HCPro's
Medicare Compliance
Training Handbook

The Revenue Integrity Training Toolkit

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MHA, ACHE

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HCPro
a division of BLR

The Revenue Integrity Training Toolkit is published by HCPro, a division of BLR.

ISBN: 978-1-68308-126-5

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About the Author

Elizabeth Lamkin, MHA, ACHE

Elizabeth Lamkin, MHA, ACHE, has more than 20 years of experience as a single- and multihospital hospital CEO at teaching, community, and investor-owned hospitals. Lamkin now consults on operational effectiveness and is a national speaker and author on operations, quality, utilization, and billing compliance. She serves on the advisory board and Government Affairs Committee for the American College of Physician Advisors.

Lamkin holds a master's degree in healthcare administration from the University of South Carolina, Columbia, ACHESA-accredited program and a bachelor's degree in business administration from the University of South Carolina.

Introduction

Ronald J. Rejzer, MD, CHCQM-PHYADV

As a chief physician advisor for a busy healthcare system, I interact with revenue cycle every day, so I am excited to see a comprehensive handbook detailing the revenue cycle process that shows the depth and breadth of revenue cycle and how all roles relate to each other for integrity of the process beyond finance. This book takes a fresh approach to building a formal revenue cycle plan and team that will meet the demands of the expanding regulatory environment now and in the future. The role of care managers, clinical documentation improvement specialists, physician leaders, and other departments engaged in activities critical to revenue cycle integrity are highlighted and explained in an easy-to-visualize graphic. Additionally, the information contained in the book will be an invaluable guide to physician leaders in healthcare organizations by providing a framework of information allowing for meaningful participation in difficult decision-making discussions with the CFO and directors of the revenue cycle process, ultimately contributing to the financial success of an organization. Recognizing that the revenue cycle process is not an isolated silo but truly is an enterprisewide system responsibility will allow the reader to become a more informed and valuable member of the leadership team.

Editor's note: *Dr. Ronald J. Rejzer received his medical degree in 1980 from Hahnemann Medical University in Philadelphia, followed by a residency at the Medical College of Virginia/VCU in family medicine. He has participated in physician advisor roles for more*

than 12 years. He currently serves as the senior vice president and chief physician advisor at Parkland Hospital in Dallas, overseeing case management, utilization management, appeals and denials, and coding documentation improvement initiatives. As a founding member of the American College of Physician Advisors (ACPA), Dr. Rejzer served as the president of ACPA from 2014 to 2016. Dr. Rejzer is also a diplomat of the American Board of Quality Assurance and Utilization Review Physicians with a subspecialty certification as a physician advisor.

Overview

This book is a nontraditional look at the work of revenue cycle and the revenue cycle stakeholders. Although there is a body of knowledge discussing revenue cycle from a purely financial perspective, there is little that takes a broader, enterprisewide look at the revenue cycle. This gap is significant because the revenue cycle in healthcare is a complex system supported by activities as diverse as nursing and financial. With this handbook, we hope to close the gap and bring all members of the revenue cycle together.

Healthcare is undergoing an unprecedented transformation that will fundamentally change the way we operate. As reimbursement moves to a value-driven system, all stakeholders, including physicians and clinical staff, must work as a team to get the results we want for our hospitals and our patients. This team effort is especially relevant for revenue cycle, which has traditionally been considered a function of the finance department, but in today's healthcare, what happens throughout the patient's stay has a serious effect on billing and billing compliance. The intent of this book is to identify and explain the components and stakeholders of the revenue cycle system that must come together to provide optimum revenue cycle performance and produce compliant claims.

Since healthcare facilities are divided into departments for ease of management, department walls or silos have to be broken down for maximum results and effective enterprise teamwork. This is not an easy task when one considers the various specialty staff and functions that are involved. Just consider the individual and specialized professional organizations at regional, state, and

national levels that are dedicated solely to a single profession or specialty, or even a specialty within a profession. In this booklet, we offer a systemwide approach to bring the silos and stakeholders together.

In addition, we will focus on creating effective systems and building a continuum within the organization. We will not, however, focus on specific regulations or other factors that tend to change rapidly. Instead, the goal is to create systems and methods to stay current and to improve performance as a team, regardless of the changing nature of the regulations.

CHAPTER 1

Revenue Cycle Integrity: A System Enterprise

Revenue cycle, like quality assurance and performance improvement (QAPI) and organizational compliance, impacts a large portion of any healthcare facility and its staff. It follows that, like QAPI and compliance, it is important to have a facility revenue cycle plan (RC plan) to guide the goals and activities of revenue cycle. A comprehensive and effective plan will take time to develop and integrate, but it will become the living document and road map for how revenue cycle operates in the facility. Having a plan is also the best way to bring all the stakeholders together, define roles and responsibilities as an enterprise, and maintain accountability. The RC plan is not just a financial function but an enterprise plan. Below is an outline for the RC plan adapted from the Centers for Medicare & Medicaid Services (CMS) quality example plan (CMS, QAPI Module Operational Guide, 2013).

The Revenue Cycle Plan

The RC plan will guide your organization's revenue integrity efforts. To start the plan development process:

- Develop the purpose of the plan
- Develop the guiding principles of revenue cycle
- Develop the scope for revenue cycle at your facility

Leaders and Team Members

The CFO, or CFO designee, leads the RC plan development. As this is a facility plan, a performance improvement team working together on the RC plan provides the best structure to engage key stakeholders and ensure continued buy-in and accountability. See Figure 1.1 for suggested team members. Other leaders, such as care management/case management (CM) directors, members of the medical staff, physician advisor(s), and nursing leaders will need to support the staff in their areas and allow time to work on plan development. It should take no longer than 30 days to write the plan and up to 60 days for the approval process through the appropriate committees up to the governing body. Engage the quality department for assistance in the process, as they have the tools, skills, and experience building plans and maneuvering through the approval process.

Your RC plan is intended to assist you in achieving what you have identified as the purpose, guiding principles, and scope for revenue cycle; therefore, spend the time necessary to define the purpose, principles, and scope for revenue cycle. Whether the CFO or other C-suite member leads this process, look to the facility mission, values, and strategy for guidance. All revenue cycle members identified in Figure 1.1 should understand their role in revenue cycle and have input into the RC plan. The RC plan then becomes a living document or road map that you will continue to refine and revisit.

Once the plan is complete, treat it like any other facility plan in terms of the approval process through the committee structure. In this case, we suggest the plan be approved through the QAPI committee, then utilization management (UM) and the medical executive committee, and then be presented to the governing body with other facility plans for final approval. The pathway for

multi-committee approval reflects the multiple departments and stakeholders the plan will affect.

Use the following instructions to create your RC plan.

Revenue cycle goals: *Goals should be based on the SMART principle: specific, measurable, actionable, relevant, and have a timeline for completion.*

I. Scope
   a. Describe how revenue cycle is integrated into all finance, utilization, and related service areas (departments) of your organization
   b. Define revenue cycle interdisciplinary components (see Figure 1.1)
   c. Describe how the RC plan will address each component of revenue cycle as outlined in Figure 1.1
   d. Define how the revenue cycle supports the governing body compliance plan

II. Guidelines for governance and leadership
   a. Describe how revenue cycle is integrated into the responsibilities and accountabilities of top-level management and the board of directors (if applicable)
   b. Describe how revenue cycle will be adequately resourced
      i. Designate one or more persons to be accountable for revenue cycle leadership and for coordination
      ii. Outline the plan for developing leadership and facilitywide training on revenue cycle
      iii. Describe all stakeholder time and technical training as needed for revenue cycle

iv. Indicate how you will determine if resources are adequate for revenue cycle (outcomes such as denials, bill holds, patient complaints, etc.)

c. Revenue cycle leadership

i. While many functions in the organization are involved in revenue cycle, you will likely have a small group of individuals who will provide the backbone or structure for revenue cycle in your organization. Who will be part of this group? Many of these individuals may be on your current utilization management committee (UMC).

ii. Describe how this group of people will work together, communicate, and coordinate revenue cycle activities. This could include, but is not limited to:

1. Establishing a format and frequency for meetings
2. Establishing a method for communication between meetings
3. Establishing a designated way to document and track plans and discussions addressing revenue cycle
4. Describing how the revenue cycle activities and compliance will be reported to the governing body, i.e., board of directors and executive suite

III. Feedback, data systems, and monitoring

a. Describe the overall system that will be put in place to monitor revenue cycle services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through revenue cycle.

i. Input from identified stakeholders such as billing and clinical documentation improvement (CDI) activities
ii. Adverse outcomes such as self-reporting to CMS
iii. Performance indicators
iv. External and internal audits
v. Complaints

c. Describe the process for collecting the above information.
d. Describe the process for analyzing the above information, including how the findings will be reviewed against benchmarks and/or targets established by the facility.
e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard(s) for individual performance improvement projects.
f. Identify who will receive this information (i.e., executive leadership, revenue cycle staff and leadership, medical staff leadership, physician advisors, clinical leadership, care management), in what format, and how frequently information will be disseminated.

IV. Systematic analysis and systemic action

a. Any change that is made in revenue cycle has the potential to have broader impact than intended, so it is important to recognize any unintended consequences of your actions. Describe how your organization will identify these consequences (positive or negative).
b. Describe the process you will use to ensure you are getting at the underlying causes of issues rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

V. Communications

a. Outline the audiences for revenue cycle communications and the frequency and format of these communications (see Figure 1.2). Include the committee structure in the RC plan.

VI. Evaluation

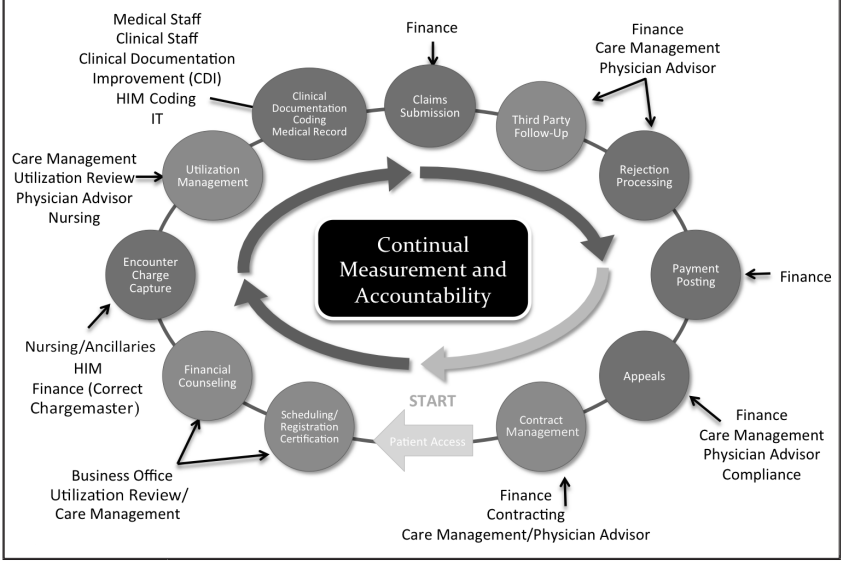
a. Describe the process for assessing revenue cycle in your organization on an ongoing basis
b. Describe the purpose of this evaluation: to help your organization expand your skills in revenue cycle and increase the impact of revenue cycle in your organization

VII. Establishment of plan

a. Date your plan and establish clear guidelines of when you will revisit the plan (e.g., at least annually)
b. Determine how you will track revisions or updates to the plan
c. Determine how changes to the plan will be communicated

Figure 1.1 shows how the roles and components of the revenue cycle interact in the RC plan.

Figure 1.1 Components for revenue cycle integrity



Source: PACE Healthcare Consulting

Revenue cycle interdisciplinary component roles and responsibilities

By developing an RC plan, each of the stakeholders in revenue cycle will be clear on their role in revenue cycle integrity. Each facility may be different, but the roles described here should be a part of any hospital revenue cycle team.

As shown in Figure 1.1, individual roles become part of the revenue cycle team, and by following the flow of the patient, stakeholder roles can be defined. Following are the individual roles for revenue cycle–related hospital staff.

Scheduling/registration (access)/certification

Patients enter the healthcare and hospital system from multiple portals of entry including through emergency department (ED), by direct admission, and through procedural departments such as cardiac catheterization laboratory and surgery, making registration and certification challenging. An added challenge is the changing regulations related to patient status. No longer is it enough to simply follow guidelines such as InterQual (McKesson, 2016) or MCG, formerly Milliman (CMSA, 2016), to determine inpatient status or outpatient status. (Observation is a service provided to outpatients and is billed according to specific rules.) In the 2016 CMS Outpatient Prospective Payment System, the 2-midnight rule was included with the intention of defining and clarifying what constituted inpatient status (CMS, "Fact sheet: Two-Midnight Rule," 2015). This has presented a challenge to patient financial services (PFS), the business office, physicians, and UM staff, as each patient must be assessed quickly and a physician must write an inpatient order certifying the patient is expected to stay over two midnights.

To add to the difficulty, traditional Medicare and Medicaid patients follow one set of rules, while commercial and managed Medicare (MM) patients typically have another set of rules based on individual facility contracts or unique payer rules.

No patient should enter the facility without notification to the registration department, which then determines what payer class the patient falls under and implements the appropriate procedure. For Medicare, there will be verification and certain CMS forms required. For commercial payers and MM, there is insurance

Communication and Utilization Review

A new way of doing business must be established to review 100% of patients at each point of entry within a very short time frame. For Medicare patients, CM review for medical necessity must happen within 12 hours of being placed in a bed. A system of communication and notification to registration, utilization review (UR), and CM of a patient entering the facility should be established and explained in the RC plan. Getting patient status and documentation right in the beginning is much easier than attempting to correct errors on the back end.

verification. Certification should be obtained through the utilization department, which notifies care managers and registration of the approved patient status. All patients require consent to treat and other regulatory forms with which your staff should be familiar.

For after hours and patients entering through the ED, the registration function may be consolidated in the ED but the procedures should be the same. Authorization should be obtained as soon as possible after the patient enters the system, but in some cases cannot be obtained until the payer staff is available.

Pre-certification for commercial patients and screening for admission criteria for government payers is not a guarantee of payment. Good documentation of the process, including who gave approval along with physician documentation of the reason the patient requires services, will help with any appeals if the claim is denied or audited.

A procedure should be in place for how PFS and UR will handle patients for whom the facility is out of their plan network. No

matter how your facility handles out-of-network billing, it is most important that the patient understand that he or she is out of network and, if nonemergent, may need to check with his or her carrier. For uninsured patients, registration should notify PFS to begin the process for emergency Medicaid or a charity application.

Patient scheduling also plays a key role in maintaining revenue cycle integrity. Most hospitals have a good system for identification of ED patients in need of hospital services, whether inpatient or outpatient. However, patients are often scheduled for procedures in the hospital directly from a physician office by the physician office's scheduler. There must be a notification and admissions review of all these cases to ensure appropriate pre-certification, medical necessity, and necessary paperwork—such as patient history and physical—is present and complete. Missing or incorrect paperwork can adversely affect billing. Facilities must have one centralized admission process that applies to all patient entry points. Training each department that schedules patients to follow the facility procedure or provide registration resources at each point to entry, or both, can greatly enhance revenue cycle integrity.

The admission, discharge, and transfer (ADT) department can act as a watchdog for revenue cycle integrity. Upon request for a bed, ADT should check for all required paperwork, approvals, and bed status prior to assigning a bed. Excluding exceptions for rare emergency bed placement, if any required piece is missing, a bed should not be assigned until all required steps are complete.

Financial counseling

More than ever, patients are behaving as educated consumers who are well informed—or at least partially informed—on the financial aspects of healthcare. Financial counseling must be accurate, customer-oriented, and able to fill in the gaps (or make corrections) in information the patient already knows. Based on the complexities of patient status, discussed in the previous section, counselors will need to be well trained and armed with knowledge of how bed status and different payers impact the patient's financial obligation. CMS has mandated certain notifications and signatures that the financial counselor should be able to explain and obtain. In some cases, the financial counselor may have to request that CM speaks with the patient, but the goal is for this step in the process to be handled by PFS.

PFS should have access to an organized list of payers and terms for each payer, including MM. The list should include basic information on traditional Medicare, such as the billing differences between outpatient observation and inpatient, and patient responsibility for each. This will maintain consistency in counseling.

Financial counseling is not only for inpatients and observation. Outpatient departments will need particular training on copays and collections at the point of service to streamline the process and avoid billing and collections problems after the patient leaves.

Encounter charge capture

Throughout the patient encounter, charges must be captured accurately. Charge capture is most typically handled by clinical staff that may have the least amount of revenue cycle training. An accurate chargemaster makes it easier for clinical staff to get charge capture right, especially with the complex rules around observation and outpatient billing (CMS, OPPS final rule, 2016). The RC plan should include a process for the chargemaster to be reviewed and updated annually. A defined education plan for clinical staff should be in place. Education should include accurate charges and not be simply a review of timely charges.

An accurate and current chargemaster will also help the facility avoid denials or other coding mistakes. The American Hospital Association (AHA) reported that of all the hospitals participating in their RACTrac™ reporting system for first quarter 2016, 9% of inpatient automated denials were related to coding, and 25% of outpatient automated denials were due to coding errors (AHA, 2016).

In addition, health information management (HIM) should audit concurrently for accurate charge capture and participate in annual chargemaster updates based on any coding changes.

The HIM role starts early in revenue cycle and plays a role throughout. At each point of entry, the HIM staff ensures that the medical record number, patient name, and other key information is correct with no duplication or misspellings. HIM and CDI staff often work in tandem to review documentation and query

physicians when information is missing or unclear while the patient is still in the hospital to produce a clean chart and accurate charges.

Utilization management

UR is the term CMS uses and is specifically mandated by CMS' *Conditions of Participation* (*CoP*) 482.30 (CMS, *CFR* 482.30, 2015), which describes the licensure requirements hospitals must meet. However, the term UR is used in different ways in different organizations. We differentiate UR as an activity within the larger umbrella of the UM function to encompass all activities required for appropriate utilization including the UMC. For purposes of this book, UR is the activity of certification, case management medical necessity review, physician advisor (PA) review, and CDI review and audit.

In revenue cycle, the admission UR role is one of the most important because this is the point at which the CM screens the patient for medical necessity to recommend to the admitting physician an appropriate patient bed status on the front end. By developing a strong front-end screening and UR process, you will reduce incidents of condition code 44, denials, and back-end work in appeals or bill holds.

Throughout the patient stay, CM and the PA will perform UR to ensure the patient qualifies for a continued stay, whether inpatient or outpatient, and advise the attending physician. On the rare occasion a patient has been placed in inpatient status and ultimately is changed to outpatient, condition code 44 will be required and is clearly defined by CMS (GPO, 2004; CMS, 2004).

The revenue cycle in a hospital or health system is a continuum, and each department and role within the cycle has to work in unison to be successful.

Due to the nature of today's healthcare environment, some staff may not realize that they're part of the revenue cycle. If there's a weak link, the entire system can quickly be jeopardized due to issues with compliance, reimbursement, and ultimately patient care. ***The Revenue Integrity Training Toolkit*** will help get everyone, from billers to clinicians, on the same page, improving systemic information flow and feedback loops.

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ISBN-13: 978-1-68308-126-5
90000
9 781683 081265