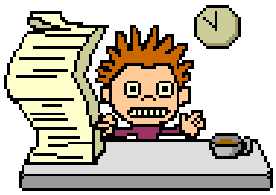
Charge Entry

- **Timely**
  - **7 Days/week**
- **Accurate**
- **Patient care or data entry dilemma**



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Doing Charge Capture & Linkage Correctly

- **Verification of correct patient**
- **Verification of correct encounter**
- **Service ordered**
- **Service documented**
- **Charges captured/entered correctly**
- **CDM updating**

68

Metrics

- **Charge capture quality**
- **CDM Issues:**
  - **Duplicate items**
  - **Incorrect or missing HCPCS/CPT-4 codes**
  - **Incorrect or invalid revenue codes or modifiers**
  - **Labeled as "miscellaneous"**
- **98%**
- **0% all factors**

(Source: HFM Toolbox Sept. 2004 & HFMA Self-Assessment Tools)

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HIM's Role – Charge Capture

- **Is HIM involved in charge capture?**
- **Line item charge entry by coders**
- **Validating charges with source documentation**
  - **Identifying missing, duplicate or mischarges**
    - **Which departments?**

70

HIM's Role – Charge Capture

- **Monitoring the impact of late charges on the coding assigned**
- **Charge master support/control**
  - **Identifying items that can be CDM driven**
  - **Defining what is to be coded by HIM vs. the CDM**
- **HIM's ability to interpret PM and Transmittals**

71

Health Information Management

- **MPI management**
- **Securing the records at discharge- Retrieval and Reconciliation**
- **Discharge processing**
- **Chart analysis**
- **Documentation Improvement**
- **Coding**
- **Obtaining additional documentation are appropriate**
- **Release of Information**
- **Transcription**

72

Health Information Management

- Forms/Template Management
- Open Record Review
- PHI Access control
- Archives Management
- Distributing Coding Guidance
- Denial Support
- Report generation
- Watchdog

73

Evaluating Where HIM Supports or Impedes the Revenue Cycle

- Do we ensure every record is received?
- Received timely?
- Are our processes fine-tuned?
- When do we analyze the unbilled list?
- Are we capturing reasons why cases are unbilled?

74

Evaluating Where HIM Supports or Impedes the Revenue Cycle

- **Are cases on the unbilled list with "0" balance?**
- **Does the same patient appear on the list with the same date of service several times?**
- **Is there a communication method to alert PFS of misplaced/missed charges?**

75

Evaluating Where HIM Supports or Impedes the Revenue Cycle

- **What's my coders' productivity vs What's my expectation?**
- **Do the coders have the documentation they need?**
- **Is coding accuracy audited?**
- **What is being done to ensure the documentation is there?**

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Metrics
Published Productivity Standards

Type	Advance 2007	HFMA 2007	AHIMA 2008
Inpatient	28.1 min. (17/day)	23-26/day	24/day
Ambi Surg	18.4 min. (26/day)	36-40/day	40/day
ED	7.9 min. 61/day)	150/230/day	120/day
Ancillary	2.5 min. (192/day)	150-230/day	240/day

77

Evaluating Where HIM Supports or Impedes the Revenue Cycle

- **How promptly is ROI handling requests?**
- **Is documentation readily available on-line? Does staff have access to it?**
- **What distracts staff from ensuring the record is received, processed, and coded in a timely fashion?**

78

Metrics

- **DNFB and HIM Billholds**
  - **Awaiting coding**
- **ROI T/A for Payer Requests**
- **Transcription Backlog**
- **Chart delinquency rate**

- **4-6 days in A/R (from discharge)**
- **≤2 work days**
- **≤ 1 day**
- **≤ 10%**

(Source: Hammer 2007)

79

Patient Financial Services (PFS) Business Office/Patient Accounts

- **Financial counseling**
- **DNFB**
- **3rd party collections**
- **Self pay collections**
- **Credit balances**
- **Denials management**
- **Cash posting**
- **Contract management and payment review**
  - **Payment accuracy**
- **CDM**
- **Claims management**

80

Who Contributes to the Claim?

- Scheduling-Verify eligibility
- Registration-Confirm benefits coverage, capture insurer information
- Case management-provide medical necessity information
- Patient care-charges
- HIM-Coding
- Billing-Edits and processing to secondaries
- Payment posting-Accuracy/timeliness
- Revenue recovery-Appeals
- Managed care-Appropriate terms, rate complexity

81

Patient Financial Services

- Claim reconciliation
  - Is there a claim for each encounter?
  - Are there charges missing?
  - Who is late submitting charges?
  - Are there duplicate charges?
  - Are invalid CDM codes appearing?

82

Patient Financial Services

- **Claim rejection management**
  - **Edit correction**
  - **Edit resolution**
  - **Scrubbing**

83

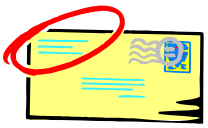
Patient Financial Services

- **Rejection types**
  - **Pre-billing edits-scrubbers**
  - **EDI edits-clearinghouse or payer system**
  - **Claim rejections ≠ Claim denials**
    - **Unless untimely handled**

84

Patient Financial Services

- **Bad mail**
  - **Return to sender**
  - **Returned by payer**
- **Cost**
  - **Loss of interest on money**
  - **Labor time to re-work**



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Patient Financial Services

- **Claim processing**
  - **Contract management**
    - **Automated or Manual**
    - **Communication with managed care contracting manager**
    - **Built-in reports: Data to identify root causes of underpayments**

86

Patient Financial Services

- **Bill hold settings**
- **Secondary payer processing**
- **Receiving the remittance**
  - **Cashiering function**
  - **Controls-checks and balances**
- **Distributing bulletins/notices of new rules**

87

Credit Balances

- **What are they?**
  - **Accounts that have more payments than charges**
- **How did they get there?**
  - **Misposted allowances**
  - **Duplicate payments**
  - **Misposted charges that are reversed after billing**

88

Metrics

- % Clean claims submission
  - 97%
- Days in A/R
  - ≤ 55 days
- Billing turnaround
  - 5 days from date of service or discharge
    - Coding timeliness (4-6 days)
- Late charges as % of total charges
  - <2%

(Source: HFM Toolbox Sept. 2004 & HFMA Self-Assessment Tools)

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HIM's Role – PFS

- Study Zero Balance Accounts
  - Identify missed charges and mis-charges
  - Timely route charge sheets found in records
  - Monitor sources
  - Act on findings

90

HIM's Role – PFS

- **Timely processing of ROI requests for payers**
- **Demonstrate data management skills by:**
  - **Capturing data from the Contract Management database and cross populating it with coding and cost data**

91

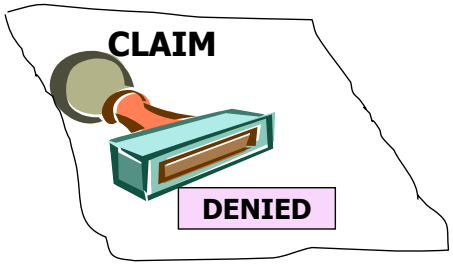
Patient Financial Services

- **Denials management**
- **Appeals coordination**
  - **Adds to the Days in A/R**
  - **Adds to the Cost of Collection**

92

Denial Management

- **Denials ≠ Bad Debt, Charity Care, Refunds, Contractual Adjustments**
- **Denials = Provider Fault**



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Denial Management Team

- **Team Challenges**
  - **Peel the onion**
  - **Success will require balancing relationships between various factors**
    - **Increase collections vs. increase complaints**
    - **Proactively doing more at the front end with same or less staff**
- **Use PI/Six Sigma tools**

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Denials Management

- **Players (Similar to Revenue Cycle Team)**
  - **PFS**
  - **HIM**
  - **Scheduling**
  - **UR/CM/Discharge Planning**
  - **Compliance**
  - **Departments contributing charges to the claim**
  - **Departments representing source of denials**
  - **IT and Decision Support**

95

Common Reasons for Denials

- **Submitted to the wrong payer or at the wrong address**
- **Coordination of benefits**
- **Ineligibility/non-covered benefits/non-coverage**
- **Duplicate claim**
- **Medical Necessity**
- **Technical**
- **ADRs**
- **Carve-outs**

96

What Contributes to Denials?

- **Untrained staff**
- **Front-end failures**
- **Difficulty in confirming eligibility**
- **Reductions in covered benefits**
- **Inaccurate contract management system definitions**
- **Failure to obtain precertification**
- **Coding**

97

Denial Management – Tracking and Trending

- **Maintain a Denial Management Database:**
  - **Reason**
  - **Payer**
  - **Service area/Source**
  - **Accounts denied/total accounts**
  - **Denied charges/total charges**
  - **Denials accepted/by denial code**
  - **Physician**
- **Watch for upcoming article in JAHIMA 3/09**

98

Metrics

- **Rate of appeals overturned** — **40-60%**
- **Denial reason codes** — **≤ 25**

(Source: Hammer 2007)

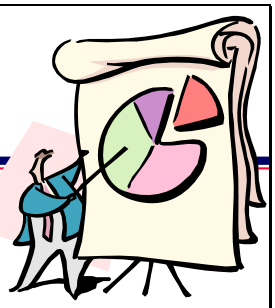
99

HIM's Role – Denial Management

- **Assisting in edit rejections before billing (OCE and CCI)**
- **Querying physicians before billing**
- **Identify CDM voids/errors**
- **Contributing to the appeal document**
- **Distributing new "rules" published**

100

Decision Support's Spoke



- **Payer mix/analysis**
  - **Reimbursement by case type**
  - **Comparison between payers**
- **Case mix/analysis**
  - **What/who is driving the CMI**
- **Resource use by DRG, APC, MD, etc.**
- **Tracking Opportunities**
- **Denial Success by Payer**

101

Publishing Report Cards

- **For each function within the Revenue Cycle**
- **Within a function-Employee to Employee**
- **Documenting the success of revenue cycle activities**

102

HIM's Role – Decision Support

- Collaboratively integrating clinical and financial data
- Explaining CMI changes
- Ensuring encounters are properly categorized
- Collaborating with IT to select systems that capture management and planning data
- Serving as "decision support"

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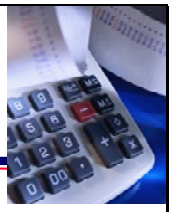
Finance & Accounting's Spoke



- Revenue and Income comparison
  - Between months/years/prior comparable periods
- Accounts receivable monitoring
- Cash flow analysis
- Managed Care contracts
- Setting prices/rates

104

Setting Prices

- **Defensible Price Modeling**
  - **Chargemaster pricing should make sense to a variety of interested parties**
  - **Transparency**
  - **Public requests for prices**

105

HIM's Role – Finance & Accounting

- **Collecting the data for rate analysis**
  - **Frequency**
  - **By patient type**
  - **Assist in analyzing public reports**
- **Ensuring CDM descriptions are consumer-friendly**
- **Identifying CDM items that are priced above government price**
- **Contribute insight**

106

HIM's Role – Finance & Accounting

- **Identifying impact of DRG changes on organization**
- **CMI Profiling (physician, payer, etc.)**
- **Collecting resource usage data by top 10 conditions/DRGs**
- **Comparing DRG trends one year to next**

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HIM's Role – Finance & Accounting

- **Controlling DNFB-to improve cash flow**
- **Reviewing managed care contracts**
  - **Issues with certain DRGs**
  - **Reimbursement for copies**
  - **Payment commitments (within X days or an average of X days)**

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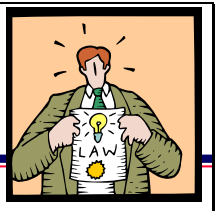
Compliance's Spoke



- **Establishing a framework for all staff to avoid actions that result in fraud, abuse, or waste**
- **Monitoring the organization's performance relative to the regulations**
- **Audit management**
- **Monitoring the regulations**

109

Compliance – Regulations

- **False Claims Act**
- **Stark Rule**
- **3-Day Crossover**
- **HIPAA**
- **EMTALA**
- **Tax Exemption**
- **Etc. etc. etc.**

110

Compliance

- **Audit Teams**
  - **Validating Coding**
  - **Physician Documentation**
  - **Validating Charges-charge auditing**
  - **Ensuring proper billing practices**
- **Corrective Action**
  - **Education**

111

HIM's Role – Compliance

- **Clarifying impact of new coding rules**
- **Taking the lead on RACs**
- **Clarifying impact of new documentation rules**

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HIM's Role – Compliance

- **Monitoring ROI**
- **Working with PFS to ascertain appropriateness of 3 day merges**
  - **Related/Unrelated**
- **Helping to interpret PMs impact on facility**

113

Information Technology's Spoke

- **Report creation**
- **Selection and installing of software**
- **Transaction set conversions and validation**
- **HIPAA nuances**

114

HIM's Role – Information Technology

- **Collaborating on custom reports**
- **Keeping IT abreast of new technologies**

- **Involving IT in demos of products that enhance the Revenue Cycle**
- **Sharing materials about products**

115

Revenue Cycle Team Values

- **Collaboration**
- **Communication**
- **Cooperation**
- **Constant process improvement**

Cash-Flow

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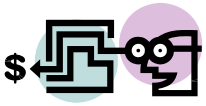
Revenue Cycle

- **Complex**
- **Lots of opportunity for collaboration**
- **Lots of opportunity for success**
- **Requires hard work**



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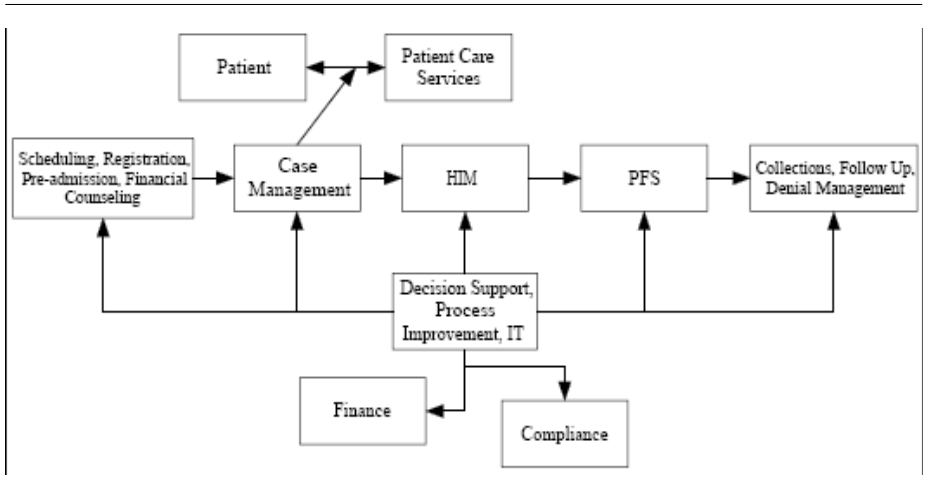
YOU as the Revenue Cycle Administrator



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- **"Are you Optimizing Your Contract Performance Data?" HFMA Executive Roundtable. HFMA. November 2008.**
- **"Integrating Clinical and Financial Data for Revenue Cycle Improvement." HFMA Executive Roundtable. HFMA. December 2008.**
- **"Strategies for Reducing Bad Debt." HFMA Educational Report. HFMA. January 2009.**
- **P&P Board Statement 15 Regarding Reporting Charity Care and Bad Debt December 2006**

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Questions

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Appendix

Resource/Reference List 66
Speaker Information
CE Certificate Instructions

Appendix

Resource/Reference List

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615

http://www.hfma.org

https://www.vha.com/portal/server.pt/gateway/PTARGS_0_120363_0_0_18/

https://www.vha.com/portal/server.pt/gateway/PTARGS_0_2_6781_1052_505725_43/http%3B/portlets.vha.com%3B80/portlets/VHASearchPortlet/ciopener.aspx?ci=297693

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http://assets1.csc.com/health_services/downloads/10118_1.pdf

Speaker Information

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Ms. Dunn is a Past AHIMA President and recipient of AHIMA's 1997 Distinguished Member and 2008 Legacy Awards. She is Chief Operating Officer of St. Louis-based, First Class Solutions, Inc., a national health information management consulting firm providing coding compliance and operational consulting services.

Rose started her career as Director of Medical Records at Barnes Hospital, a 1,200-bed teaching hospital in St. Louis. She was promoted to Vice President at Barnes and was responsible for more than 1,600 employees and new business development. After Barnes, she joined MetLife where she worked with managed care organizations nationwide on a variety of operational, medical management, and network development issues. Rose also has served as a Chief Financial Officer of a dual hospital system in Illinois.

She is active in several professional associations including American Institute of Certified Public Accountants, American College of Healthcare Executives, Healthcare Financial Management Association, and American Health Information Management Association. She holds fellowship status in HFMA, ACHE and AHIMA. She also is certified in healthcare privacy and security.

She is the author of several texts including ***Finance Principles for the Health Information Manager, More with Less, Coder Productivity,*** and ***Haimann's Healthcare Management.*** In addition, she has published more than 200 articles and 300 presentations across the United States on a wide variety of topics.

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