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Integrate Revenue Cycle, Clinical Documentation and Utilization Management

September 13th, 2017

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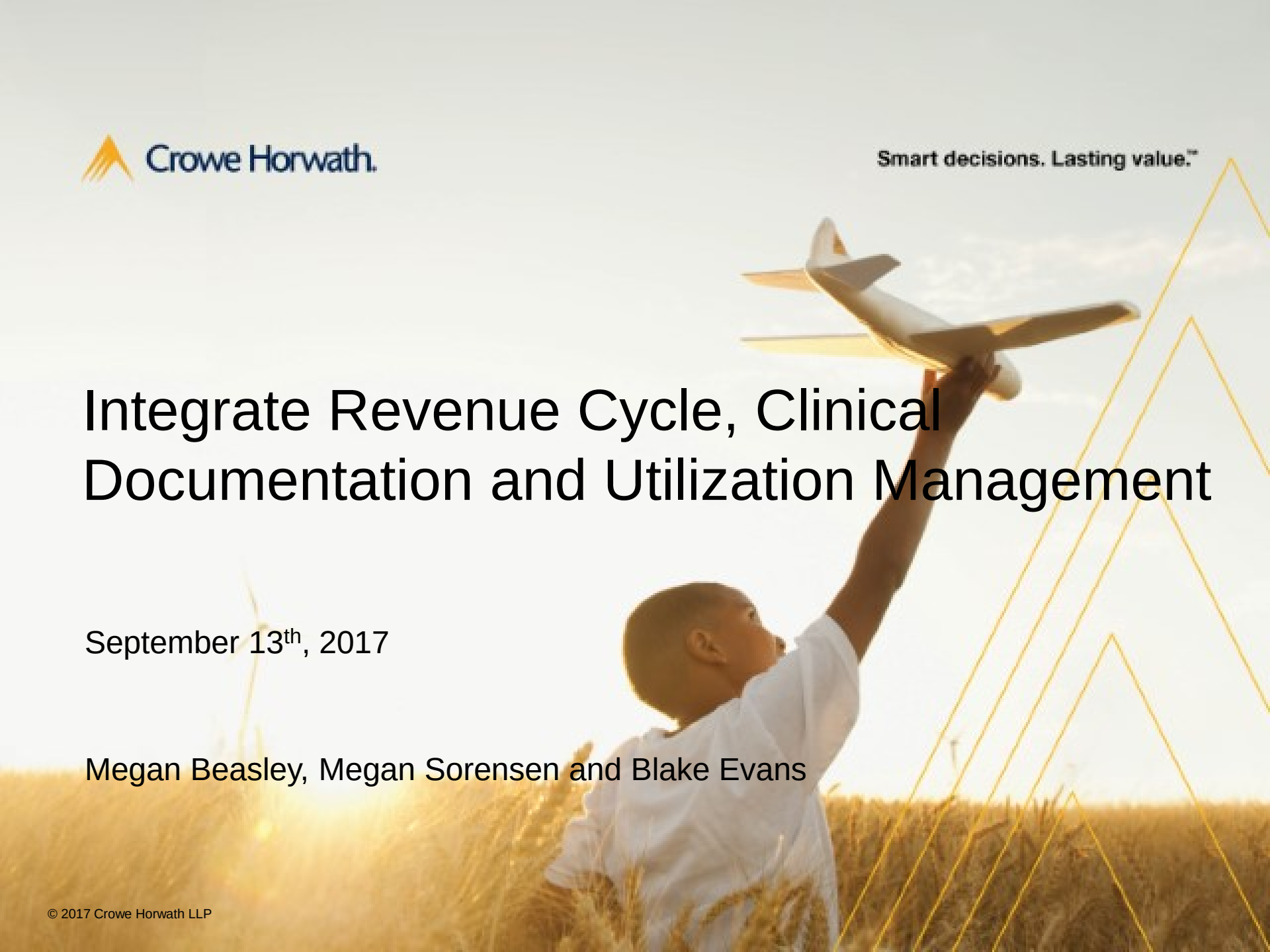


Today's Speakers

Megan Sorensen

Megan is a Senior Advisor within Crowe's Healthcare Performance Practice. She has nearly 4 years of healthcare experience focusing on charge capture, CDM, clinical denials, utilization management, and coding compliance. Megan is a Certified Professional Medical Auditor (CPMA).

Megan Beasley

Megan Beasley is a Senior Manager within Crowe's Healthcare Performance Practice. She has more than 8 years of experience in the healthcare industry focusing on charge capture and revenue integrity engagements in regards to data gathering, analysis and interpretation, process improvements initiatives, and formulating conclusions and recommendations for clients. She is a Registered Health Information Administrator), Certified Professional Coder (CPC) and Certified Professional Medical Auditor (CPMA).

Blake Evans

Blake is a Senior Manager and the Revenue Cycle Operations Leader within Crowe's Healthcare Performance practice, based in Chicago. He has over 10 years of healthcare experience within several hospital systems, focusing primarily on patient access and other revenue cycle related roles.

Key Points for Today

- Overview of Each Department
  - Revenue Cycle
  - Clinical Documentation Improvement
  - Utilization Management
- Aligning Responsibilities
  - Education Program for Providers
  - Physician Advisor Roles
  - Payer Communication
  - Reporting and Dashboards
  - Length of Stay Monitoring
  - Concurrent In-House Reviews
  - Clinical Denials
- Integration of the Departments

Polling Question #1

- What is the average Accounts Receivable days metric for not-for-profit hospitals?

a) 34.1 days
b) 64.3 days
c) 55.8 days

Overview of Each Department

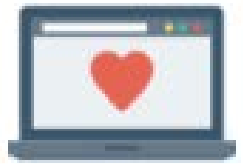
Revenue Cycle

Front: Prior to patient arrival and day of arrival

- Scheduling
- Pre-Registration
- Insurance Verification
- Registration

Middle: Patient stay and interaction with provider

- Case Management
- Utilization Review
- Clinical Documentation
- Coding/Transcription



Back: Post-Discharge and service

- Billing
- Collections
- Denial Management
- Customer Service

- **Patient's insurance coverage and benefits are verified by checking payor** databases via computer or phone
- **Authorizations and pre-certifications obtained** (many insurance companies require prior authorization for hospital services)
- Contacts insurance company for **initial notification of patient admission.**

- The **interpretation of medical record documentation** to identify all diagnosis, conditions, reasons for treatment, services and procedures performed
- **Assignment of necessary ICD, CPT, DRG, and/or HCPCS Codes**
- **Concurrent and retrospective review** of a admission status and medical necessity

- **Bills are labeled unbilled status** to allow for changes by front end or middle revenue cycle staff
- Following edit **bills are labeled final billed status**, scrubbed on final time for edits, and sent out the door to payor
- **Denials our received** from payor and resolved in billing office

Clinical Documentation Improvement

"Clinical Documentation Improvement (CDI) programs facilitate the accurate representation of a patient's clinical status that translates into coded data." – AHIMA

- The primary role of a CDI program is to concurrently review clinical documentation in order to ensure that all aspects of the patients' conditions, treatments and outcomes are accurately and completely captured in the medical record

- Responsibilities for a CDI Specialist (CDIS) typically include the following:
  - Review inpatient medical records on a daily basis to identify opportunities for missing or incomplete documentation
  - Assign and maintain working DRG throughout patient stay
  - Collaborate with HIM, case management, and clinical teams to promote enhanced quality of care
  - Analyze patterns and trends in clinical documentation to identify opportunities for improvement
  - Develop provider education strategies to continually improve clinical documentation and address negative trends

Clinical Documentation Improvement

- Beyond the obvious impact on coding and reimbursement, a successful CDI program can significantly improve various key hospital metrics, including:
  - **Medical Necessity Documentation –** Ensuring documented reasoning meets medical necessity guidelines for admissions, testing, procedures, etc.
  - **Compliance –** Monitoring record to identify possible compliance risks related to coding or documentation
  - **Quality of Care –** Ensuring that all comorbidities are clearly documented in order to accurately represent the Observed to Expected ratio (metric utilized as key indicator of quality of care)
  - **Patient Safety Indicators –** Promoting the accurate capture of all conditions present on admission in order to prevent negative safety measures

Utilization Management

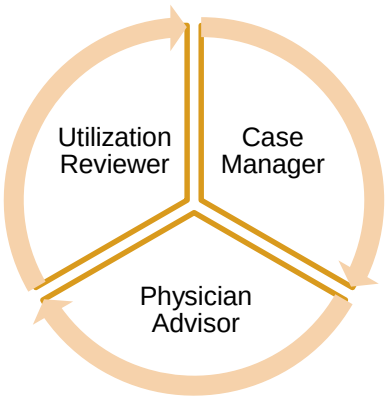
- Utilization Management is meant to manage healthcare costs by ensuring that appropriate care is being provided to each patient through case-by-case assessments

Utilization Review (UR)

- Responsible for assigning proper status to a patient; i.e. Observation vs. Inpatient
- Verify services provided to patients are documented in an accurate manner
- Reviewing patient status to ensure appropriate status has been selected (Observation vs Inpatient)
- Contact insurance company for authorization and approval for inpatient stay
- Conducts concurrent and retrospective review of patient status and medical necessity

Case Management (CM)

- Responsible for assessing, planning, facilitation care coordination, evaluation and advocates for the patients' care plan
- 5 Ways Case Managers contribute to hospital's bottom line:
    1. Proving patient outcomes
    2. Reducing readmission risks
    3. Eliminating avoidable days
    4. Enhancing claims management
    5. Boosting core competencies under PPACA (Patient Protection Affordable Care Act)



Utilization Management

- Along with managing the encounter throughout the patient's stay, the Utilization Management department handles certain clinical denials
  - Pre-emptive denial process including reconsiderations, retro-authorizations and prepping the Attending Physician or Physician Advisor for the peer to peer process
  - Formal appeal process for denials related to lack of pre-authorization/notification and lack of medical necessity
    - Department should monitor outstanding appeals for determination and additional levels of appeal

- Utilization Management teams should understand all payer requirements for authorization, notification and differences in their appeal processes

Polling Question #2

- Approximately how much revenue is lost by hospitals across the country each year?

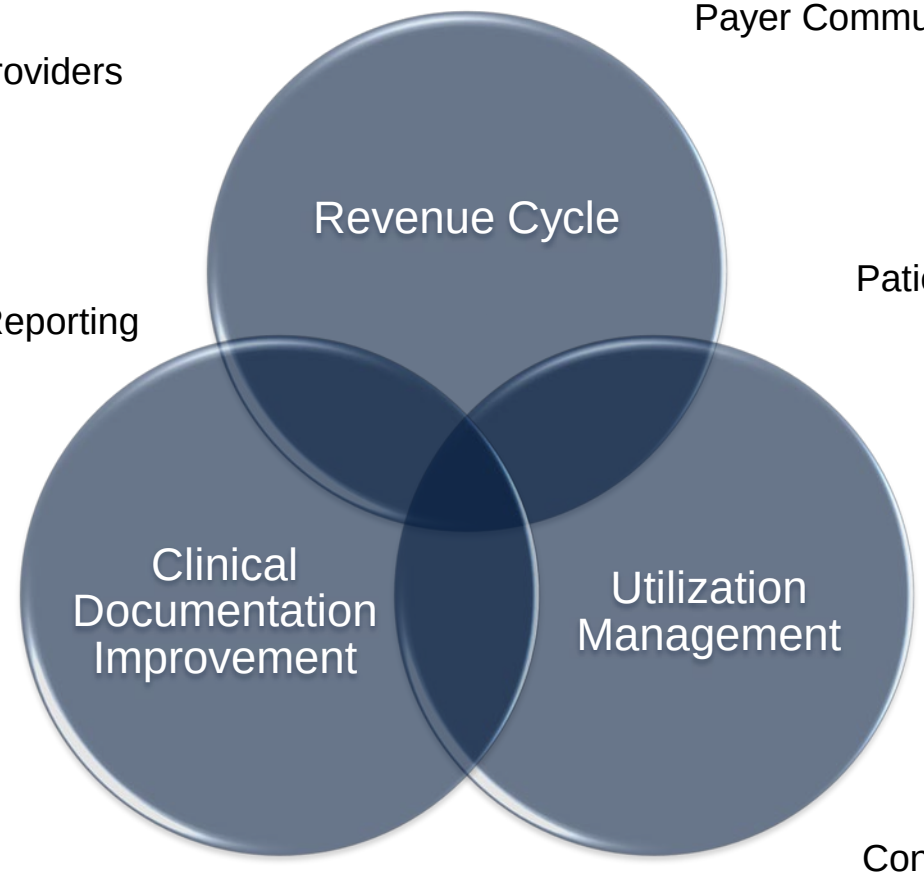
a) **$262 billion**
b) $173 billion
c) $88 billion

Aligning Responsibilities

Aligning Responsibilities

Payer Communication and Contracting

Education Program for Providers



Patient Status and Authorization

Dashboards and Reporting

Clinical Denials

DRG Validation Audits

Concurrent Reviews

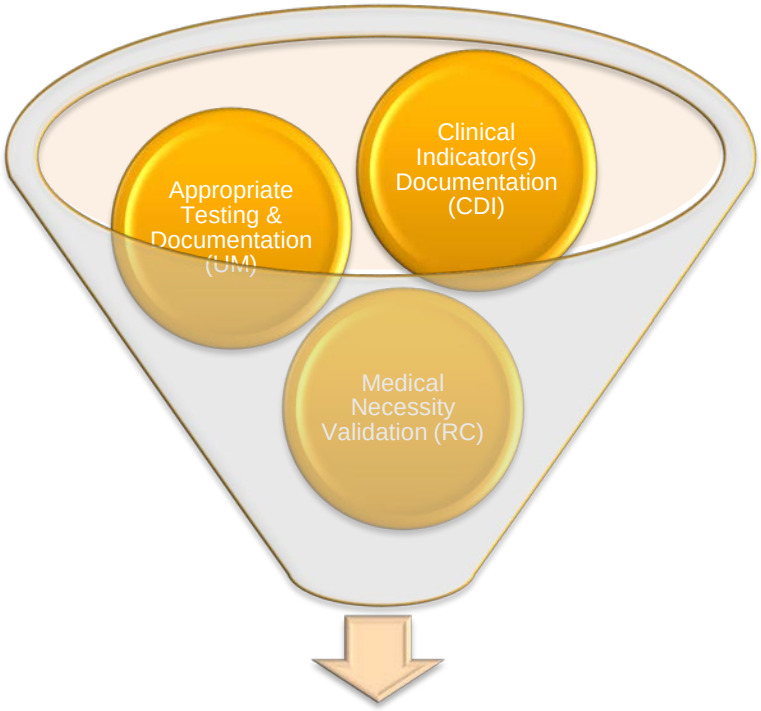
Length of stay (LOS)

Physician Advisor Role

Education Program for Providers

All Departments

- The Education and Training Program should be facilitated by the Physician Advisor in combination with members of the various departments. These programs should consist of the following:
  - Utilizing data analytics and trends to develop education needs for the organization
  - Develop focus points on documentation requirements
  - Targeted education or reminders to providers surrounding improved documentation needs to include the most detailed summary of the care being provided to patients
  - Education based on new CMS policies, guidelines and medical necessity



Consolidated Messaging

Physician Advisor Roles

All Departments

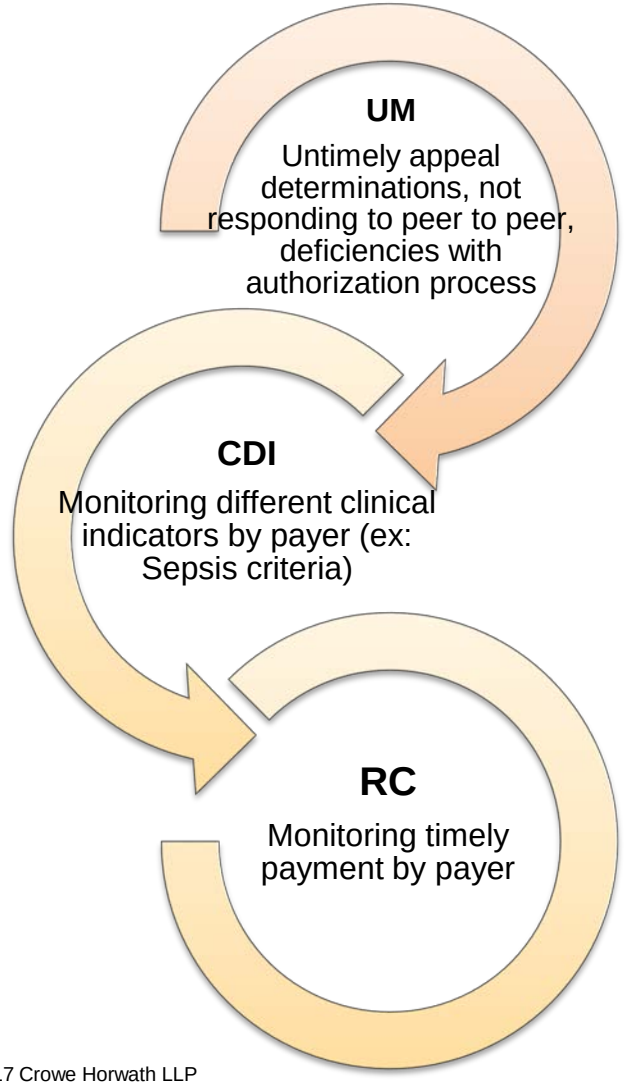
The role of a Physician Advisor has become essential to healthcare. Physician Advisors may be involved in many areas, including patient quality and safety, billing status determinations, clinical documentation, patient length of stay, utilization management, and appeals

- **Roles of a Physician Advisor**
  - Advisory – resource for case management, direct link to the Medical Staff to increase utilization review and quality, assist with medical necessity questions, liaison with other physicians
  - Administrative – review peer to peer cases as well as more complex cases
  - Educational – educational resource for case management, review other physicians, educate staff to increase collaboration

- **Benefits of a Physician Advisor Program**
  - Serve as an educational resource for UM and CDI
  - Serve as a means of appeal for health insurance claim denials
  - Decreased claim denials
  - Decreased avoidable days
  - Decreased hospital costs associated with denials
  - Improved documentation processes
  - Reduced length of stay

Payer Communication

All Departments



- Each department has a need to communicate with managed care payers
  - To avoid overlap, communication should occur between departments to identify issues with common payers with deficiencies
  - Efforts can be joined between departments to escalate deficiencies/issues to payer representatives
  - Deficiencies should be brought to the attention of the provider's Managed Care Department to incorporate into Managed Care negotiations

Reporting and Dashboards

All Departments

Denials Committee

- 835 data analysis
- Appeal determination tracking
- DRG Validation Audit results tracking
- LOS by payer and provider

- Combining efforts within reporting can create visibility into each department, help departments avoid duplication of work efforts, and create an accountability loop for improvement

Key Denial Performance Metrics				
Metric	January 2017	Previous Month	3-Month Rolling Avg	Corporate Avg
Initial Denial Rate[1]	5.70%	5.56%	5.34%	6.66%
Final Denial Write-off Rate[2]	0.26%	0.66%	0.46%	0.45%
Denial Realization Rate Variance[3]	-2.66%	-2.94%	-1.32%	-3.75%

		Previous Month		3 Month Rolling Average		12 Month Rolling Average		
Attending Physician	Month A	$ Denied	% Change	Avg $ Denied	% Change	Avg $ Denied	% Change	Denials ($) 13-Month Trending ($ are in Millions)
Physician A	$128,224	$229,778	-44.2%	$99,591	28.8%	$48,382	165.0%	
Physician B	$88,420	$0	0.0%	$0	0.0%	$0	0.0%	
Physician C	$40,277	$27,805	44.9%	$9,358	330.4%	$6,648	505.9%	
Physician D	$39,911	$0	0.0%	$11,911	235.1%	$14,910	167.7%	
Physician E	$36,966	$48,120	-23.2%	$38,615	-4.3%	$19,817	86.5%	

Reporting and Dashboards

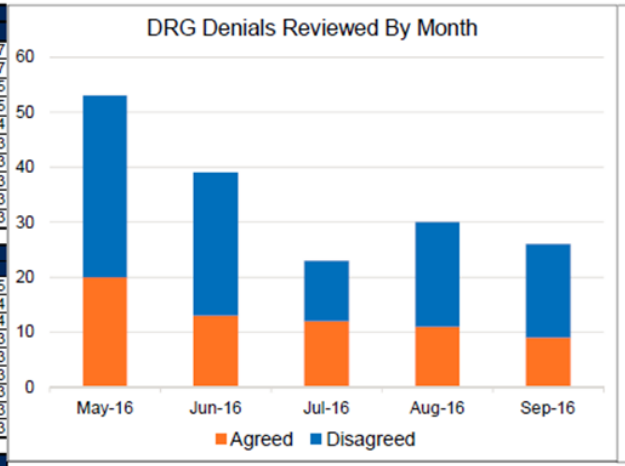
All Departments

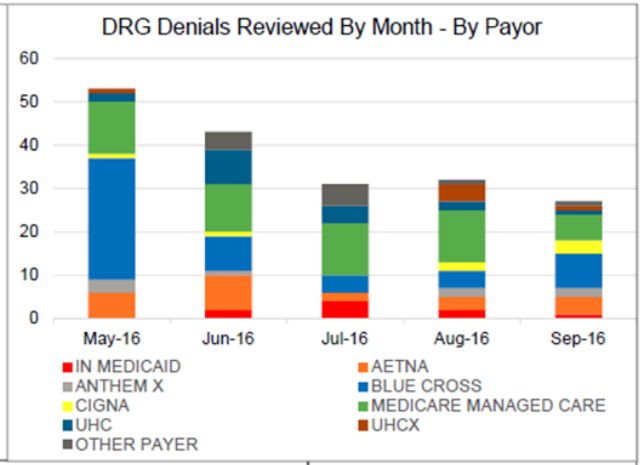
DRG Denials by DRG Original DRG	Agree	Disagree	Grand Total
871	4	3	7
794	3	4	7
682	4	1	5
765	2	3	5
190	2	2	4
896	3		3
872	2	1	3
286	3		3
64	1	2	3
742	3		3

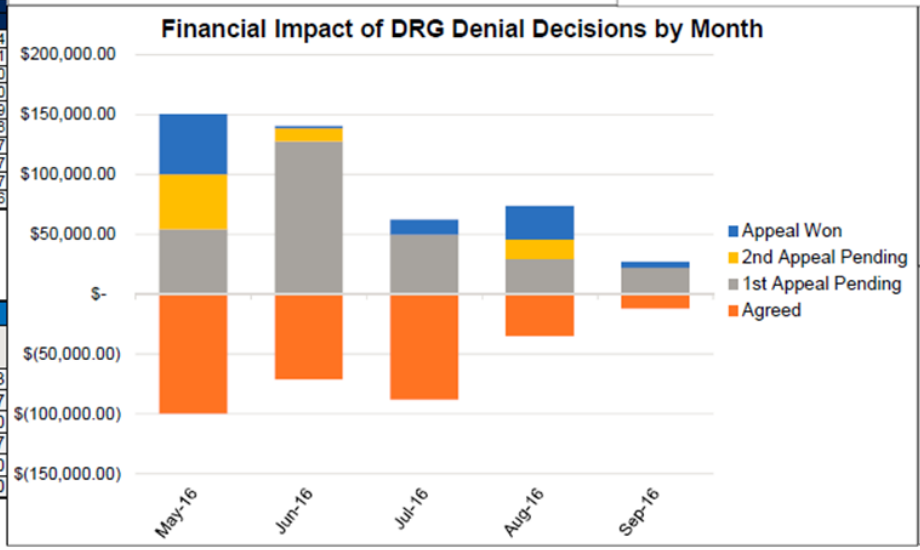
DRG Denials by Physician Attending Provider	Agree	Disagree	Grand Total
Physician 1	3	2	5
Physician 2	3	1	4
Physician 3	1	3	4
Physician 4	3		3
Physician 5	1	2	3
Physician 6	1	2	3
Physician 7	2	1	3
Physician 8	2	1	3
Physician 9	2	1	3

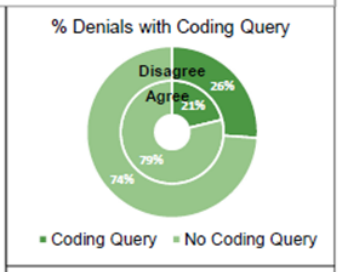
DRG Denials by Coder Coder	Agree	Disagree	Grand Total
Coder 1	8	6	14
Coder 2	7	4	11
Coder 3	4	6	10
Coder 4	7	3	10
Coder 5	6	3	9
Coder 6	6	2	8
Coder 7	4	3	7
Coder 8	5	2	7
Coder 9	5	2	7
Coder 10	2	4	6

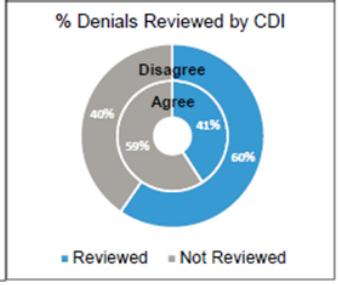
YTD DRG Technician Productivity		
Denial Decision	Accounts	Potential Revenue Impact
Agreed	65	-$306,453
Disagreed	106	$453,067
1st Appeal Pending	69	$282,360
2nd Appeal Pending	14	$73,267
Successful Appeal	23	$97,440
Unsuccessful Appeals	0	$0
Appeal Success Rate	100%	







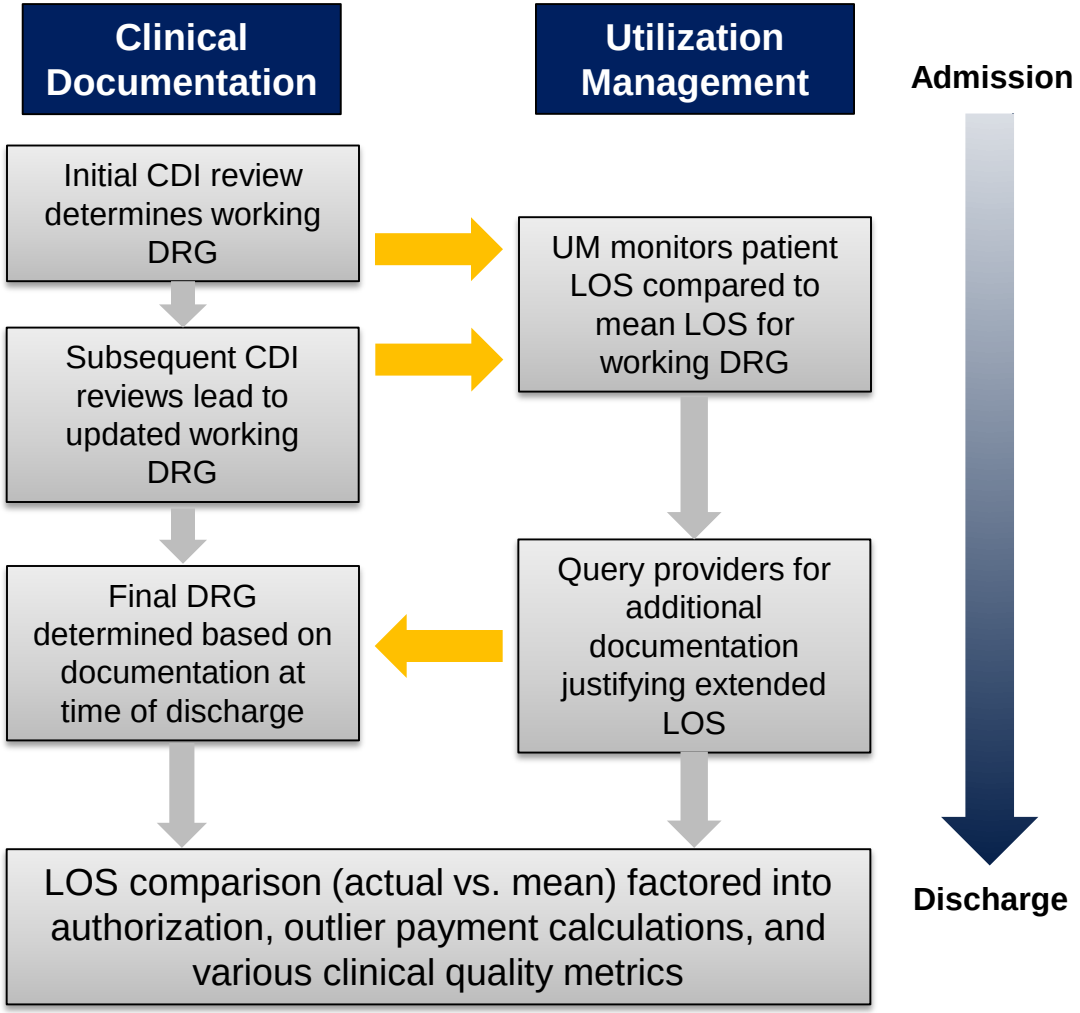




Length of Stay Monitoring

Utilization Management & Clinical Documentation Improvement

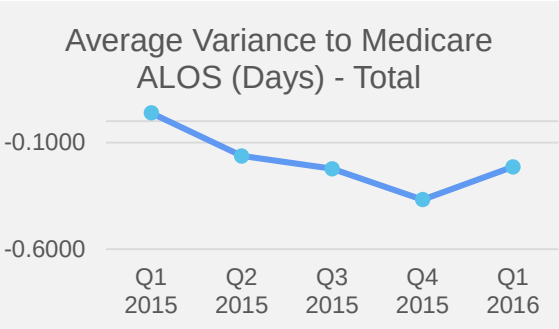
- Length of stay (LOS) used in hospital planning and various clinical quality metrics
- Monitored and impacted by both CDI and UM through concurrent record review
- Coordination between CDI and UM can significantly improve average LOS and overall patient quality



Length of Stay Monitoring

Utilization Management & Clinical Documentation Improvement

	General Statistics - Inpatient				
	Total				
	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Length of Stay (Days)	4.87	4.67	4.43	4.26	4.61
Average Variance to Medicare ALOS (Days)	0.0382	-0.1630	-0.2232	-0.3680	-0.2143
Total Count of Patients	4,469	4,471	4,895	5,046	4,730
ALOS > Medicare ALOS	1,562	1,524	1,586	1,533	1,571
ALOS <= Medicare ALOS	2,907	2,947	3,309	3,513	3,159
% of Patients > Medicare ALOS	34.95%	34.09%	32.40%	30.38%	33.21%
% of Patients <= Medicare ALOS	65.05%	65.91%	67.60%	69.62%	66.79%



Physician Breakdown - 5 Highest ALOS to MC ALOS Variance (Days)		
Physician	Average Variance	Count
Kim Smith	12.03	35
Tim Paine	6.90	43
Christy Shook	6.29	120
Mark Johnson	5.78	36
Miranda Jones	5.04	58

Discharge Floor Breakdown - 5 Highest ALOS to MC ALOS Variance (Days)		
Floor	Average Variance	Count
2North	9.21	139
2West	0.87	477
4North	0.41	906
3East	0.38	1454
5West	0.16	300

DRG Breakdown - 10 Highest ALOS to MC ALOS Variance (Days)		
DRG	Average Variance	Count
289	4.32	45
61	3.97	94
790	3.54	78
553	3.01	59
722	2.77	37
729	2.54	85
562	2.53	53
963	2.17	29
86	1.98	31
542	1.05	85

Concurrent In-House Review

Utilization Management & Clinical Documentation Improvement

Utilization Management

Connecting provider, payer, and patient and validating level of care and length of stay

Clinical Documentation Improvement

Supporting documentation improvement and connecting the provider to the medical record

Admit → Patient Care and Documentation →

Polling Question #3

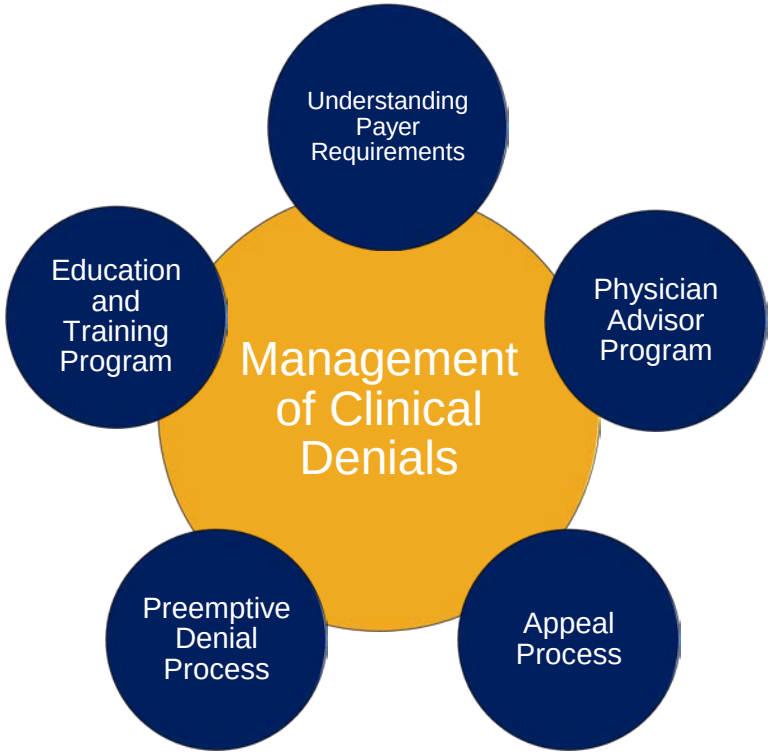
- What is the average claim denial rate for large hospitals?

a) 15.8%
b) 4.5%
c) 20.3%
d) 8.1%

Clinical Denials

Utilization Management & Revenue Cycle

- Denials of payment on the basis of medical necessity, length of stay, level of care, coding and other clinically driven categories
  - These denials may occur concurrently (patient is still in-house) or retrospective (after the patient is discharged), and typically begin as a preemptive denial
- Overlap may occur in the working of appeals, monitoring of open appeals until resolution, reporting of denial trends, and communication with the payer on status of denial/appeal
- Utilization Management and Revenue Cycle should have full visibility into the full denials cycle from start to finish
  - Departments can work together to monitor open appeals and communicate with the payer until a resolution is received



Authorization and Patient Status Changes

Utilization Management & Revenue Cycle

Patient Status

Patient Access

- **Process:**
- Inputs initial patient status from ED, direct admission physician order, or Inpatient Surgery Status

- **Thing to Monitor:**
- Incorrect patient status from admitting source
- Errors when inputting status in ADT system
- Many time there is no initial admission order at the admission

Utilizations Review

- **Process:**
- Verifies initial patient status with physician admission order
- Validate patient admission status using appropriate approval criteria (Milliman, Interqual, Two-Midnight Rule)

- **Thing to Monitor:**
- Ensuring signed patient admission order is the EMR

Authorization

Patient Access

- **Process:**
- Validate patient registration information, i.e. demographics and insurance
- Contact insurance company for initial notification of admission
- Insurance company will give “skeleton" authorization

- **Thing to Monitor:**
- Incorrect registration information
- Notification of admissions should be completed with 24 hours for most payors

Utilization Review

- **Process:**
- Conduct concurrent and retrospective review
- Submit clinical documentation for authorization approval
- Document authorization in PAS system

- **Thing to Monitor:**
- Incorrect patient status from admitting source
- Errors when inputting status in ADT system
- Contacting payor for concurrent review prior to notification of admission process

DRG Validation Audits

Clinical Documentation Improvement & Revenue Cycle

- DRG audits have become increasingly common from both government and commercial payers

- Audits generally consist of two components:

1. **DRG Validation -** Does the coded information on the hospital claim accurately reflect the clinical information in the patient's medical record?

2. **Clinical Validation -** Does the medical record justify that the patient actually possessed the conditions that were documented (i.e. is there sufficient evidence for the stated diagnoses)?

- Appealing DRG Audits can be complicated due to the different sets of clinical indicators recognized by different payers
  - A diagnosis can be valid for one payer and invalid for another, depending on the specific criteria utilized

DRG Validation Audits

Clinical Documentation Improvement & Revenue Cycle

- Successful management of DRG validation audits requires coordination between CDI and the denials management team

CDI provides guidance on clinical indicators to appeals team

Clinical Documentation

- Review for appropriate diagnostic sequencing based on presenting problems and complicating conditions
- Ensure that clinical indicators are present to support patient diagnoses

Denials Management Team

- Receive DRG Audits and coordinate appeal process based on payer-specific criteria
- Monitor patterns and trends in DRG audits to identify common documentation gaps

Denials team provides upstream feedback to CDI team to improve documentation review

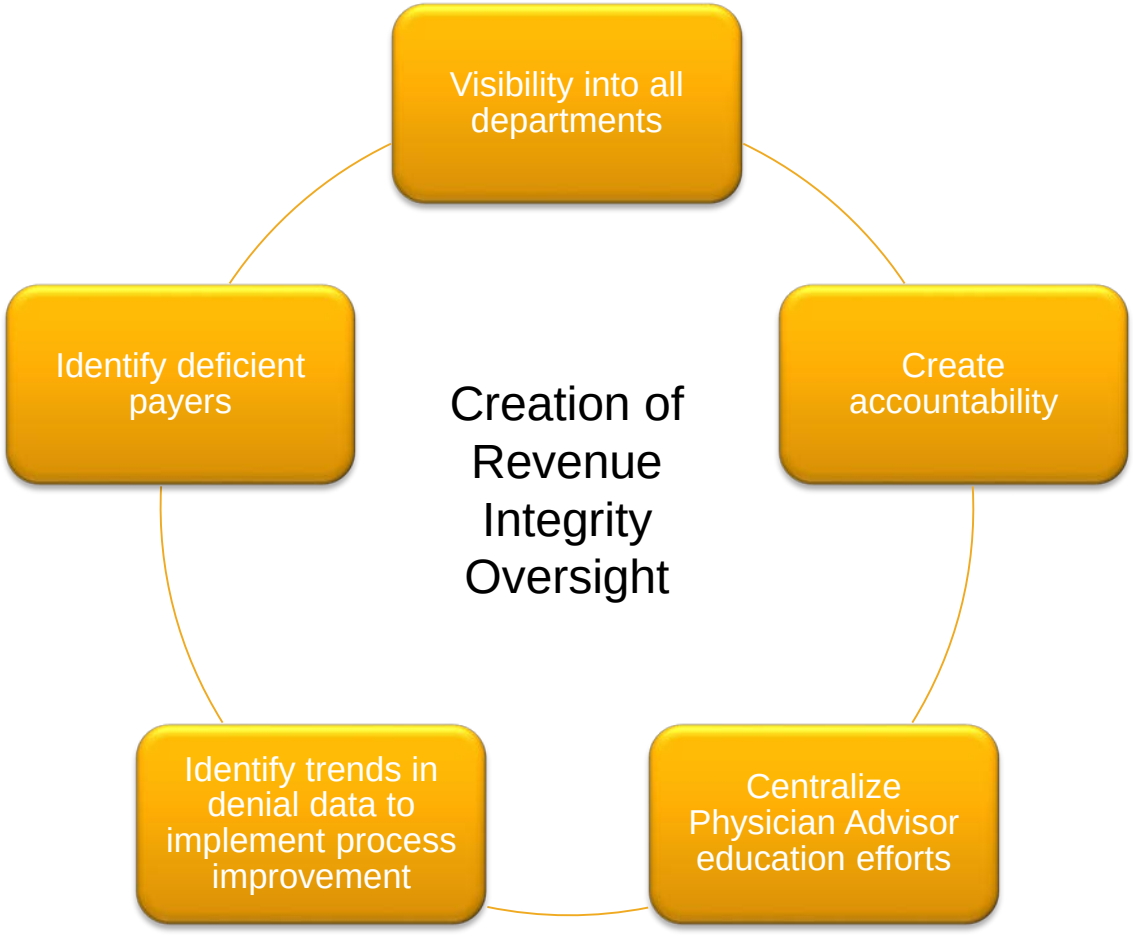
Polling Question #4

- Over the past two years, providers have seen an uptick in DRG validation audits. What has the average increase been?

a) Some increases but barely noticeable
b) Increased over 50%
c) Our department doesn't deal with these type of audits

Integration of the Departments

Align System Access and Reporting



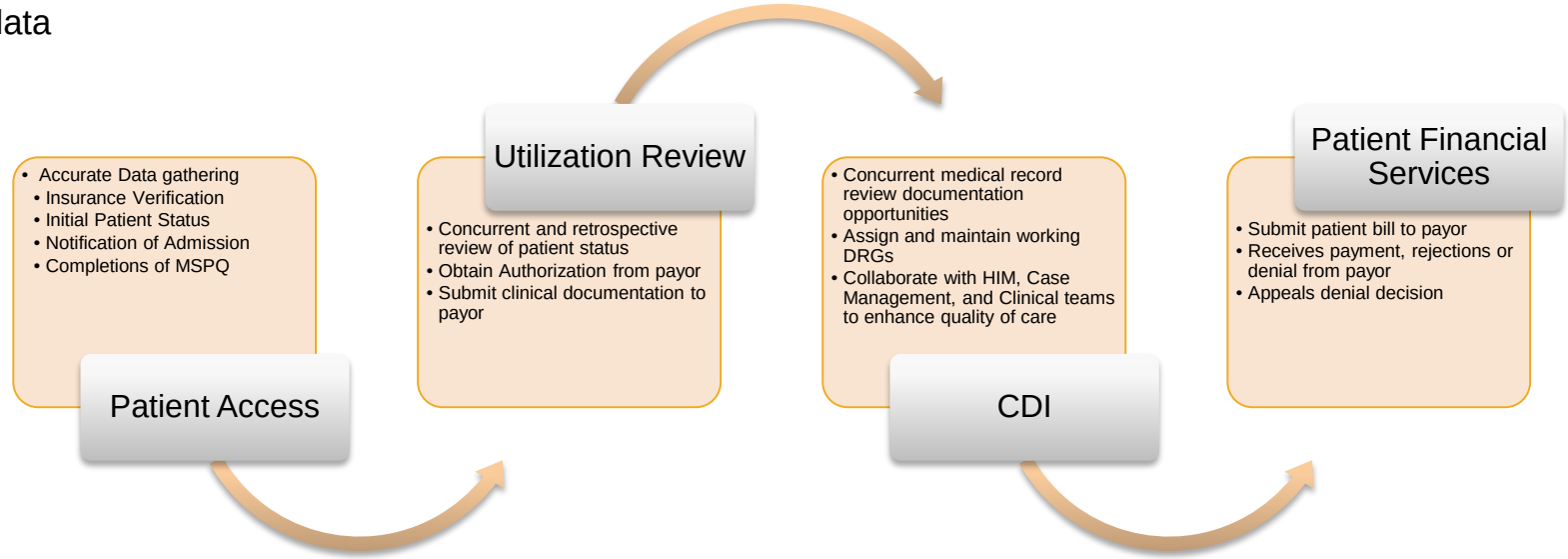
Strategies for Department Alignment

1 Accurate data

Implement registration quality assurance tools and audits to ensure accurate registrations data

2 Find the right criteria

Whether Milliman, Interqual, or Two Midnight rule, find the criteria that aligns with your top payors



3 Communicate

Establish routine communication between all departments for continuous process improvement

4 Focus on Clinical Denials

Utilize clinical denials data for operational improvement and involve applicable departmetns in appeals process

Thank You

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