NAHRI National Association
of Healthcare Revenue Integrity

CORE FUNCTIONS
of Revenue
Integrity

Valerie A. Rinkle, MPA | Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS
Terri Rinker, MT (ASCP), MHA | Anna Santoro, MBA, CCS, CCS-P, RCC
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Angela Lynne Simmons, CPA, Author
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Mike Mirabello, Layout/Graphic Design
Jake Kottke, Layout/Graphic Design
Mike King, Cover Designer

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About the Authors

Valerie A. Rinkle, MPA

Valerie A. Rinkle, MPA, is a lead regulatory specialist and instructor for HCPro's Revenue Integrity and Chargemaster Boot Camp®, as well as an instructor for HCPro's Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version. Rinkle is a former hospital revenue cycle director and has more than 30 years in the healthcare industry, including more than 12 years of consulting experience in which she has spoken and advised on effective operational solutions for compliance with Medicare coverage, payment, and coding regulations. Rinkle serves as an advisory board member for the National Association of Healthcare Revenue Integrity (NAHRI).

Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS

Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS, is president/CEO and principal consultant for SLG, Inc., in Raleigh, North Carolina. She is a nationally known speaker and author on the charge description master (CDM), outpatient facility coding, and billing compliance, and has more than 30 years' experience in the healthcare industry. Goodman has been actively involved and held leadership roles in a number of professional organizations on the local, state, and national levels, including NAHRI.

Anna Santoro, MBA, CCS, CCS-P, RCC

Anna Santoro, MBA, CCS, CCS-P, RCC, is a revenue integrity director at Hartford Healthcare in Newington, Connecticut. She has 20 years of experience with chargemaster, claim edits, denials, and coding. Santoro serves as an advisory board member for NAHRI.

Donna Schneider, RN, MBA, CPHQ, CPC-P, CHC, CPCO, CHPC

Donna Schneider, RN, MBA, CPHQ, CPC-P, CHC, CPCO, CHPC, is the system revenue compliance officer at Yale New Haven Health in Connecticut. Schneider is a Registered Nurse with a Bachelor of Science degree in Nursing and a Master of Business Administration, both from the University of Connecticut. She has more than 30 years of healthcare experience in clinical intensive care, managed care contracting, network management, quality, compliance, privacy, and quality analytics. Donna has worked for managed care organizations, hospitals in both the community and academic settings, and home health care. She is a frequent speaker at her healthcare organization and local healthcare seminars. She volunteers for several community and professional boards. Schneider is an avid marathon runner, having qualified for and run in the Boston Marathon four times. She serves as an advisory board member for NAHRI.

Angela Simmons, CPA

Angela Simmons, CPA, is vice president of revenue and reimbursement at Vanderbilt University Medical Center in Nashville. A Texas Certified Public Accountant, she brings more than 30 years of experience in healthcare operations and finance and in public accounting for healthcare entities. Simmons has expertise in healthcare policy, reimbursement principles from government programs (Medicare and Medicaid), and healthcare financial analysis and cost accounting. Much of her focus throughout her career has been on identifying revenue opportunities and pursuing them through improving hospital operations and by Medicare filings and appeals. Prior to relocating to Vanderbilt, she was the director of clinical revenue and reimbursement for the University of Texas MD Anderson Cancer Center, where she was responsible for Medicare and Medicaid reimbursement, cost accounting, revenue and rate-setting, financial analysis, and clinical decision support reporting. Simmons serves as an advisory board member for NAHRI.

Terri Rinker, MT (ASCP), MHA

Terri Rinker, MT (ASCP), MHA, is the revenue cycle director at Community Hospital Anderson, an affiliate of the Community Health Network in central Indiana. She thrives on working with her team to develop new and improved processes for the revenue cycle, and was awarded her organization's award for innovation in 2012. In the past 20+ years, she has worked to find creative ways to bridge the gap between the clinical and financial side of healthcare. Whether partnering with her clinical counterparts to produce humorous educational videos about healthcare reimbursement or sending out monthly newsletters, Rinker is always looking for ways to engage clinical staff and non-clinical staff. Rinker serves as an advisory board member for NAHRI.

Introduction

by Valerie A. Rinkle, MPA

This book is a milestone. It represents the progression of the idea of revenue integrity from a concept to a full-fledged discipline that is being recognized as a professional identity and credential. Therefore, it is important to review the history of revenue integrity, where it is as of this book's publication, and how it is likely to evolve.

History of Revenue Integrity

The term and concept of revenue integrity began emerging early in the 21st century. This emergence was partly in response to concerns that phrases such as maximizing and optimizing revenue might imply gaming or failure to comply with regulations, laws, and business ethics. Using the term "integrity" acknowledges compliance with requirements as well as ethical business practices in obtaining and managing revenue.

The concept of revenue integrity gained strength due to the proportional increase in outpatient revenue and the fact that managing outpatient revenue in more complex than managing inpatient revenue. This is evidenced by the fact that the Medicare Code Editor (MCE) for inpatient claims has 19 edits compared to the 101 edits (as of January 2017) from the Integrated Outpatient Code Editor (I/OCE) applicable to outpatient claims. Furthermore, the National Correct Coding Initiative (NCCI) edits began in 1996, and by the early to mid-2000s, providers were feeling the impact of these edits and needed to grow and obtain the competency skill set required to respond to, and ultimately, prevent edits can erode net revenue and slow cash flow.

Finally, as electronic health record (EHR) software implementations accelerated across the country beginning in 2010, the accounts to which these edits applied could be routed to work queues. Who was

qualified to resolve the issues and edits on the accounts in these work queues? Suddenly, consultants said that revenue integrity specialists were appropriate to work the accounts in the queues. The challenge, however, was that no single existing discipline in the classic revenue cycle functions could address the edit issues in the work queues. In addition, there were no good models for integrating different disciplines, such as coding, billing, case management, etc. This leads us up to the present. Today, the concept of revenue integrity has evolved beyond a concept into a required function for healthcare providers up to and including formal revenue integrity departments and organizations. This evolution has created the need for a professional organization, standards, and ultimately a credential to validate the hard work that these professionals have invested to learn, lead, and improve revenue while also adhering to compliance requirements.

Revenue Integrity Functions

The National Association of Healthcare Revenue Integrity (NAHRI) states that the basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that are able to withstand audits at any point in time. This definition was not easy to arrive at, because revenue integrity encompasses so many functions that must be coordinated and integrated in a manner that continuously results in root cause correction and process improvements. The tenets outlined in NAHRI's definition are at the heart of effective revenue integrity.

Also key to revenue integrity is a sound understanding of the revenue cycle processes, including the following:

- Front-end processes, such as patient access and provider credentialing

- Midcycle processes, such as documentation, charge capture, and coding

- Back-end processes, including claim production and billing, follow-up and collections, payment review and payer contracts, denial management, and financial and key performance indicator reporting

Revenue integrity is woven into each of these processes and surrounds them with additional elements, such as sound compliance and privacy practices, automation and technology, leadership and mentoring of staff, demonstration of ethics at the highest level, diligent monitoring, analytics, and anticipation of changes in the healthcare reimbursement and regulatory landscape.

Core Functions of Revenue Integrity will outline some of these key functions and address how revenue integrity as a concept is intended to integrate the functions so that continuous process improvement occurs to avoid repetitive issues and to ensure optimal payment that can withstand scrutiny. This book is both a primer and a guide for professionals and organizations in their quest for revenue integrity.

Revenue Cycle

Revenue cycle management is ensuring all the front-, middle-, and back-end processes are working well and are monitored to meet the cash flow requirements of the organization. But within these processes, there is a myriad of complex components. Revenue integrity professionals work with revenue cycle professionals to drill down into the details of each component to learn the legal requirements, the technology and automation opportunities, the process weaknesses, and future changes that must be addressed.

Once these items have been identified, revenue integrity then turns this detail into education, training, procedures, and enhanced automation. Often, a change to just one component can represent a major project requiring a budget, timeline, and stakeholder involvement. Revenue integrity professionals not only identify the project need but also calculate the return on investment and then become the project managers who execute and achieve the anticipated benefits.

Due to the heightened ethical approach of revenue integrity professionals, they are often acutely aware of patient safety, privacy, and experience issues as well as staff training and morale issues. These concerns are always at the forefront of the efforts initiated. Maneuvering through these issues takes emotional intelligence and leadership that NAHRI will help foster in those attracted to this emerging profession.

Coding

Coding is a middle function of the revenue cycle, but it is complex and requires coordination between the certified coders who dynamically code accounts based on documentation and the codes that arise from charge capture and the chargemaster. This coordination takes place in numerous places, including the following:

- The medical records abstracting modules
- The grouper software and bi-directional interfaces between the abstract and grouper software

- The interface between the chargemaster and abstract

- The synchronization of code edits at the point of health information management (HIM) coding and claim production in billing

Revenue integrity staff may or may not have coding credentials, but a strong knowledge of coding principles and guidelines is necessary for both ICD-10 and Healthcare Common Procedure Coding System coding as well as HIPAA transaction sets, including the National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) requirements for claims. A working knowledge of modifiers and code edits is also necessary to help resolve issues that arise on an account-by-account basis and to systemically solve recurring issues based on analytics.

Coding principles differ between inpatient and outpatient accounts, and appropriate codes may differ for the same service based on payer reimbursement methods and contract terms. Revenue integrity professionals must keep this myriad of coding issues in mind as they work with staff. Much of this knowledge is self-taught if not learned through formal education, but it is a necessary element of effective revenue integrity within an organization.

Denial Management

Although denial management—or more precisely, denial prevention—is a component of the revenue cycle, it is one that demands dedicated resources, analytics, and project management skills. Denials must be trended and segmented and then routed to team or staff members who have the expertise to evaluate the denials. Evaluation includes determining whether to appeal within the timelines required by the payer, developing and filing the appeal when appropriate, determining the reason for the denial in the first place, and pursuing root cause corrective action to prevent more denials.

Denial management requires leadership and management skills with a relentless drive for accuracy. Denial management entails collaboration with clinicians (e.g., surgeons, nurses, allied health professionals). Often, to develop an appeal, clinicians other than the healthcare provider, such as primary care physicians, therapists, and others, may need to be contacted. Clinicians can provide persuasive rationale as to the appropriateness of a service even when it does not meet the letter or technical demands of a coverage policy. Increasingly, denials relate to noncovered services due to coverage policies that include requirements of failed conservative treatments over extended periods of time. The hospital provider should not assume that the performing clinician has validated coverage per the payer policies, much less

provided the source documentation to the hospital in advance of scheduling the procedure. The hospital medical record must stand on its own when submitted to the payer to substantiate coverage of the service, not to mention supporting the charges on the claim. The hospital should not perform financial advocacy and up-front estimates with the patient without first confirming coverage. Once a patient hears the estimate of what he or she may owe out of pocket, it is very reasonable for the patient to assume that coverage of the procedure or service has been verified.

This will become a key component of the denial prevention process that is just beginning to dawn in revenue integrity processes. More will be developed in the next few years concerning the need for formal preservice coverage analysis teams as part of the patient intake and financial advocacy processes.

Edit Management

Another area that requires leadership and management skills is edit management. Edits occur at just about every step of the account/revenue cycle process. However, they require sophisticated knowledge of coding, including modifiers, claim locators, and billing requirements. This knowledge is not easily obtained. Although providers purchase software tools to bolt onto their EHR systems to assist in edit management, those tools merely identify an edit and do not provide the analytical framework to evaluate and resolve the edit. What occurs with accounts routed to work queues due to edits is that the staff may not know how to resolve the issue, so staff do not correct the edit and merely route the account to yet another work queue for another staff member to solve. Billers send accounts back to coders, and coders send the same accounts right back to billers, and neither knows how to resolve the edit. I call these "whirlpool" accounts, because they swirl among staff and work queues in the organization, many times being written off as past timely filing because they get caught in the swirl of work queues.

Because staff are incentivized to work through as many accounts as possible in a day to meet cash flow objectives, these accounts often receive a much higher volume of "touches" and yet are not ultimately resolved. This approach is a drain on resources. A better way forward is needed with accounts that have these types of edit issues. Such accounts should be viewed by the revenue integrity management team together—that is, they should all view the account together in a room using the same tools each of their staff have at their disposal to research and solve the issues and ask the following type of questions:

- Is the edit a valid edit?

- Is it a code edit or a bill edit? If it is a code edit, do the coders see the same edit as the billers see? If not, why not?

These and other questions need to be asked and answered to get to the root of the issue. What a morale booster to be able to report back to staff that the root cause has been identified, solutions have been put into place, the total number of similar accounts spread throughout work queues have been identified, and the solution will be broadcast to those accounts and they will be cleared out. Staff should not be worried if work queues are cleared of some accounts. New accounts and more work will always arise because new codes and new edits occur quarterly, and providers begin performing new and different services all the time. What does not make sense to revenue integrity is to continue adding staff resources to handle a growing volume of accounts in work queues.

Charge Capture

Effective charge capture is another area requiring skilled interactions with clinicians. Fortunately, most providers have evolved from days past when charges and supply stickers were identified on fee tickets that were routed to data entry personnel. With EHRs, charge entry should be automated as much as possible. Because nursing and other nonclinician (clinicians are medical doctors, nurse practitioners, physician assistants, and clinical nurse specialists with privileges to order and perform services) require orders before they can perform any services, the automated charge capture process always starts with a proper and complete order—whether that order be via Computerized Provider Order Entry (CPOE) or on a prescription that needs to be transcribed or entered into the order process manually.

The order should trigger the documentation template that the staff must complete to document that they carried out or executed the order. This documentation should trigger the charge capture. Revenue integrity professionals should work to eliminate the need for staff to first complete their required clinical documentation of the services provided per the order and then take a second or subsequent step to go to a separate screen to capture charges. This latter process is no more than automating the paper charge tickets of days gone past and creates a two-step process, whereas full clinical documentation in the template setup via an order is a one-step process.

However, most EHR implementations default to the two-step process, thereby requiring revenue integrity professionals to manage multiple projects, department by department, to update and improve the charge capture process and charge triggers to a more efficient one-step method. Each department, and at times each type of service within a department, may require numerous steps, including updates to order sets to accomplish improvements in charge capture. Managing this process is a significant function for revenue integrity professionals to implement and manage.

Eligibility and Coverage

Numerous topics related to insurance have already been mentioned—coverage policies, patient financial liability, financial counseling, and advocacy. These issues stem from a detailed understanding of insurance eligibility and coordination of benefits. They are another major source of denials, so revenue integrity professionals are involved in breaking down the component parts and building up people, process, and technology initiatives to prevent and improve problems around eligibility issues.

Like eligibility, coverage policies stem from understanding payer policies but also understanding the concept of medical necessity and how it is substantiated in medical record documentation via orders, diagnoses, procedure notes, and progress notes. When a patient desires a service that does not meet the payer's coverage policies, then advance notice and formal waivers must be issued to protect both the organization and the patient from unexpected liability. Revenue integrity professionals closely monitor the regulatory and payer requirements regarding notice and collaborate with case management for notices applicable to inpatients.

Included with the legal requirements is the fact that these notices and waivers are a requirement of patient rights that revenue integrity professionals strive to protect along the patient continuum of care.

Regulatory Changes and Advocacy

Healthcare is one of the most regulated industries in the United States, and probably no other industry's revenue is quite as impacted by quarterly and annual regulatory changes. Therefore, a significant amount of due diligence is required to monitor regulatory changes, evaluate the operational and financial impact, and communicate with executives, other managers, and staff. This due diligence is differentiated from that performed by compliance professionals because revenue integrity is focused on operationalizing the compliance requirements rather than on the steps of the compliance plan or program.

But regulations are written in government speak, which means that revenue integrity professionals must become translators within their respective organizations—taking the regulatory requirements delineated in government terms and breaking them down into healthcare operational terms, action steps, and, ultimately, strategic implications for the organization. The good news is that there is a process for revenue integrity to influence the changes imposed by the government. The regulatory process required by the Administrative Procedures Act (APA) includes the process for proposed rules, where comments are

required to be solicited and can be submitted to persuade government policymakers of the operational and administrative burdens their policies would impose, not to mention unintended consequences, both financially and for beneficiaries. Revenue integrity professionals feel a keen sense of responsibility to not only educate and inform their organizations of changes but also to advocate for the industry as a whole by participating in forums and submitting public comments to the proposed regulations that they must monitor.

Finance and Reimbursement

It is incumbent upon revenue integrity to understand how patient accounts feed the general ledger, which feeds income statements and ultimately the Medicare and Medicaid cost reports of the organization. This level of understanding is vital to helping the organization realize that each and every one of its claims and its collective cost report data influence future Medicare payment rates. Furthermore, these mechanisms are foundational to the financial viability of the organization.

Revenue integrity management know that collection staff will not use payment or contractual adjustment and write-off transaction codes if they are too many and too complex. Inconsistent application of payment and adjustment codes leads to a form of "garbage in, garbage out," preventing meaningful analysis. There is a balance that revenue integrity should help maintain so that analytics performed from financial accounting practices is accurate and meaningful. This includes carrying the torch of what charges represent. They are to be consistently and reasonably related to the cost of the service and applied uniformly, whether the patient is an inpatient or outpatient and regardless of payer or no payer source. This is the gross charge and can be contractually adjusted or discounted either prebilling or postreceivable from the payer. What is crucial is that the charge is posted at the gross level in the patient accounts appropriately and related to the underlying costs.

Revenue integrity staff members are usually responsible for maintaining the chargemaster and prices for the organization. This task includes raising the issue when prices should be reduced or modified when the underlying cost at one provider or location of service is different. Doing so requires analytics to understand comparative pricing for similar services as well as price transparency requirements and payer contract price limitations as well. For nonprofit organizations, it also includes monitoring the Internal Revenue Service (IRS) section 501r requirements for financial assistance.

Collaboration with finance, payer, and cost reporting staff is crucial to the effective performance of these revenue integrity functions. This includes a deep understanding of all the different payment methodologies that apply to the provider's services, including the Medicare prospective payment systems for inpatient and outpatient hospital services, to physician, ambulatory surgery, and other fee schedules up to and including accountable care, bundled payment, and capitation.

Monitoring correct payment is vital as many payers adopt reimbursement methods in which they are not well versed or in which their software systems are not sophisticated or accurate. Diligence in confirming accurate payment to contract terms is a key function of revenue integrity.

Conclusion

These topics and many others will be surveyed and explained in the upcoming chapters. Both basic and sophisticated issues will be discussed, so this book is designed for a wide range of revenue integrity professionals. If there is an area discussed for which your organization does not have processes, then use the information as a tool to fill in gaps. It is also hoped that *Core Functions of Revenue Integrity* will be used to encourage and develop those staff who are inquisitive and potential rising stars within your revenue integrity organization. As leaders, we must be stewards of the collective knowledge and skills acquired within the organization for revenue integrity and ensure a continuing legacy. This book can be a tool to help both management and staff gain additional understanding and a solid underpinning for what is hoped to be a fulfilling and enjoyable career in this profession.

1 Understanding How Revenue Integrity Fits Into the Revenue Cycle

by Donna Schneider, RN, MBA, CPHQ, CPC-P, CHC, CPCO, CHPC

Overview of the Revenue Cycle

Understanding the revenue cycle is important for those who have job responsibilities related to revenue integrity. The revenue cycle work begins with registration and then flows through to the following:

- Precertification/prior authorization

- Prebilling review

- Case management

- Clinical documentation improvement (CDI) specialists

- Chargemaster review

- Revenue integrity review

- Utilization review

- Managed care contracting

- Patient accounts (financial services)

- Billing

- Accounts receivable follow-up

As you can see, the revenue cycle encompasses many clinical and administrative functions related to the capture of charges and appropriate payment of the patient bill. It becomes quickly apparent that multiple staff members touch various aspects of the patient medical record to create a clean billing record.

The revenue integrity professional is charged with ensuring that the proper procedure and diagnosis codes are billed for the service ordered and for ensuring that the codes match the documentation in the clinical record. In this regard, the goal of revenue integrity is to secure the correct payment, which is as important to organizations as it is to patients. With high-deductible medical plans, patients need to have correct billing records, as they are heavily responsible for a growing percentage of their healthcare expenses.

As most clinical professionals are taught, "If it was not documented, it was not done." That adage remains true. However, given the amount of scrutiny of the healthcare medical record and the complex world of healthcare regulations we live in today, the age-old adage has changed. It now reads, "If the service is not documented, it was not done. If the service is billed, not documented, and paid, there will be a repayment, and potential fines."

The Role of Professionals in the Revenue Cycle

To give a better understanding of the broad scope of staff functions, the list below is a general guide to the revenue cycle information provided by various roles within the health system:

- **Registration.** There are staff who gather patient information, including demographics, insurance, procedure to be performed, diagnosis, provider name, and any other pertinent information needed specific to the entry in the computerized patient record of the organization.

- **Precertification/prior authorization.** Prior to the date of service, these staff members contact the insurance company or organization responsible for payment to provide required diagnosis and procedure information to obtain approval to perform a service. Most payer organizations will qualify this approval with the statement that "precertification/prior authorization does not guarantee payment." That said, if a medical provider does not obtain the requisite precertification/prior authorization, the service will usually be denied under the realm of an administrative denial and no payment will be made, despite rendering medical care. These staff generally work in the outpatient setting, which can include radiology, laboratory, and physical, occupational, or speech therapy.

- **Prebilling.** These staff members test specific claims or claim types in the computer system to gather information on computer edit requirements. They may also gather any additional information required to send a claim that is free from errors to secure payment in an expedited fashion.

- **Case management.** These staff members are usually clinically trained nurses and/or social workers. They review the clinical documentation of the patient, generally in the inpatient setting, to ensure

that the patient remains under a level of care that can only be treated in the hospital. Case managers also work to secure safe discharge plans for the patient given the specific patient is needs and preferred discharge setting.

- **CDI specialists.** These are staff members, usually clinically trained nurses, who will work with attending physicians and hospitalists to ensure accurate and timely capture of all diagnosis and procedure information in the inpatient medical record. These staff have been primarily focused in the inpatient setting, but as healthcare moves its focus to value-based reimbursement and the outpatient realm, CDI specialists must also focus on physician documentation in an ambulatory setting, such as physician offices, radiology, and ambulatory surgery.

- **Chargemaster review.** These staff are responsible for ensuring that the organization maintains an accurate chargemaster in both Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes, revenue codes, and general ledger linkages.

- **Coding.** These staff usually specialize in physician coding or outpatient or inpatient hospital coding. They are responsible for reviewing the physician documentation to review or assign the appropriate billing and diagnosis code. Physicians typically code their own services in office settings. In this instance, coders will review the codes assigned by the physician and may suggest edits depending on the scope of the practice. Larger facility organizations work with their physician and clinical teams to query medical staff to ensure correct assignment of CPT, revenue, and diagnosis codes.

- **Utilization review.** These staff work to secure inpatient approvals from insurance companies or payment sources for one day or every day until the end of an inpatient stay. Frequently, they are clinically trained physicians or nurses. They are tasked with navigating a complex maze of clinical and administrative payer policy guidelines. This role often requires a tremendous amount of faxing paper back and forth, unless the provider organization has allowed the payer organization on-site or virtual review of the electronic medical record. Additionally, utilization review staff members will work to establish peer-to-peer reviews between the inpatient facility physician reviewer and the payer organization physician reviewer. Peer-to-peer reviews are the key to securing payment when the payer has deemed that the level of inpatient care no longer meets the level covered under the patient's specific insurance contract.

- **Managed care contractors.** These are staff that work to negotiate specific payment rates and terms with insurance companies, payer organizations, and large self-insured employers for services provided by their organization. Their role involves financial analysis and management. They are also responsible for communicating with members of the revenue cycle team to interpret and assist in

operationalizing the requirements of the specific payer contract and working as a liaison between the provider organization and the payer to smooth out payment/denial issues.

- **Patient accounts (financial services) billing.** These staff send out bills to specific payers. They generally work by geography or payer types to ensure that work queues for bills are reviewed for claim edit errors that must be fixed to allow the claim to leave the organization and arrive at the payer for payment.

- **Account denial follow-up.** These staff review claims that are unpaid or were denied. They follow up on pending claims and provide guidance on denied claims to secure payment for the organization.

- **Health information management.** These staff members secure the integrity of the medical record and ensure that each record, whether inpatient or outpatient, is deemed complete based on required information delineated by organizational policy. Medical records should be complete prior to sending the bill for payment.

Revenue integrity professionals are a key component of the revenue cycle. These staff work to ensure that internal controls are in place to create clean claims that are supported by documentation, billed to the correct payer, and paid correctly. Some organizations place the chargemaster professional in the core of the revenue integrity function so they can implement accurate billing codes and edits based on the service line. Equally important is the education that revenue integrity professionals provide to both clinical and administrative staff daily. The revenue integrity staff often translate from the clinical to the administrative area, describing the services provided, the coding for those services, and the associated revenue impact. Revenue integrity professionals update both clinical and administrative staff on the pre-certification or prior-authorization requirements of the service and any other billing limitations or edits.

Compliance and Privacy Professionals in the Revenue Cycle

Alongside the revenue integrity professional is his or her partner in the office of privacy and corporate compliance. Revenue integrity staff frequently reach out to their compliance and privacy colleagues for help with the following:

- Requests for specific information on governmental regulations

- Assistance with interpreting new billing requirements

- Assistance with managing medical record requests for payers or auditors

Healthcare is riddled with requests for medical records. Many of those requests are to audit medical services to ensure that the facility properly documented and coded the diagnosis it billed. Often, Medicare and Medicaid send these requests to revenue cycle staff who must collaborate with their colleagues in compliance and privacy to get the job done. Although the billing documentation may seem clear, there are nuances in payment policies or government regulations, so it is best for departments to work collaboratively to ensure that nothing is misinterpreted.

Compliance and privacy professionals educate staff to prevent billing errors when possible and analyze and mitigate errors if they are made. They are responsible for reinforcing billing rules and regulations, which means ensuring that staff are educated on the rules applicable to their facility and, as a last resort, working with management and human resources to sanction staff in the event that policy is violated.

Compliance and privacy must collaborate with revenue cycle professionals to establish a proactive auditing and monitoring plan each fiscal year. This plan would be based on the following:

- Activity from previous self-audits

- Activity from previous payer audits

- Activity within the organization's state

- Reviews conducted by the Office of Inspector General

- Audits conducted by the organization's Medicare Administrative Contractor and state Medicaid agency

It is a best practice for the organization to establish a monthly meeting between revenue integrity, revenue cycle, compliance, and privacy professionals to share plans auditing and monitoring as well as to go over OIG reviews. The group should review areas in which claims need to be refunded to a specific payer so they can discuss the source of the error and the mitigation plan to ensure that the error does not occur in the future. Federal guidelines state the organization can take up to six months to quantify an error once discovered. That said, at or before the six-month mark, once quantified, the organization has up to 60 days to refund the appropriate payer. Best practice would be for one individual in the organization to track all of those associated refunds and due dates to be reviewed by the joint revenue cycle, revenue integrity, compliance, and privacy team so that all deadlines can be maintained and reported quarterly to the governing body of the organization. Compliance and privacy staff will also provide

guidance on privacy questions and release of medical record information as situations arise within the revenue cycle.

The Role of Revenue Integrity in Organizational Compliance

The revenue integrity professional plays a key role in compliance within the organization by the virtue of their role in the design and maintenance of the chargemaster. These staff work to ensure that the chargemaster can live up to an audit by any payer at any time. Additionally, revenue integrity staff members are frequently involved in the analysis and quantification of any billing error, question, or concern. These staff will run reports and analyze data to determine the extent of the billing problem and payment implications. They also work with the information technology and information security staff to design edits and flags in the electronic medical record system to prevent the occurrence of the same or similar billing error in the future. The revenue integrity professional supports the following seven elements of a successful compliance program and is an integral piece of the compliance program design and effectiveness:
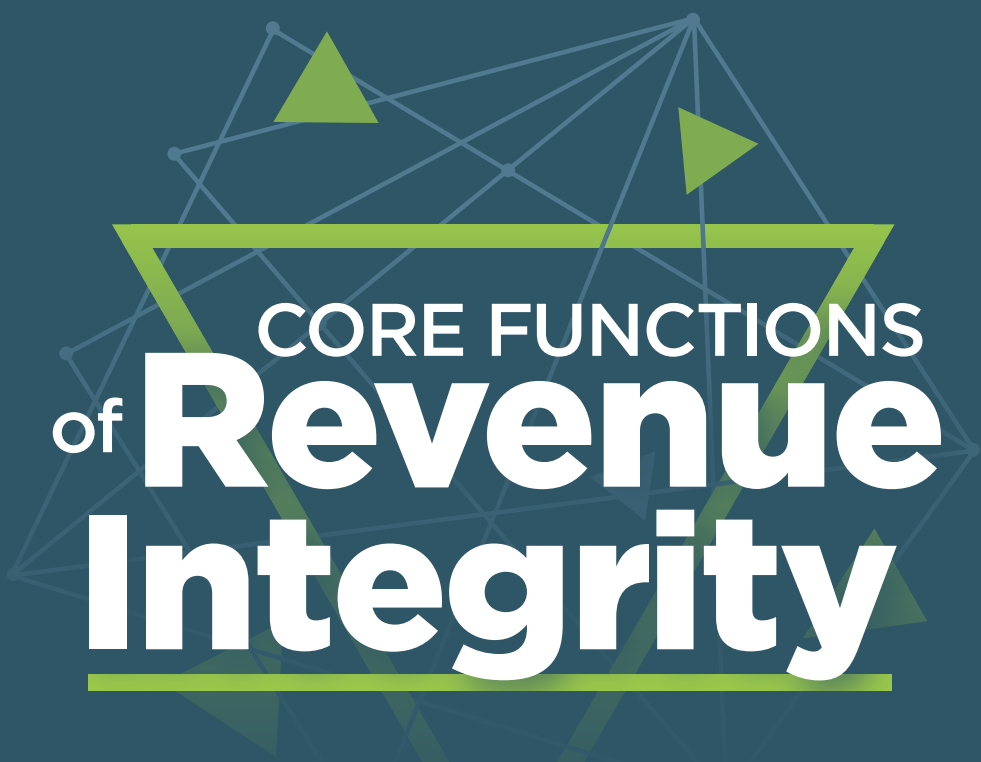
1. **Standards of conduct/policies and procedures.** Revenue integrity professionals work to design a variety of policies and procedures. These staff, along with others in the organization, are held to the standards of the code of conduct adopted by the organization's board of directors.

2. **Compliance officer and compliance committee.** Revenue integrity professionals provide valuable insight and information to the compliance officer and staff for reporting on claim accuracy and audits to the compliance committee.

3. **Education.** Revenue integrity professionals assist in education of diagnosis and procedure code-specific documentation requirements to ensure the submission of clean claims to the payers.

4. **Monitoring and auditing.** Revenue integrity professionals assist in the audits and monitor items as designed in the annual compliance work plans.

5. **Reporting and investigating.** Revenue integrity professionals may encounter and report items of compliance concern and assist the compliance department with the investigation of the issue to facilitate timely and appropriate remediation.

6. **Enforcement and discipline.** Revenue integrity professionals are subject to the same requirements for enforcement and discipline as the rest of the organization's workforce. Their expertise is valued in terms of looking at the compliance issue and how best to address specific disciplinary actions, given the nature of the infraction.

7. **Response and prevention.** Revenue integrity professionals may be called upon to assist in the response and prevention of compliance issues given their broad knowledge of the revenue cycle and expertise in billing and payment collections.

The role of the revenue integrity professional is vast and varied and deeply embedded in the success of the revenue cycle. It is these staff members who contribute to the success of the compliance and privacy programs at each organization. The collaboration of revenue integrity, revenue cycle, privacy, and compliance results in oversight of the documentation, billing, collection, and integrity of the medical record. This helps ensure that the organization can successfully respond to all audit requests without sanctions or fines.

In the complex world of healthcare, it is not a matter of if an organization will receive an audit request but when the audit request will arrive. Knowledgeable, educated revenue integrity professionals who collaborate with their colleagues in compliance and the revenue cycle will be on the forefront to assist their organization in the challenges these audits present.

NAHRI
National Association of Healthcare Revenue Integrity

CORE FUNCTIONS
of Revenue Integrity

As more facilities develop revenue integrity programs and departments, there is an ever greater need to develop educational materials and training for these professionals. NAHRI's **Core Functions of Revenue Integrity** examines how each piece of revenue integrity comes together on a macro and a micro level by looking through the lens of 10 core functions. It provides actionable advice and guidance for revenue integrity professionals, whether they are new hires or experienced veterans.

This book provides a well-rounded perspective on revenue integrity, covering everything from payment systems and reimbursement methodologies to denial appeals and charge capture review. It is authored by six NAHRI advisory board members whose collective knowledge and experience will help revenue integrity professionals ensure their programs are running effectively and capturing revenue opportunities.

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ISBN-13: 978-1-68308-658-1

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