Revenue Integrity and the HIM Professional's Role in the Revenue Cycle

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Agenda

- AHIMA Weighs In—"Shake-up, Wake-up"
- HIM Professionals Supporting Opportunities in Revenue Cycle
- Sample Alternative Roles for HIM
- Non-traditional Employers Weigh In
- Revenue Integrity—What IS It?
- Stony Brook University Hospital Fast Facts
- Revenue Integrity/HIM-Revenue Cycle Opportunities
- Embracing Revenue Cycle Functions
- Summarize
- Your Questions

Shake-up, Wake-up

Journal of AHIMA, May, 2016

- According to AHIMA, Bureau of Labor Statistics estimates demand for HIM professionals to grow by 22% by 2022
- HOWEVER: Demand for coding professionals may DECREASE significantly during the same time period
- AHIMA: We all need to consider where we are in our careers and where we want to be in the future—and take actionable steps to attain the goals

Shake-up, Wake-up

Journal of AHIMA, May, 2016

- AHIMA provided a "reimagined HIM profession" in the above noted Journal
  - HIM departments have downsized with advent of EMRs
  - HIM professionals must update their skills and education to continue their employment and to provide added value to their organizations
  - Hospital "systems" are transitioning to "shared service center" models in which each facility focuses on one type of HIM service for the entire enterprise
  - Information Governance is taking a more central role among healthcare administrations—are we making sure that we're seen as the leaders in this arena, or will IG be delegated to the IT department?

HIM Profession-Expanding Into Critical Roles Supporting the Revenue Cycle

- According to AHIMA, HIM professionals play an increasingly vital role in the revenue cycle. As reimbursement is shifting from volume of patients treated to value and quality of services provided, opportunities have significantly increased for HIM professionals to play a meaningful part in healthcare revenue cycle management.
- Increasing involvement by HIM professionals:
  - Helps their organizations avoid penalties for not meeting various quality metrics
  - Assists with meeting compliance initiatives
  - Ensures appropriate reimbursement while improving patient outcomes

HIM Profession-Expanding Into Critical Roles Supporting the Revenue Cycle(Continued)

- "Professionals specializing in revenue cycle management work in a variety of roles including billing management for hospitals and health systems, revenue-related data analysis, medical practice business management, and auditing coding and billing for accuracy and compliance," says Rosann O'Dell, MS, DHSc, RHIA, Clinical Assistant Professor, Kansas University
- "National and regulatory trends in public reporting, deployment of Web sites featuring care comparisons by outcome and cost, and pay-for-performance initiatives have dramatically escalated the importance of aggregating, analyzing, and reporting accurate statistical data, both internally and externally.
- Proactive management of continual process improvement and benchmarking against national best practice standards has risen in prominence and recognition throughout the industry as a major contributing factor in becoming and remaining a top ranked institution in comparison databanks and in pay-for-performance areas.
- Healthcare facilities must now pay attention to a number of new external and internal HIM-related pressures that can adversely affect the revenue cycle

Anderson, Gail; Underwood, Mal. "HIM: the Underrated and Seldom Stated Driver of Revenue Cycle Success." AHIMA's 77th National Convention and Exhibit Proceedings, October 2005

What Non-traditional Employers Are Saying

- *"The integrity of the information in the electronic health record is a critical component in helping to ensure patient safety as well as to ensure that quality increases while driving down an organizations cost."*-Siemen's Corp.
- *"With the complexity of provider Pay for Value program designs and the emergence of "big data" as the foundational epi-center to guide and inform provider performance efforts, the legislative/regulatory data /technology, data/ technology, quality/coding, and quality management/ population management knowledge and expertise of the HIM professional is relevant and a necessary addition in the health insurance payer realm. An RHIA professional has brought strength and leadership in all areas to strategically advance [Our] Pay for Value programs."*-Highmark Medical
- *"Given the rigor with which Health Information Management (HIM) professionals learn about data and information structures in healthcare, there are opportunities within the (pharmaceutical) industry (given the HIM skillset), specifically clinical trial information management, understanding of the healthcare delivery system, and assistance in building the industry's role in the health information technology environment."*-Pfizer Medical

AHIMA Pamphlet: "HIM Professionals, Your Best Investment"

HIM Leadership Roles

Information Governance Officer (IGO)/ Chief of Information Governance (CIG)	Chief of Information Intelligence (CII)/Business Intelligence Officer (BIO)
Chief/Director of Health Informatics Administration	Chief Inormation Strategy Officer (CISO)
Information Asset Officer (IAO) / Director of Information Access (DIA)	Information Integrity Officer (IIO)/ Director of Information Integrity (DII)
Chief/Director of Information Exchange Management	Privacy & Security Assurance Officer
Chief/Director of Enterprise Information Management	Chief/Director of Information & Data Analytics
Inofmration Research Director/Manager/Analyst	Consumer Informatics/Advocacy Manager/Specialist
Enterprise Application Director/Manager/Analyst	Business Intelligence Director/Manager/Analyst

AHIMA Pamphlet: "HIM Professionals, Your Best Investment"

What IS Revenue Integrity?

What IS Revenue Integrity? (Cont.)

"To many, 'revenue integrity' is new, its catchy, it's what is hot in healthcare revenue cycle, audit and compliance. "I WANT IT! . . . . But what is it?" Really, it can depend on who and when you ask."

Caroline Rader Znaniec, Healthcare Revenue Integrity Advisor
Luna Healthcare Advisors, Posted On "LinkedIn", June 13, 2014.

"Results of a 2012 national healthcare industry survey revealed that 60 percent of hospital executives believe revenue integrity is essential to their organization's financial health. The November 2011 Craneware survey found that operational efficiency, compliance and legitimate reimbursement (the holy trinity of revenue integrity) rank highest on the list of concerns currently plaguing hospital financial managers."

"Revenue integrity tops list of concerns for hospital executives", Healthcare Finance, 4/9/2012

What IS Revenue Integrity (Continued):

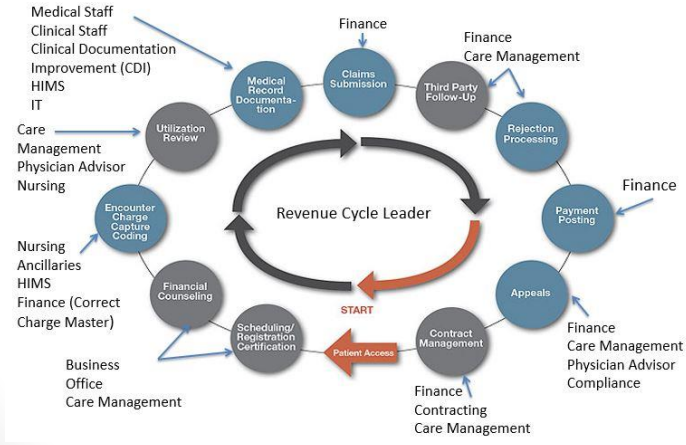
Applied to the healthcare industry, **revenue integrity** is the achievement of operational efficiency, compliance, and legitimate reimbursement. Revenue integrity can be achieved only with the proper processes, tools, and related expertise aimed at effectively pricing, charging, and coding for services and supplies related to patient care.

*www.craneware.com/resources/white-papers/**revenue-integrity**-in-healthcare*

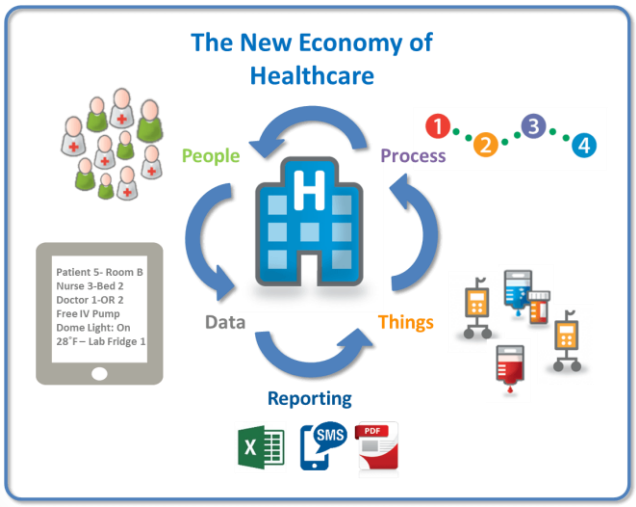
Revenue integrity is the organization's desire to completely capture all possible opportunities for reimbursement, in a manner which is compliant with all applicable rules and regulations. It is a holistic approach that guides an organization toward achieving operational efficiency, complete regulatory compliance, and total reimbursement.

HIM Systems Are Integral to Revenue Cycle Integrity

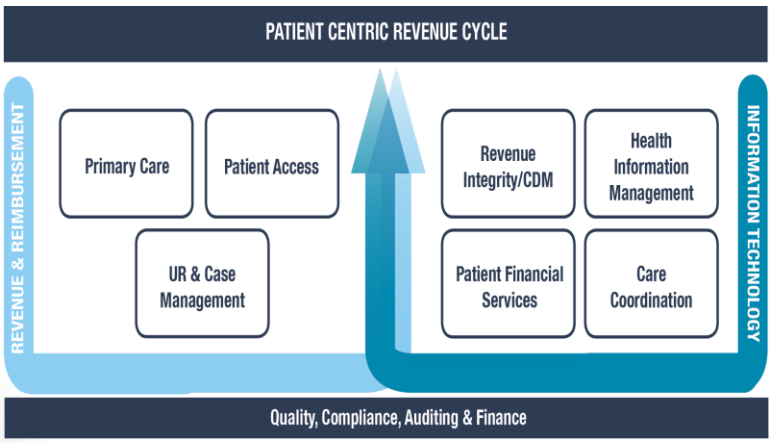
Components for Revenue Cycle Integrity



Another Theory of The Revenue Cycle…



HIM Systems Are Integral to Revenue Cycle Integrity (cont.)



The New Elephant In The Room!

Some Examples of R.I./HIM R.C. Related Processes

- We'll take the next while discussing some of the processes which SBUH has implemented in the R.I./HIM Department to support R.C. functions
- The following is meant to provide examples of ideas that may be implemented in our respective organizations
- Most important, I'd like the participants to leave with the following thoughts: "What else can I do to embrace and additionally contribute to the Revenue Cycle process? Is the HIM Department in my organization positioned to be included as an integral part of the process within my organization?"

Stony Brook University Hospital Fast Facts

2016 Statistics:

- Beds: 603
- Inpatients (excluding newborns): 31,715
- Emergency Department visits: 108,936
- Outpatient visits: 940,404
- Births: 4,169
- Surgeries (cases): 24,620
- Imaging studies: 315,755
- Laboratory tests: 6,200,688
- Research expenditures: $86,953,916
- Employees: 6,501
- Physicians: 1,221
- Volunteers: 1,378

Stony Brook University Hospital Fast Facts (cont.)

- **Level 1 Trauma Center and Tertiary Care Center**
- **Level 4 (Most Advanced) Regional Perinatal Center**
- **Children's Hospital**
- **State-designated AIDS Center**
- **State-designated Burn Center**
- **State-designated Comprehensive Psychiatric Emergency Program**
- **Accredited Ventricular Assist Device Program**
- **Kidney Transplantation Program**
- **Bone Marrow and Blood Stem Cell Transplantation Program**
- **Accredited Chest Pain Center with Percutaneous Coronary Intervention (PCI)**
- **Advanced Cerebrovascular Research Center with dedicated biomedical engineering lab**
- **ALS (Lou Gehrig's disease) Association Certified Center of Excellence℠**
- **Alzheimer's Disease Assistance Center**

iCARE

SBUH Statement of Values:

Integrity – We are honest and ethical in all our interactions.

Compassion – We provide empathic care with attentive listening and affirmation.

Accountability – We hold ourselves accountable to our community, to our organization and to each other for our performance and behaviors.

Respect – We foster an environment of mutual respect and trust, embracing diversity in people and thinking.

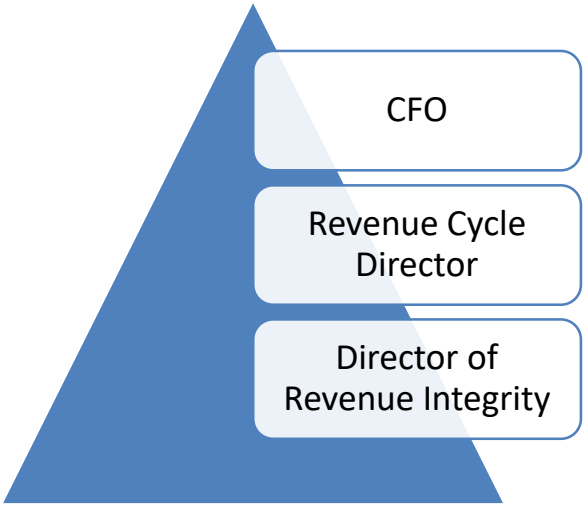
Excellence – We set the highest standards for safety, clinical outcomes and service.

SBUH Revenue Integrity/HIM Department

Revenue Integrity/HIM Facilitates Collaboration

- SBUH determined in late 2013 that an emerging "best practice" in the healthcare industry for assuring collaboration between functions of coding, clinical documentation, billing compliance, finance, and administration could be best achieved through an overall Revenue Integrity departmental structure
- Today's discussion will focus on areas in which Revenue Integrity/HIM collaboration has resulted in significant "return on investment", including compliant code assignment, improved denials management processes, accurate clinical quality metrics (HACs, PSIs), and detailed reporting to Hospital Administration, as well as beginning to advance Information Governance awareness through the HIM Operations Division.
- These are areas that enhance the traditional HIM functions, and provide opportunities for the HIM professional to meet new challenges, and, in some instances, reflect future roles for the HIM profession.

SBUH Revenue Integrity/HIM Department



Revenue Integrity/HIM Department Background

- Department reports to Director of Revenue Integrity who reports to Revenue Cycle Director who reports to CFO
- Formed in November 2013
- Department consists of several division working in concert:
  - Inpatient Coding-also appeal of coding denials from RAC, commercials
  - Ambulatory Coding-responsible for 26 hospital services
  - Clinical Documentation Improvement-also collaborates with Q.M.
  - Health Information Management (Information Access,, document scanning, **advancing 'Information Governance' concepts and ensuring EMR integrity**; assisting patients with Patient Portal, etc..)
  - R.I. Staff Development-Coding & CDI staff training and ongoing education
  - Additional Revenue Integrity Department responsibilities, coordinated by the Associate Director, Revenue Integrity :
    - Revenue Integrity ROI process for requests related to Hospital revenue (e.g. insurance DRG verification, RAC, MAC, CERT requests, etc..)
    - Denied & Delayed Claims Analysis & Reporting Process for Administration; review of ambulatory departments for missed billing opportunities
    - **New Initiative**: Revenue Integrity Claim Scrubber Validation and Review

Revenue Integrity/HIM Department Background (cont.)

- CDI and Coding processes utilize 3M/HDM product for both Inpatient and Ambulatory, integrated into the Cerner Access HIM system
- SMART (PricewaterhouseCoopers) secondary pre-bill review
  - Identifies cases for DRG validation
  - Flags AHRQ, PSI and HAC cases for pre-bill review by CDI
- All mortalities are reviewed by CDI Associate Director and Inpatient Coding Associate Director prior to billing
- 3M CDIS system was implemented for CDI use during May 2017
- 99% of all reviews are conducted "pre-bill"
- Focus is quality of coded and documented record, moving beyond "CC/MCC" to metrics and quality scores

Revenue Integrity/HIM-Embracing Revenue Cycle Functions

- In early 2016, the R.I. Director was requested to collaborate with the Administrative Directors of the various clinical services (medicine, surgery, oncology, behavioral health, E.D., ancillary, etc.) to identify and reduce "denials"
- There was very limited availability or information to support this initiative
- R.I. developed a new "Clinical Data Analyst" position within the Department to identify and assist with developing data dashboards and KPI's that the Administrative Directors could utilize to rectify issues identified from the data dashboards.
- Metric of 30% improvement in 2016 denial $ compared to 2015 was initially established and quickly found to be overly aggressive. Revised to 20% improvement as the goal for 2016

Revenue Integrity/HIM-Embracing Revenue Cycle Functions

- Ambulatory (Outpatient) services were the main focus for 2016
- Inpatient Final Denials increased in 2016 compared to 2015
  - Possibly due to more accurate internal reporting
  - New registration/scheduling program implemented in mid-2015 which resulted in delayed billings, possibly resulting in additional denials which were finalized in 2016
  - Change in hospital commercial payer contracts as a result of ICD-10 from per diem based payments to DRG based payments

Denials Management?

"First we're going to run some tests to see how your insurance reacts."

More Denials Management?

"Lucky devil - he's got private medical insurance."

Revenue Integrity Embracing Denials Management

- Working with the Administrative Directors of Operations and the Chief Operating Officer, the R.I. Data Analyst developed a "Dashboard" for monthly reporting
- A "Combined clinical services" dashboard example is shown on the following slides
- All of the samples demonstrated in this presentation were developed using Excel spreadsheets and pivot tables
- The basis of the information was the Patient Financial Services "Claim denials by denial reason" reports.

Sample Hospital Final Denials Dashboard-Inpatient-2016

	HARD DENIALS		Q1	Q2	Q3	Q4	2016	2015	Variance	% Variance
Inpatient	ADMISSION THRU OP MOD	CM ($)	($126,699.72)	($172,869.85)	($316,157.59)	($220,016.23)	($835,743.39)	($639,574.52)	$196,168.87	-30.7%
		CM (#)	14	20	25	13	72	51	(21)	-41.2%
	CODING POSTED UNTIMELY	CM ($)	$0.00	$0.00	($13,656.45)	$0.00	($13,656.45)	$0.00	$13,656.45	-100.0%
		CM (#)	0	0	1	0	1	0	(1)	-100.0%
	COMBINED ADMISSION	CM ($)	$0.00	$0.00	($9,151.99)	$0.00	($9,151.99)	($19,118.99)	($9,967.00)	52.1%
		CM (#)	0	0	1	0	1	2	1	50.0%
	CONT STAY DENIAL MED NEC	CM ($)	($135,557.54)	($53,458.47)	($92,385.14)	($204,837.66)	($486,238.81)	($409,847.42)	$76,391.39	-18.6%
		CM (#)	15	5	13	5	38	36	(2)	-5.6%
	I/P MC PRE-CERT. ALLOWANCE	CM ($)	($170,594.95)	($56,355.09)	($80,776.74)	($113,781.49)	($421,508.27)	($182,690.74)	$238,817.53	-130.7%
		CM (#)	16	8	9	12	45	29	(16)	-55.2%
	INCORRECT INS REGISTRATION	CM ($)	$0.00	($14,545.92)	($211,919.82)	($25,266.58)	($251,732.32)	($3,843.63)	$247,888.69	-6449.3%
		CM (#)	0	1	3	1	5	1	(4)	-400.0%
	INSUFFICIENT INFORMATION	CM ($)	($8,056.84)	$0.00	$0.00	($11,684.42)	($19,741.26)	($32,679.12)	($12,937.86)	39.6%
		CM (#)	2	0	0	1	3	2	(1)	-50.0%
	IP TOO LATE TO BILL	CM ($)	($251,281.01)	($424,376.64)	($223,577.37)	($524,724.21)	($1,423,959.23)	($384,849.85)	$1,039,109.38	-270.0%
		CM (#)	21	45	25	49	140	63	(77)	-122.2%
	MED NEC DENIAL	CM ($)	($667,933.53)	($502,700.61)	($931,008.21)	($352,935.39)	($2,454,577.74)	($1,267,516.40)	$1,187,061.34	-93.7%
		CM (#)	65	54	83	28	230	126	(104)	-82.5%
	MEDICAL RECORD ADJ	CM ($)	$0.00	($8,392.11)	$0.00	$0.00	($8,392.11)	($7,570.46)	$821.65	-10.9%
		CM (#)	0	3	0	0	3	1	(2)	-200.0%
	NON COVERED SERVICES	CM ($)	$0.00	$0.00	($14,568.02)	$14,773.95	$205.93	$0.00	($205.93)	-100.0%
		CM (#)	0	0	2	1	3	0	(3)	-100.0%
	NON PARTICIPATING PROVIDER	CM ($)	($334,414.04)	($498.27)	($257,925.67)	$62,732.74	($530,105.24)	($1,056,238.37)	($526,133.13)	49.8%
		CM (#)	12	7	5	1	25	20	(5)	-25.0%
	OBSERVATION DENIED	CM ($)	$0.00	($10,950.79)	($10,886.78)	($19,423.21)	($41,260.78)	$0.00	$41,260.78	-100.0%
		CM (#)	0	2	1	1	4	0	(4)	-100.0%
	OTHER DENIALS	CM ($)	($18,923.00)	($3,287.64)	$0.00	$0.00	($22,210.64)	($79,131.71)	($56,921.07)	71.9%
		CM (#)	2	2	0	0	4	5	1	20.0%
Inpatient ($)			**($1,713,460.63)**	**($1,247,435.39)**	**($2,197,651.36)**	**($1,395,162.50)**	**($6,553,709.88)**	**($4,083,061.21)**	**$2,470,648.67**	**-60.5%**
Inpatient (#)			**147**	**147**	**170**	**112**	**576**	**336**	**(240)**	**-71.4%**

Sample Hospital Final Denials Dashboard-Outpatient-2016

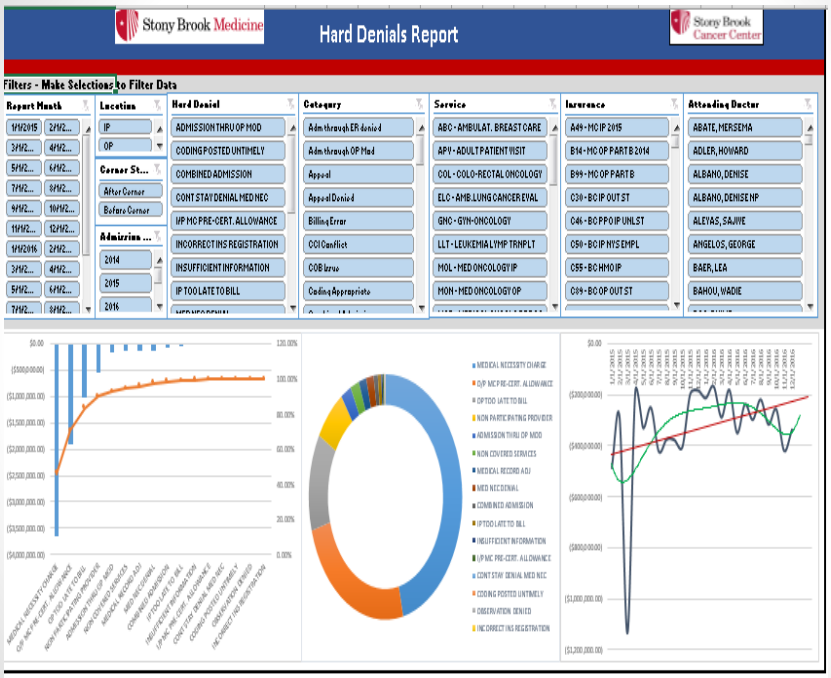
	HARD DENIALS		Q1	Q2	Q3	Q4	2016	2015	Variance	% Variance
Outpatient	CODING POSTED UNTIMELY	CM ($)	($5,998.00)	($3,279.87)	($6,407.51)	$0.00	($15,685.38)	($39,526.92)	($23,841.54)	60.3%
		CM (#)	1	1	1	0	3	9	6	66.7%
	INCORRECT INS REGISTRATION	CM ($)	$0.00	$0.00	($3,634.00)	($16,493.28)	($20,127.28)	($38,366.90)	($18,239.62)	47.5%
		CM (#)	0	0	2	14	16	48	32	66.7%
	MEDICAL NECESSITY CHARGE	CM ($)	($970,826.53)	($1,167,188.76)	($1,221,603.06)	($1,284,689.31)	($4,644,307.66)	($7,221,016.64)	($2,576,708.98)	35.7%
		CM (#)	4,027	4,643	4,003	4,430	17,103	17,150	47	0.3%
	MEDICAL RECORD ADJ	CM ($)	($41,770.96)	($267,340.79)	($105.00)	($28,175.28)	($337,392.03)	($32,742.40)	$304,649.63	-930.4%
		CM (#)	19	226	1	31	277	28	(249)	-889.3%
	NON COVERED SERVICES	CM ($)	($79,129.45)	($104,929.70)	($74,527.67)	($130,003.61)	($388,590.43)	($363,202.43)	$25,388.00	-7.0%
		CM (#)	282	297	217	405	1,201	939	(262)	-27.9%
	NON PARTICIPATING PROVIDER	CM ($)	($102,746.91)	($98,391.75)	($65,576.26)	($7,694.06)	($274,408.98)	($684,765.18)	($410,356.20)	59.9%
		CM (#)	58	45	28	29	160	382	222	58.1%
	O/P MC PRE-CERT. ALLOWANCE	CM ($)	($276,497.56)	($185,276.07)	($217,038.68)	($434,697.46)	($1,113,509.77)	($1,265,507.47)	($151,997.70)	12.0%
		CM (#)	146	145	148	206	645	318	(327)	-102.8%
	OP TOO LATE TO BILL	CM ($)	($517,431.58)	($956,003.99)	($690,066.79)	($899,732.87)	($3,063,235.23)	($2,846,914.72)	$216,320.51	-7.6%
		CM (#)	362	571	533	479	1,945	2,582	637	24.7%
Outpatient ($)			**($1,994,400.99)**	**($2,785,931.14)**	**($2,297,240.60)**	**($2,861,908.44)**	**($9,939,481.17)**	**($12,140,332.27)**	**($2,200,851.10)**	**18.1%**
Outpatient (#)			**4,895**	**5,930**	**4,996**	**5,673**	**21,494**	**21,427**	**(67)**	**-0.3%**
Total Hard Denials		CM ($)	**($3,707,861.62)**	**($4,033,366.53)**	**($4,494,891.96)**	**($4,257,070.94)**	**($16,493,191.05)**	**($16,576,906.51)**	**($83,715.46)**	**0.5%**
		CM (#)	**5,042**	**6,077**	**5,166**	**5,785**	**22,070**	**21,794**	**(276)**	**-1.3%**
		Unique Pt #	**3,451**	**4,328**	**3,584**	**3,654**	**15,017**	**15,071**	**54**	**0.4%**

Sample Hospital Service Specific Drill-Down

- Individual clinical service reports with additional claim details are provided to each of the Administrative Directors for their respective areas of responsibility
- Individual report metrics were developed with the Administrative Directors input to provide a robust report that can be used to effect change in their areas
- These claim detail reports permit the user to perform deep dives to identify service, physician, patient level information related to the reported denials

CT TID 2015 Cancer Services Detailed Summary

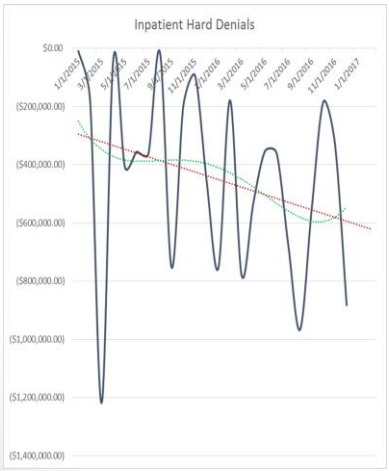
Service Name	Hard Denial	Category	Charge	Count of PT NO CD
MON - MED ONCOLOGY OP	MEDICAL NECESSITY CHARG	LCD not Met	($524,062.74)	95
		Revenue Enhancement Proj	($176,061.39)	272
		Path & Lab	($87,236.80)	668
		MUE Error	($21,230.60)	25
		Appeal	($18,049.30)	3
		Incomplete/Missing Informa	($14,333.49)	10
		Overlapping Claim	($4,410.00)	3
		Billing Error	($3,725.50)	5
		Combined claim	($1,799.00)	2
		Not Medically Necessary	($312.00)	1
		Non-Covered Service	($1.08)	2
		Corrected Charge	$42,784.41	95
	MEDICAL NECESSITY CHARGE Total		($808,437.49)	1,181
	O/P MC PRE-CERT. ALLOWAN	No Auth/ Notification/ Pre-C	($521,339.77)	85
		Corrected Charge	($2,303.81)	4
	O/P MC PRE-CERT. ALLOWANCE Total		($523,643.58)	89
	MEDICAL RECORD ADJ	Medical Record Adj	($104,912.67)	113
		Corrected Charge	$50.00	1
	MEDICAL RECORD ADJ Total		($104,862.67)	114
	COMBINED ADMISSION	Combined Admission	($51,745.57)	71
	COMBINED ADMISSION Total		($51,745.57)	71
	OP TOO LATE TO BILL	Untimely Filing	($35,435.65)	9
		Too Late to Bill	($15,838.74)	4
	OP TOO LATE TO BILL Total		($51,274.39)	13
	NON COVERED SERVICES	Non-Covered Service	($1,952.00)	53
		Revenue Enhancement Proj	($1,555.00)	3
		Path & Lab	($90.00)	5
		Corrected Charge	$332.00	7
	NON COVERED SERVICES Total		($3,265.00)	68
	NON PARTICIPATING PROVID	Non-Par Provider	($925.00)	2
		Contractual Allowance	($726.00)	1
	NON PARTICIPATING PROVIDER Total		($1,651.00)	3
MON - MED ONCOLOGY OP Total			($1,544,379.70)	1,539

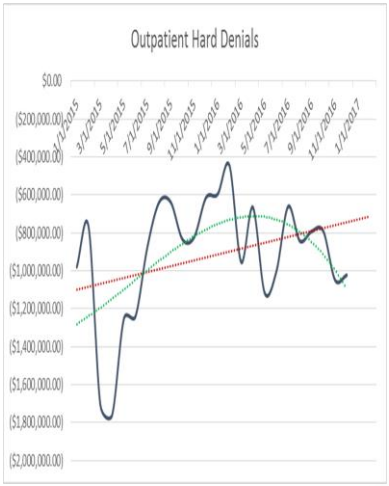


Sample Hospital-Tracking and Trending

- Trends in the data over time can be demonstrated and displayed
- These trends can also be applied to individual service lines as well as the major denial reasons

Sample Hospital Final Denials Trend-2015-2017





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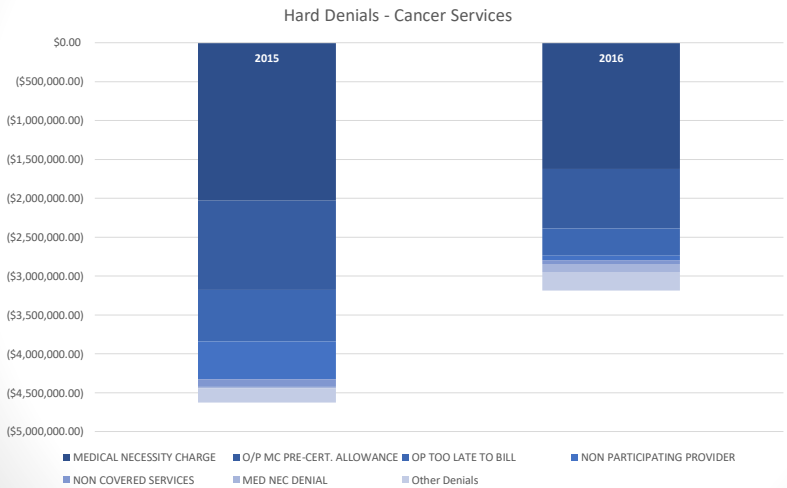
Revenue Integrity Impact – Denials Analysis-Have We Made Progress?



New York Health Information Management Association 6/06/2017

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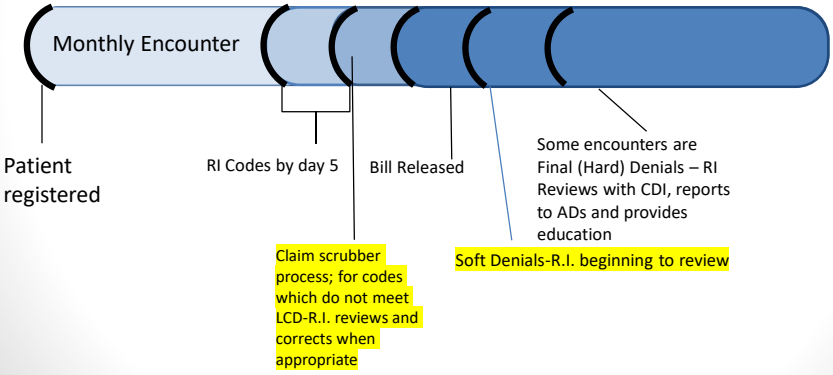
Revenue Cycle – Life of an OP Invoice

- Outpatient Cancer Service

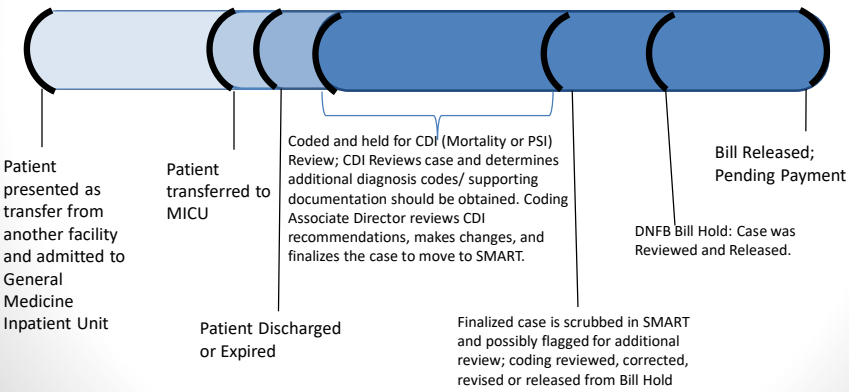
This was the process from 2015 to Jan 2017 – with education, documentation improved. For further improvement RI has now initiated Claim Scrubber review and correction to permit billing to occur.



Revenue Cycle-Life of an Invoice-IP Case Review

- Inpatient MICU Service

All Mortality and PSI cases are reviewed before billing. CDI and Inpatient Coding work together to ensure documentation and coding accuracy.



Revenue Integrity Impact – Oncology Denials Analysis-Sample Hospital

Hard Denial	Category	2015	2016
MEDICAL NECESSITY CHARGE	Revenue Enhancement	($1,152,430.44)	($363,914.47)
	Path & Lab	($208,525.33)	($405,336.43)
	LCD not met	($194,162.54)	($612,884.97)
	MUE Error	($170,291.22)	($57,683.68)
	Unbundled	($131,165.00)	($12,591.00)
	Untimely Filing	($43,954.64)	($14,286.00)
	Appeal - pending	($37,373.73)	($44,867.55)
	Appeal Denied	($24,465.60)	$0.00
	Incorrect/ Missing Info	($54,329.04)	($21,670.49)
	Non-Covered Service	($11,103.48)	($1.08)
	Front End Error	$0.00	($60,172.38)
	Billing Error	($2,948.84)	($26,444.50)
	CCI Conflict	$0.00	($2,694.00)
Grand Total		**($2,030,749.86)**	**($1,622,546.55)**

- Revenue enhancement project identified as various issues such as CCI edits or LCD not met
- LCD not Met – Identified that this occurred more frequently at one location with four providers giving ESA drugs. Patient had conditions not documented within the 30 day encounter. After analysis CDI educated all providers on ESA LCD
- MUE Error – corrected through education of Patient Accounts staff related to the correct number of units allowed

Sample Hospital Denials Heat Chart 2016 vs 2015

Service Line	% Goal
PRE-OP SERVICES	86.3%
PSYCH	39.1%
CANCER	29.4%
CARDIAC	-10.1%
NEUROSCIENCE	-16.3%
ORTHOPEDICS	-32.6%
EMERGENCY	-35.0%
SURGERY	-61.6%
OB/GYN	-121.7%
PEDIATRICS	-126.3%
Grand Total	0.5%

Overall goal was to perform 20% better than 2015 - OP Medical Necessity Charge denials improved overall by 35.7%, which mostly benefit Pre-Op Services, Psych and Cancer services. Emergency did not benefit from this due to Too Late to Bill, and Medical Record Adjustment ($624K more).

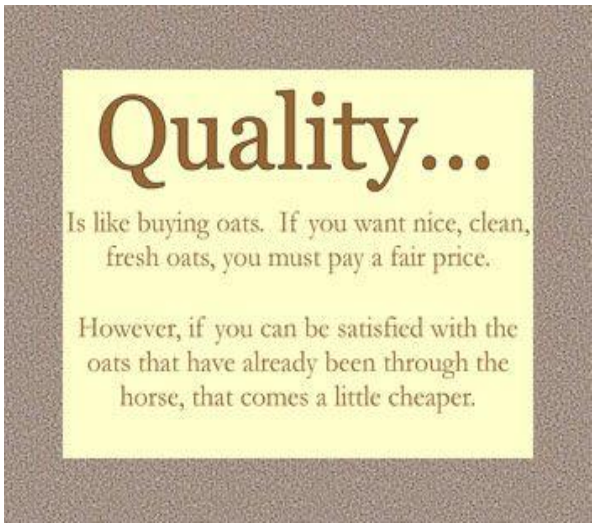
Cardiac, Neuroscience, Orthopedics, Surgery, OB/GYN and Pediatrics we affected by the overall increase in posted Inpatient Hard Denials.

- **Cardiac had a $506K increase of posted denials due to IP Medical Necessity.**
- **Neuroscience has a $208K increase of posted denials due to IP Too Late to Bill (Untimely Filing).**
- **Orthopedics had a $69K increase of posted denials due to Admission thru OP Mod, and a $58K increase due to IP Too Late to Bill (Untimely Filing).**
- **Surgery had a $442K increase of posted denials due to IP Medical Necessity, $147K increase of I/P MC Pre-Cert Allowance, and a $25K increase due to Incorrect Insurance Registration.**
- **OB/GYN had a $179K increase of posted denials due to IP Too Late to Bill and $78K increase due to IP Medical Necessity.**
- **Pediatrics had a $322K increase of IP Too Late to Bill, $191K of Cont. Stay Denial Med Nec, $134K of IP Medical Necessity, and $140K increase in Admission thru OP**

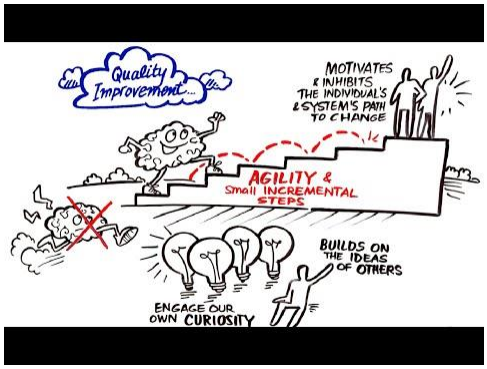
Quality Initiatives

- Following are some of the quality initiatives that R.I. has begun to implement
- CDI and Coding Divisions work closely with the Quality Management Department and report quarterly to the Clinical Outcomes Committee

Quality Is…



Clinical Quality Reporting Metrics…



A Word About Clinical Quality Reporting and R.I.

- R.I. and CDI work together to analyze and report from a national quality reporting clearinghouse (Vizient, formerly UHC)
- Data is imported to demonstrate opportunities related to various PSI quality metrics (e.g. composite PSI 90; 30 day readmissions; CC/MCC capture, etc.)
- "Heat graph" is prepared which is utilized to highlight success as well as areas with opportunities for improvement

Revenue Integrity Clinical Quality Metrics Reporting- Sample Hospital, Vizient Data (Various Metrics)

FY 14/15	Vizient Data												Specialty Rating
Providers	LOS Index	Minor SOI	Extreme SOI	Mortality Index	Medicare CMI	Non-Medicare CMI	PSI-90 Composite Score	Non-Specific PDX	CC/MCC Capture Rate%	Direct Cost Index	30 Day readmission	ICU Utilization	
Goal	≤0.93	≤20.0%	≥4.90%	≤0.8	≥2.0	≥2.0	≤0.6	≤1.7%	≥52.0%	≤0.8	≤5.0%		5.0
Internal	1.03	27.69%	6.73%	0.74	2.14	1.87	1.00	5.90%	59.51%	0.87	4.81%	26.59	3.5
Community	0.95	27.68%	7.11%	0.98	2.09	1.90	0.99	5.14%	57.70%	0.82	4.97%	22.61	3.5
Grand Total	1.98	27.69%	6.92%	0.86	2.12	1.89	0.99	5.60%	59.07%	0.85	4.89%	24.60	3.6

FY 15/16	Vizient Data												Specialty Rating
Providers	LOS Index	Minor SOI	Extreme SOI	Mortality Index	Medicare CMI	Non-Medicare CMI	PSI-90 Composite Score	Non-Specific PDX	CC/MCC Capture Rate%	Direct Cost Index	30 Day readmission	ICU Utilization	
Goal	≤0.93	≤20.0%	≥4.90%	≤0.8	≥2.0	≥2.0	≤0.6	≤1.7%	≥52.0%	≤0.8	≤5.0%		5.0
Internal	0.99	23.30%	8.73%	0.62	2.23	2.07	1.27	12.26%	63.38%	0.84	4.09%	42.23	3.9
Community	0.95	22.82%	6.03%	0.40	2.03	1.96	1.40	8.40%	58.68%	0.79	4.38%	42.14	3.5
Grand Total	0.98	25.50%	5.20%	0.51	2.13	2.02	1.38	10.30%	61.91%	0.79	4.00%		3.7

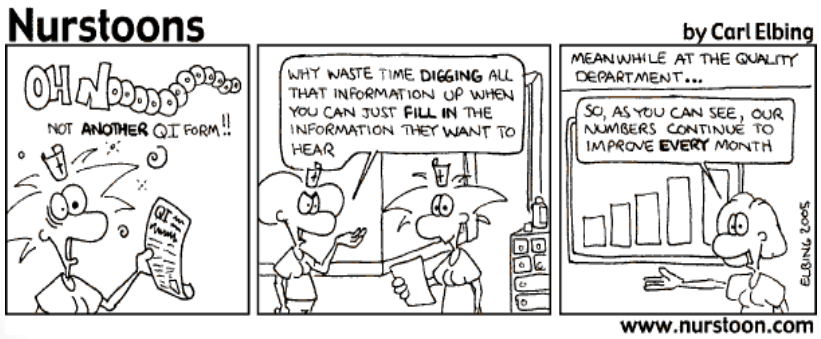
1. PSI Data ran by Discharge Physician
2. Non-Specific PDX includes ICD Signs and Symptoms codes as well as all NOS, Unspecified Codes
3. Specialty Rating is a point system; Green = 5, Yellow = 3, Red = 1; If goals are met Specialty rating will be 5.0

Exclusions: Bad data, nonviable neonates, hospice, and normal newborns

Sample Hospital Vizient Data (Continued)- PSI 90 Evaluation

AHRQ Patient Safety Composite Indicators	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
PSI90 AHRQ Patient Safety Quality Indicator Composite Rate	0.91	0.78	0.90	0.79	0.70
Target	0.68	0.66	0.63	0.62	0.61
Vizient (previously UHC) Rank	69/136	47/134	75/133	56/133	28/131
PSI's that make up PSI 90 Observed:Expected (O:E) rate	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
PSI 03 Pressure ulcer	1.60	0.00	2.40	0.81	0.86
Target	0.00	0.00	0.00	0.00	0.00
Vizient (previously UHC) Rank	82/136	9/134	103/133	62/133	47/131
PSI 06 Iatrogenic pneumothorax	1.30	0.98	0.46	1.27	0.00
Target	0.00	0.00	0.00	0.00	0.00
Vizient (previously UHC) Rank	103/136	96/134	58/133	104/133	10/131
PSI 07 Central venous catheter-related bloodstream infections	0.00	1.74	1.61	2.95	1.30
Target	0.00	0.00	0.00	0.00	0.00
Vizient (previously UHC) Rank	7/136	17/133	92/132	115/132	83/131
PSI 08 Post-operative hip fracture	0.00	0.00	0.00	0.00	0.00
Target	0.00	0.00	0.00	0.00	0.00
Vizient (previously UHC) Rank	50/136	50/134	48/133	44/133	43/131
PSI 12 Perioperative PE/DVT	1.33	0.68	1.28	1.44	1.07
Target	0.48	0.48	0.39	0.48	0.52
Vizient (previously UHC) Rank	95/136	29/134	95/133	100/133	66/131
PSI 13 Post-operative sepsis	0.36	0.67	0.50	0.60	0.12
Target	0.02	0.04	0.17	0.08	0.11
Vizient (previously UHC) Rank	30/136	73/134	56/132	75/133	14/130
PSI 14 Post-operative wound dehiscence	0.00	0.00	0.00	0.00	0.00
Target	0.00	0.00	0.00	0.00	0.00
Vizient (previously UHC) Rank	60/135	55/134	56/132	53/133	57/130
PSI 15 Accidental puncture / laceration	0.0	0.5	0.0	0.0	0.0
Target	0.0	0.0	0.0	0.0	0.0
Vizient (previously UHC) Rank	36/136	90/134	29/133	25/133	29/131

Reporting Realized and Planned Accomplishments



Strategic Vector
Clinical Outcomes

- **PSI-03**
- **PSI-06**
- **PSI-07**
- **PSI-08**
- **PSI-09**
- **PSI-11**
- **PSI-12**
- **PSI-13**
- **PSI-14**
- **PSI-15**
- **CCM/MCC Capture Rate**
- **SOI/ROM Increase**

- Completed
- On Target
- Concerns
- Needs Help
- Not Yet Begun

RI Impact Quality Reporting: Coding & Documentation

Key Accomplishments Past Period

- Began work with Oncology to identify strategies to improve documentation to lower O:E.
- Developed a plan to use SMART to better target the cases for retrospective CDI review. This will allow us to hold the cases that have better potential for impactful changes, as well as decreasing the DNFB.
- Examined and tightened up our Query escalation process with CDI Medical Director
- Continue to work with Biomedical Informatics to design a system that identifies patients that may need risk adjustment.
- Collaborating with Biomedical Informatics and IT to integrate system into current coding and billing system.

Planned Accomplishments Next Period

- Hold the gain of previous accomplishments during a period of time with decreased staffing and change of leadership.
- Implement new SMART reviews.
- Implement CDIS program that will allow for better more robust reporting capability.
- Increase Surgical CC/MCC capture rate with new processes in place.
- Address CDI resources for Surgical service improvement.

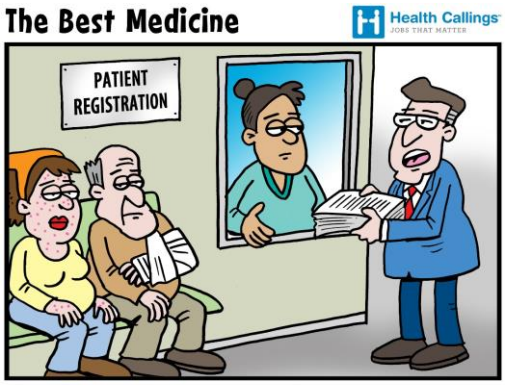
Issues and Concerns

Issue / Concern	Mitigation Plan
There may be productivity decreases with all of the change coming to the CDI staff process. We are working to minimize that as much as possible.	

Last But Not Least: Enhanced DNFB Reporting And Analysis

- Detailed DNFB reports are generated on Tuesday and Friday each week
- Provide details related to time on DNFB; Reason, Total $ < and > 7 days post-discharge
- Able to identify specific reasons for delayed billing attributable to the R.I. Department
- Provides ability to respond in detail to queries from the Director of Revenue Integrity, Revenue Cycle Director, and/or the CFO related to reasons for volume/$ on DNFB at any time
- These types of detailed reports enable the R.I. staff to focus on those areas with the greatest volume and $ amounts reported on the DNFB
- Another tool in enhancing the R.I./HIM professional's impact as a valued member of the Revenue Cycle team!

Accurate Analysis Starts With Accurate Information!



"We need to streamline our Patient Registration…. I want you to fill out these additional forms along with the existing ones and then enter all info manually into the Patient database and then print out multiple copies and distribute to all the necessary departments and Healthcare providers"

Sample Hospital IP DNFB Summary

DNFB Summary	Aging						Grand Total	Total Over 7 Days
	0 Days	1 - 7 Days	8 - 14 Days	15 - 21 Days	22 - 29 Days	Over 30 Days		
Diagnosis	$9,255,952.25	$28,128,055.12	$12,974,909.47	$6,867,509.92	$3,615,587.76	$274,203.61	$61,116,218.13	$23,732,210.76
Insurance	$26,513.05	$18,829.48	$0.00	$0.00	$0.00	$0.00	$45,342.53	$0.00
OP Plans	$27,643.29	$0.00	$0.00	$0.00	$0.00	$0.00	$27,643.29	$0.00
Short Stays	$392,066.53	$6,614,372.79	$3,208,964.21	$2,301,956.15	$0.00	$0.00	$12,517,359.68	$5,510,920.36
Grand Total	**$9,702,175.12**	**$34,761,257.39**	**$16,183,873.68**	**$9,169,466.07**	**$3,615,587.76**	**$274,203.61**	**$73,706,563.63**	**$29,243,131.12**

Sample Hospital Ambulatory DNFB Summary

OP-EXCEP List	Aging										Grand Total	Total Over 7 Days
	0 Days	1 - 7 Days	8 - 14 Days	15 - 21 Days	22 - 29 Days	Over 30 Days	Over 60 Days	Over 90 Days	Over 120 Days	Over 1 Year		
Diagnosis	$472,715.14	$4,108,616.86	$530,337.54	$367,746.37	$138,936.93	$331,591.46	$105,423.74	$74,208.63	$830,749.99	$531,123.11	$7,491,449.77	$2,910,117.77
Guar	$1,560.13	$15,184.81	$786.04	$1,586.00	$7,904.00	$21,576.39	$35,250.21	$46,938.92	$107,196.41	$551,797.26	$789,780.17	$773,035.23
IP Plan	$0.00	$1,677.00	$6,600.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8,277.86	$6,600.86
Need ICD 9/10	$0.00	$0.00	$8,755.50	$0.00	$0.00	$53,117.00	$0.00	$469.00	$0.00	$0.00	$62,341.50	$62,341.50
ZZ Doc	$0.00	$74,252.45	$61,908.55	$173,702.19	$197,577.85	$297,965.07	$131,948.90	$53,126.42	$397,956.72	$123,926.37	$1,512,365.52	$1,438,113.07
PA_BH1	$0.00	$2,296.00	$2,366.00	$26,330.72	$3,196.00	$10,282.00	$0.00	$4,149.00	$104,390.93	$609,417.76	$762,428.41	$760,132.41
REV_BH1	$0.00	$0.00	$0.00	$13,022.06	$0.00	$0.00	$0.00	$0.00	$6,209.88	$0.00	$19,231.94	$19,231.94
Units	$0.00	$0.00	$8,755.50	$7,523.80	$23,583.42	$96,303.45	$34,879.45	$43,262.42	$40,088.92	$147,795.21	$402,192.17	$402,192.17
ED Level Chg	$0.00	$109,583.25	$16,352.36	$4,235.34	$0.00	$1,835.79	$0.00	$3,859.88	$0.00	$0.00	$135,866.62	$26,283.37
Grand Total	**$474,275.27**	**$4,311,610.37**	**$635,863.35**	**$594,146.48**	**$371,198.20**	**$812,671.16**	**$307,502.30**	**$226,014.27**	**$1,486,592.85**	**$1,964,059.71**	**$11,183,933.96**	**$6,398,048.32**

Detailed DNFB

Category	Status	0 Days	1-7 Days	8-14 Days	15-21 Days	22-29 Days	Over 30 Days	Grand Total	Total > 7 Days
Coded	After Report Released	$6,916.22	$23,895.04	$0.00	$0.00	$0.00	$0.00	$30,811.26	$0.00
	Outpt Finalized 5/22/17	$0.00	$9,873.82	$0.00	$0.00	$0.00	$0.00	$9,873.82	$0.00
Coded Total		**$6,916.22**	**$33,768.86**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$40,685.08**	**$0.00**
Critical Error	Not Held in SMART, no codes in SMS	$0.00	$0.00	$33,167.10	$165,198.30	$0.00	$0.00	$198,365.40	$198,365.40
	Codes in SMS	$0.00	$16,632.18	$0.00	$0.00	$0.00	$0.00	$16,632.18	$0.00
Critical Error Total		**$0.00**	**$16,632.18**	**$33,167.10**	**$165,198.30**	**$0.00**	**$0.00**	**$214,997.58**	**$198,365.40**
Pending	CDI Review	$47,423.74	$3,534,386.30	$3,011,507.40	$2,179,981.71	$1,391,487.78	$0.00	$10,164,786.93	$6,582,976.89
	Held in SMART	$0.00	$4,380,449.34	$1,399,851.72	$938,251.77	$1,320,285.37	$0.00	$8,038,838.20	$3,658,388.86
	Clinical Review	$0.00	$3,014,187.18	$3,058,011.70	$518,853.70	$0.00	$0.00	$6,591,052.58	$3,576,865.40
	OR Hold	$0.00	$2,144,185.14	$1,450,083.57	$67,428.07	$1,198,219.48	$364,617.43	$5,224,533.69	$3,080,348.55
	Case Mgmt	$178,924.70	$3,370,041.94	$1,042,537.26	$174,562.87	$19,181.67	$0.00	$4,785,248.44	$1,236,281.80
	Mortality Review	$0.00	$881,529.19	$1,669,573.45	$1,098,632.23	$779,063.85	$0.00	$4,428,798.72	$3,547,269.53
	MD Query	$0.00	$969,664.29	$609,652.45	$423,158.00	$93,306.09	$0.00	$2,095,780.83	$1,126,116.54
	CDI Reconciliation	$0.00	$1,035,840.74	$509,807.08	$33,448.44	$36,485.27	$0.00	$1,615,581.53	$579,740.79
	Data Quality Review	$0.00	$398,858.18	$115,607.00	$354,947.76	$0.00	$0.00	$869,412.94	$470,554.76
	Report Received	$0.00	$404,941.59	$246,318.89	$79,427.41	$0.00	$0.00	$730,687.89	$325,746.30
	Endo Report	$0.00	$565,150.95	$99,418.79	$0.00	$0.00	$0.00	$664,569.74	$99,418.79
	Nomenclature Error	$0.00	$394,222.04	$25,021.84	$0.00	$0.00	$0.00	$419,243.88	$25,021.84
	Discharge Summary	$0.00	$164,488.93	$188,961.48	$0.00	$0.00	$0.00	$353,450.41	$188,961.48
	Ciox QA	$0.00	$257,129.45	$0.00	$0.00	$0.00	$0.00	$257,129.45	$0.00
	Path Report	$0.00	$161,735.29	$0.00	$0.00	$72,190.20	$0.00	$233,925.49	$72,190.20
	In Progress	$20,333.32	$205,585.62	$0.00	$0.00	$0.00	$0.00	$225,918.94	$0.00
	IP Mgmt Review	$0.00	$0.00	$101,497.44	$43,976.48	$0.00	$0.00	$145,473.92	$145,473.92
	Ciox QA	$0.00	$138,971.27	$0.00	$0.00	$0.00	$0.00	$138,971.27	$0.00
	Cath/EPS Report	$0.00	$113,158.37	$0.00	$0.00	$0.00	$0.00	$113,158.37	$0.00
	No Admit Order	$0.00	$18,153.81	$67,498.49	$0.00	$0.00	$0.00	$85,652.30	$67,498.49
	H&P	$0.00	$80,688.92	$0.00	$0.00	$0.00	$0.00	$80,688.92	$0.00
	VEEG Report	$0.00	$15,976.00	$0.00	$0.00	$0.00	$0.00	$15,976.00	$0.00
Pending Total		**$246,681.76**	**$22,249,344.54**	**$13,595,348.56**	**$5,912,668.44**	**$4,910,219.71**	**$364,617.43**	**$47,278,880.44**	**$24,782,854.14**
Uncoded	Encounter Uncoded	$7,368,264.50	$1,456,009.77	$0.00	$0.00	$0.00	$0.00	$8,824,274.27	$0.00
	Chart Received - Ciox	$0.00	$3,943,856.25	$0.00	$0.00	$0.00	$0.00	$3,943,856.25	$0.00
	Chart Received - Inhouse	$59,164.80	$1,218,290.75	$0.00	$0.00	$0.00	$0.00	$1,277,455.55	$0.00
	Case Mgmt	$0.00	$61,024.71	$0.00	$0.00	$0.00	$0.00	$61,024.71	$0.00
	No Admit Order	$0.00	$25,893.81	$5,821.00	$0.00	$0.00	$0.00	$31,714.81	$5,821.00
Uncoded Total		**$7,427,429.30**	**$6,705,075.29**	**$5,821.00**	**$0.00**	**$0.00**	**$0.00**	**$14,138,325.59**	**$5,821.00**
Grand Total		**$7,681,027.28**	**$29,004,820.87**	**$13,634,336.66**	**$6,077,866.74**	**$4,910,219.71**	**$364,617.43**	**$61,672,888.69**	**$24,987,040.54**

DNFB - Break down on Held in Smart

Status	Comments	1 - 7 Days	8 - 14 Days	15 - 21 Days	22 - 29 Days	Grand Total	Average Days
Held in SMART	Pending	$1,010,030.60	$19,683.10	$793,692.26	$1,213,168.38	$3,036,574.34	14.9
	Coding Validation - JZ	$1,429,752.59	$573,746.81	$0.00	$0.00	$2,003,499.40	6.3
	CDI CR Hold	$954,980.28	$133,983.81	$0.00	$0.00	$1,088,964.09	4.9
	Coding Validation - JM	$576,408.69	$324,979.51	$0.00	$0.00	$901,388.20	7.2
	PSI	$247,787.82	$0.00	$144,559.51	$0.00	$392,347.33	11.5
	CR Hold	$0.00	$183,969.68	$0.00	$49,516.97	$233,486.65	13.0
	In Progress	$55,744.34	$102,856.92	$0.00	$0.00	$158,601.26	7.0
	MD Query	$18,340.20	$60,631.89	$0.00	$57,600.02	$136,572.11	13.5
	OR Hold	$87,404.82	$0.00	$0.00	$0.00	$87,404.82	6.0
Grand Total		**$4,380,449.34**	**$1,399,851.72**	**$938,251.77**	**$1,320,285.37**	**$8,038,838.20**	**9.9**

Wrapping Up…

Free Advice (Because I really like this and couldn't decide where else to put it…)

Summary

- This presentation was designed to provide suggestions for HIM leadership to become more integrated within the organization's Revenue Cycle. Not every suggestion is attainable by every hospital- that will depend on size and internal organizational structure- however, hopefully the demonstrations presented will provide "food for thought" related to what is attainable at your organization.
- With AHIMA's focus on the IG opportunities within the profession, it is apparent that a successful Revenue Cycle is dependent on a robust IG process as well as Revenue Integrity-like activities
- HIM professionals who are able to participate more actively in the Revenue Cycle by ensuring that clinical information is valid and supports healthcare system quality and financial metrics, those who are able to provide additional information for Finance and Administration, beyond the basics, those who are able to integrate traditional HIM functions into areas such as CDI and Quality Management, will be positioning themselves for continued success within their organization


Thank
You!