Revenue Integrity

The Clinical and Non-Clinical Perspective

April 28, 2025

forvis mazars

Agenda

- Introductions – Valorie Clouse and Alicia Faust
- Learning Objectives
- Definitions
- Revenue Integrity (RI) Impact and Integration in the Revenue Cycle
  - Clinical RI
  - Non-Clinical RI
- Revenue Integrity Process Improvements
- Claim Creation Process
- Key Take Aways

Learning Objectives

- Describe the positive impact Clinical and Non-Clinical Revenue Integrity has on the Revenue Cycle
- Explain how to integrate a Revenue Integrity Program
- Provide the strategic takeaways to support Revenue Integrity Process Improvement

Healthcare Revenue Cycle

Front End

- Also known as Patient Access
- Includes appointment access, collecting information before patient arrival, insurance eligibility, authorization, financial clearance, and concludes with checking in the patient for services and confirming patient information.

Middle

- Also known as Revenue Integrity
- Includes CDM, pricing and charge capture for services rendered, Clinical Documentation Integrity, Utilization Review/ Case Management for insurance companies to cover services medically necessary, coding diagnosis and procedures and denials prevention.

Back End

- Also known as Business Office or Patient Financial Services (PFS)
- Includes timely workflow around submission of the claim to insurances, posting of remittances received, review and appeal for claim follow up and denials, collection efforts for patient responsibility.

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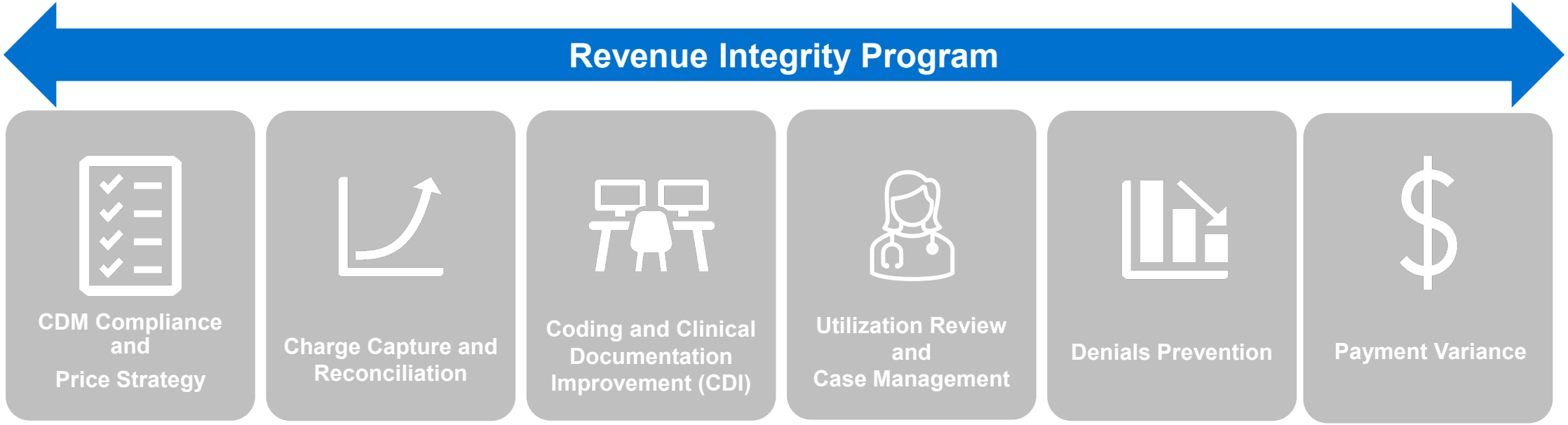
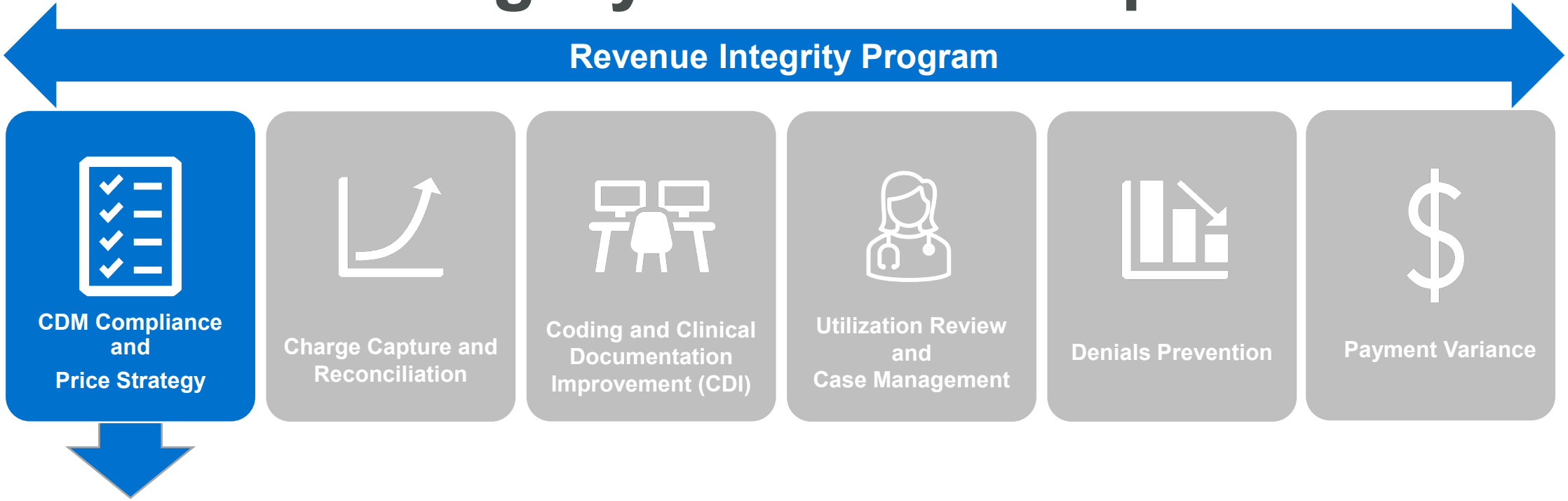
Revenue Integrity

Revenue Integrity - Definitions

The NAHRI definition of **Revenue integrity** is – "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."



Revenue Integrity – Process Improvement



- **Ownership of the Organization wide charge description master (CDM) throughout the annual CDM life cycle**
  - Charge code maintenance - add, change, delete
  - Price Strategy including alignment with budgetary cycle, patient and managed care implications
  - Acquisition cost maintenance for Emergency Room, Operating Room, Medical Supplies and Pharmaceuticals
  - Price Transparency machine-readable file (MRF) and shoppable services file (SSF)/ estimator tool compliance
- **Develop and maintain policy and procedures for:**
  - CDM Maintenance
  - Price Methodologies in-line with organizational Price Strategy
  - New Business Requests

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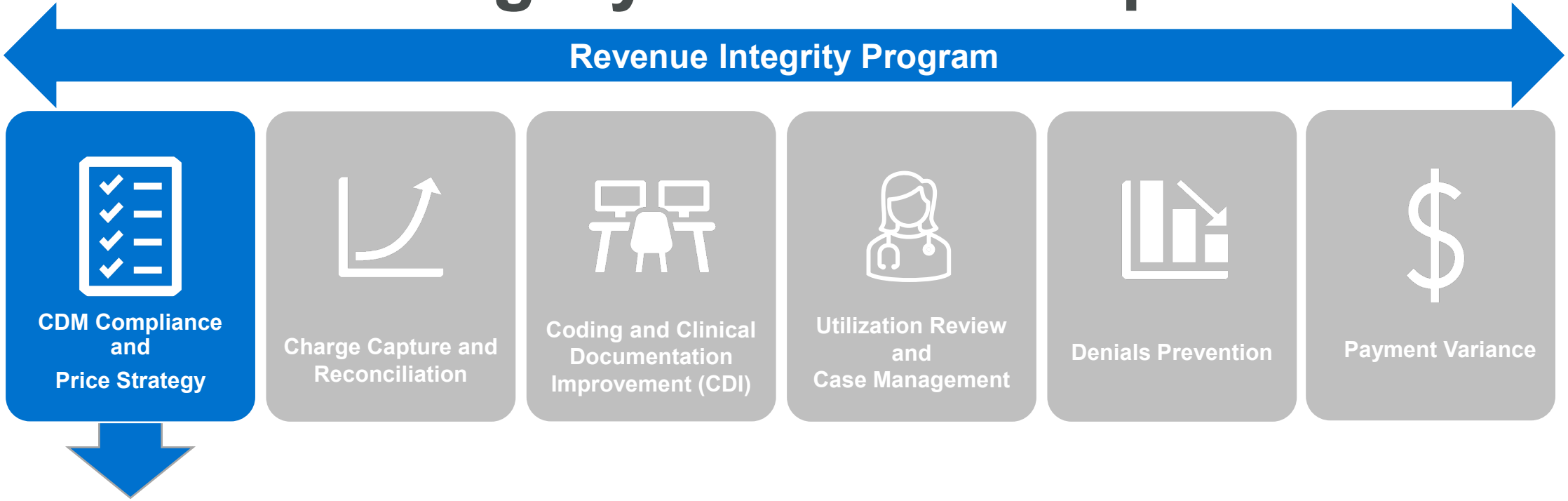
Revenue Integrity – Process Improvement



- **Owner: Revenue Integrity Department (RI) – Analyst/ Manager/ Director or Revenue Cycle Management (RCM) reporting up to the Finance Team via the Chief Financial Officer**
- **Process Improvement Opportunities:**
  - Charge codes with no usage in a two-year period. Leading Practice <60%
  - Non-compliant codes: Revenue and CPT/ HCPCS codes, Modifiers, NDCs
  - Missing charge codes needed for daily charge capture
  - Trailing or Leading Market Position
  - Unaligned Price Strategy to Managed Care Contracts, Lower Net Margins
  - Outdated acquisition cost
  - Non-compliant MRF and or SSF/ estimator tool

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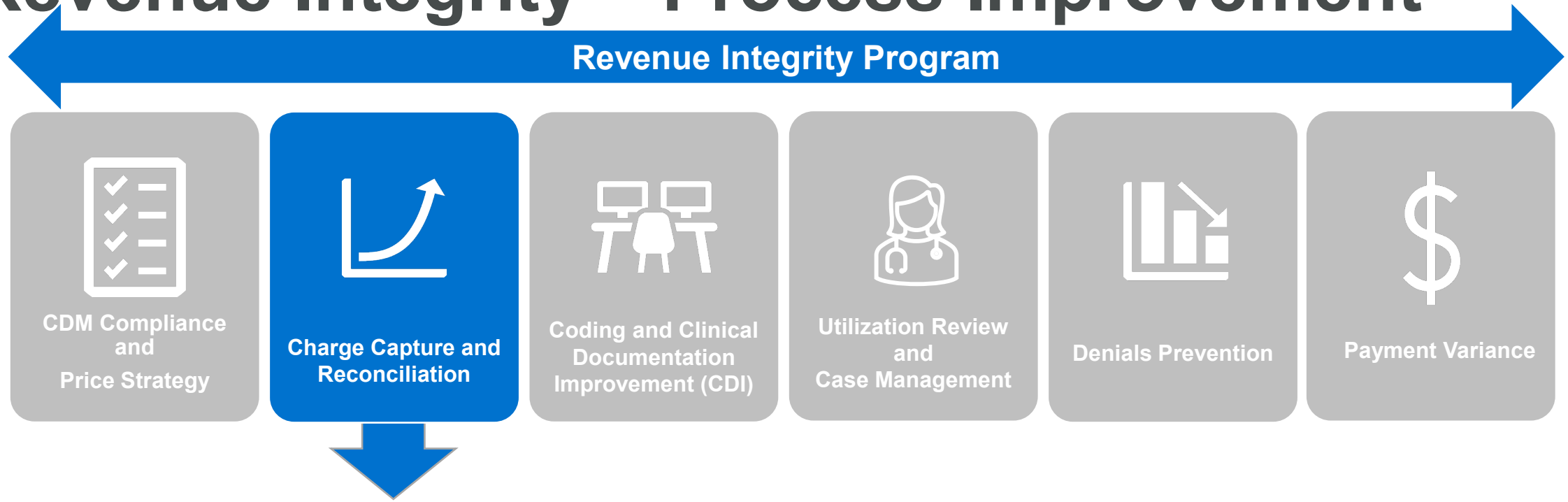
Revenue Integrity – Process Improvement



- **Accountability for the on-going Revenue Integrity charge capture and reconciliation process**
  - Consistent, timely, and accurate charge capture for patient services performed
  - Resolution of pending charges for CMS and other payor specific coding/ billing issues
- **Institutionalize charge reconciliation processes organization wide**
  - Generate reports and review clinical documentation to verify accurate charging has occurred
- **Develop and maintain policy and procedures for:**
  - Charge Capture Timeliness including clinical documentation and encounter close, coding, IT build and ticket resolution, and Revenue Integrity reporting
  - Charge Reconciliation - Gross revenue monitoring, trending, actioning and reporting

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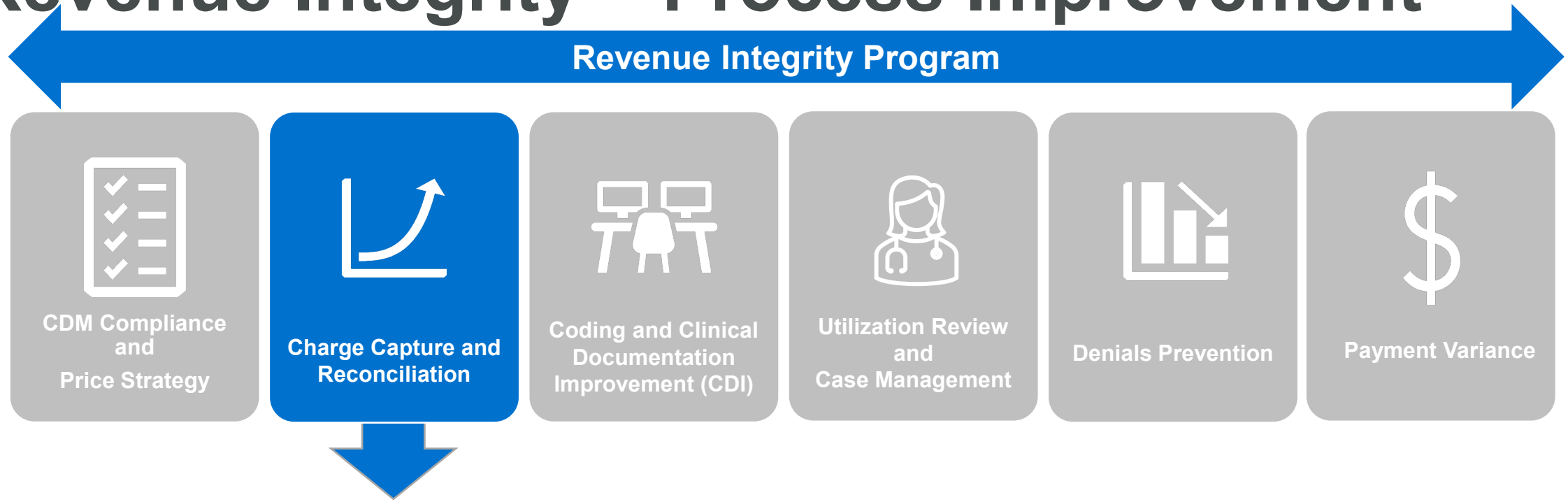
Revenue Integrity – Process Improvement



- **Owner: Revenue Integrity Department (RI) – Analyst/ Manager/ Director or Revenue Cycle Management (RCM) reporting up to the Finance Leadership Team via the Chief Financial Officer**
- **Process Improvement Opportunities:**
  - High provider open encounters and no consequences to providers
  - High Discharged Not Final Billed (DNFB) amounts/ accounts
  - No revenue monitoring and or trending
  - No department Level workqueue (WQ) monitoring and or trending
  - Lack of coder and or provider education
  - Lack of integration with CDM, Coding and CDI Teams

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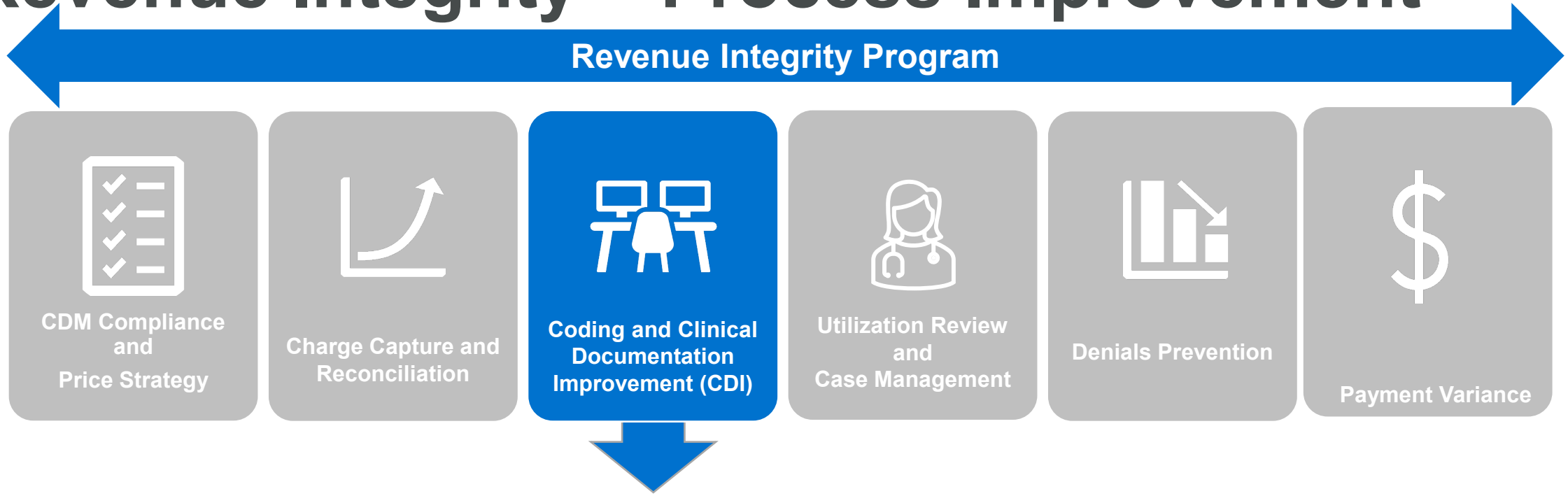
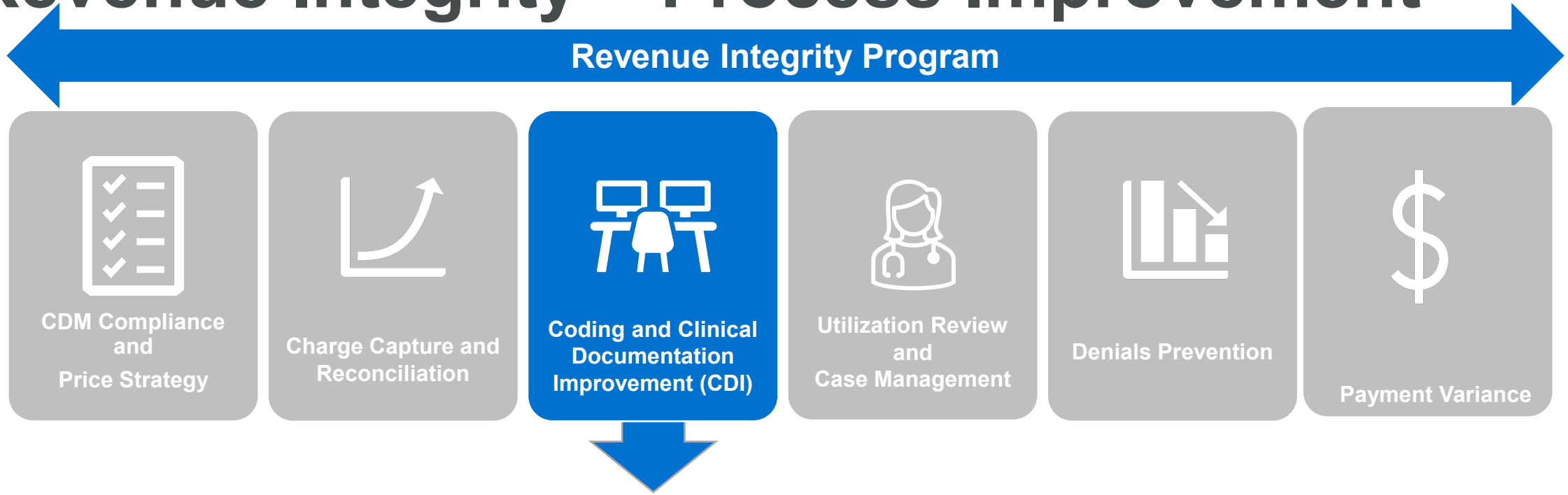
Revenue Integrity – Process Improvement



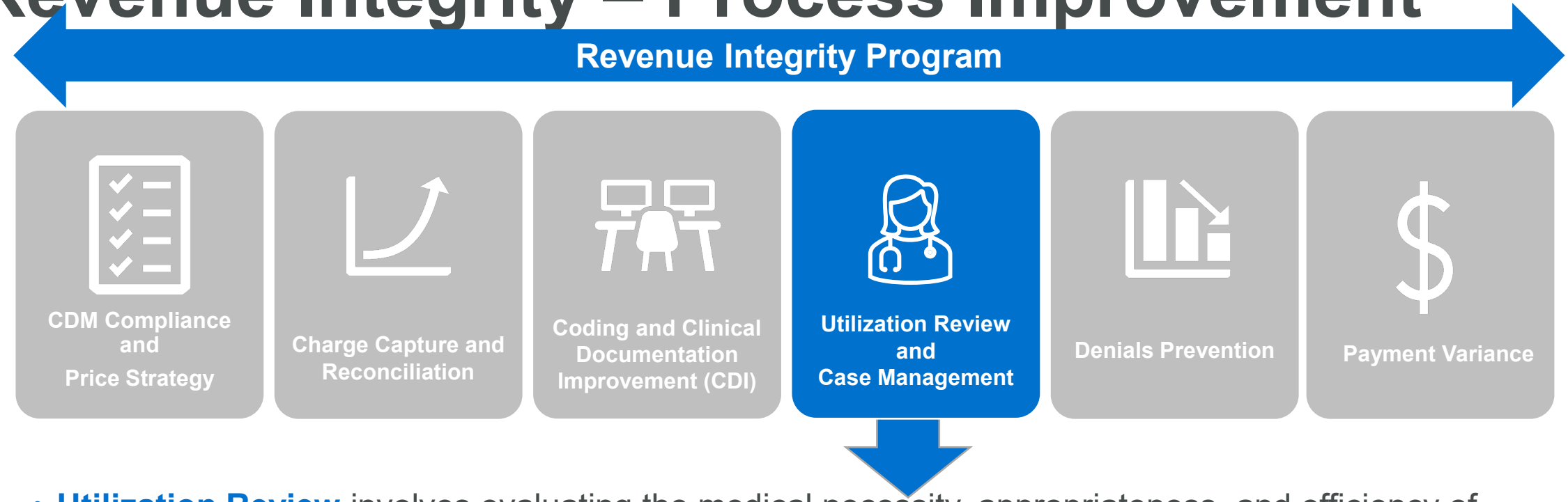
- Analyze, abstract, and code for the hospital to submit a bill for services rendered; clarifying documentation with provider for coding accuracy as needed
- Refresh quality audit program to review medical record documentation for completeness and accuracy; provide education and training as needed to clinicians and coders
- Develop and implement monthly coder productivity reporting
- Identify gaps, inconsistencies, or ambiguities in the documentation and work to resolve them.
- Communicate with physicians and other healthcare providers to clarify documentation and ensure it meets coding and regulatory requirements.
- Develop and maintain policy and procedures for:
  - Ensure consistency, completeness, and accuracy of health records and coded encounters for improved data quality, patient outcomes, and claim reimbursement

Revenue Integrity – Process Improvement



- **Owner: Revenue Integrity Department (RI) – Analyst/ Manager/ Director or Revenue Cycle Management (RCM) reporting up to the Finance Leadership Team via the Chief Financial Officer, Case/Care Management Department, or Quality Department.**
- **Process Improvement Opportunities:**
  - High provider open encounters and no consequences to providers
  - High Discharged Not Final Billed (DNFB) amounts/ accounts
  - No Coder Productivity Trending
  - Coder and provider claims/ coding audits and accuracy rates
  - Lack of coder and or provider education
  - Low Case Mix Index

Revenue Integrity – Process Improvement



- **Utilization Review** involves evaluating the medical necessity, appropriateness, and efficiency of healthcare services, procedures, and facilities
- **Case Management** focuses on coordinating patient care to optimize health outcomes and resource utilization.
- **Develop and maintain policy and procedures for:**
  - Readmissions Management
  - CoPs Compliance
  - Clinical Documentation Integrity
  - Concurrent Denials

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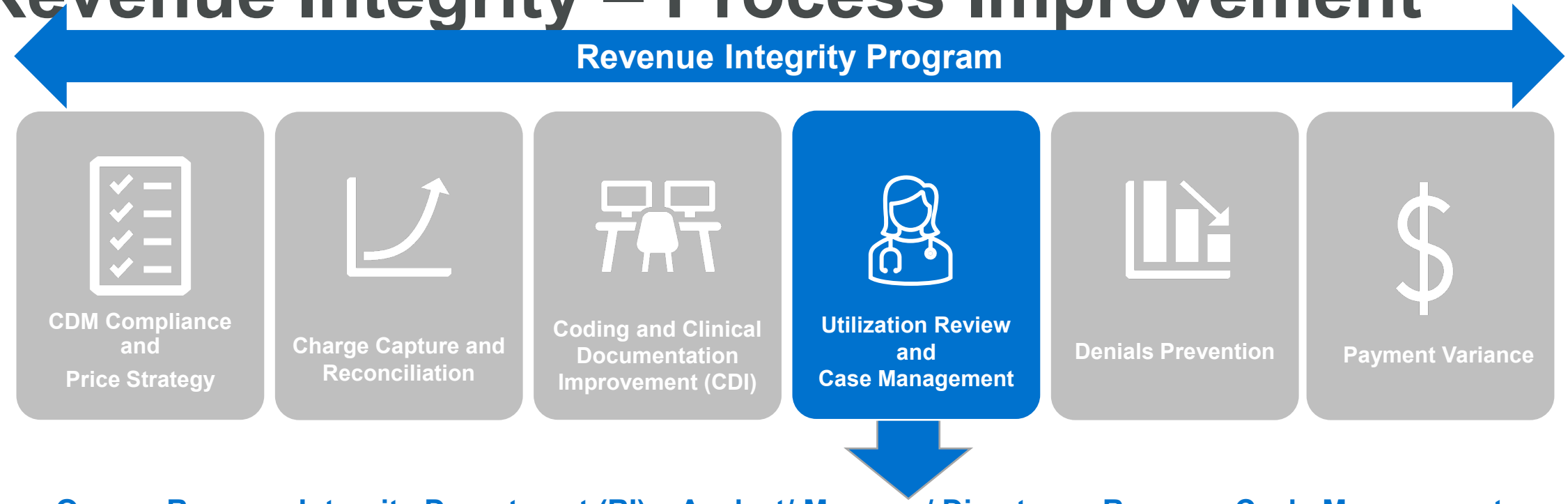
Revenue Integrity – Process Improvement



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- **Process Improvement Opportunities:**
  - Length of Stay/ Patient Throughput/ Discharge planning
  - Patient Statusing/ Medical necessity
  - **Optimize Resource Allocation**: Ensuring resources are used efficiently and effectively
  - **Improve Patient Outcomes**: Enhancing care coordination and continuity
  - **Manage Costs**: Reducing unnecessary services and hospital stays

Revenue Integrity – Process Improvement

- **Develop infrastructure to move to denial prevention while continuing to manage denial follow-up**
- **Develop and implement effective denial strategies and process improvements**
  - Identify root causes and build dedicated system edits and workqueues
  - Research, write appeals, and resubmit claims
  - Incorporate clean claim rate monitoring
  - Ensure that clinical documentation and coding are precise and comply with current regulations
- **Develop and maintain policy and procedures for:**
  - Denials Management
  - Technology and Automation
  - Interdepartmental Collaboration

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Revenue Integrity – Process Improvement

- **Owner: Revenue Integrity Department (RI) – Analyst/ Manager/ Director or Revenue Cycle Management (RCM) reporting up to the Finance Leadership Team via the Chief Financial Officer, Case/Care Management Department**
- **Process Improvement Opportunities:**
  - **Denials Root Cause Analysis**
    - CARC & RARC codes
    - Initial review
    - Initial category assignment
    - Denial worked and resolved
    - Final category assignment

    Examples:
    - ❑ COB
    - ❑ Coverage issues
    - ❑ Medical necessity
    - ❑ Prior authorization hospital vs. prior authorization physician

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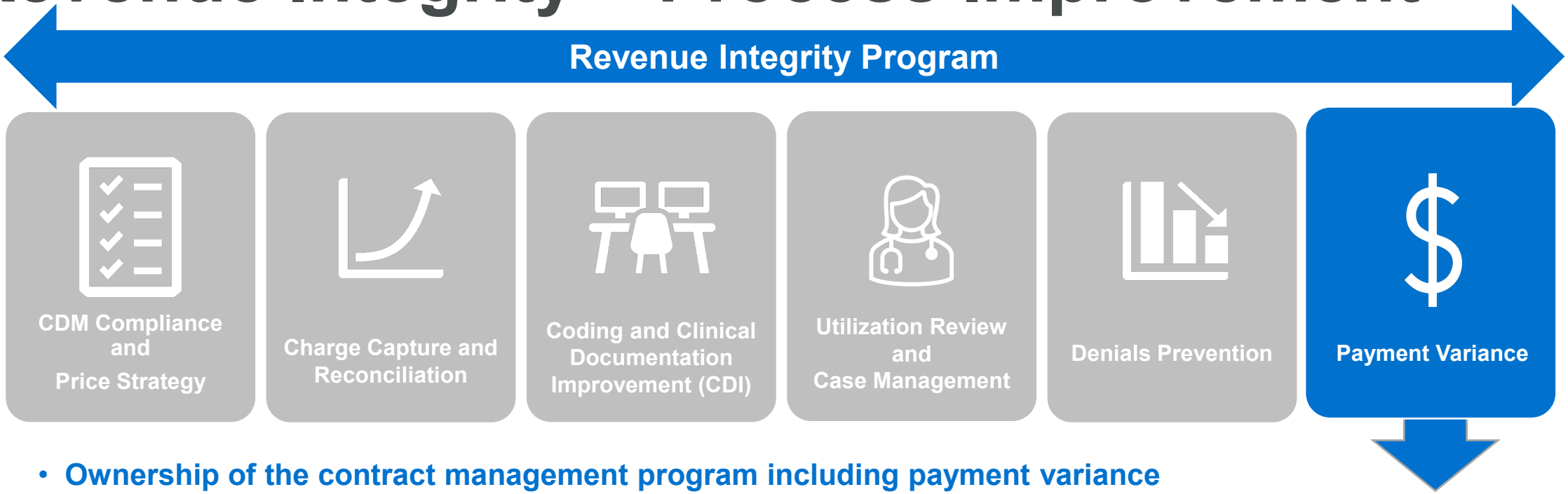
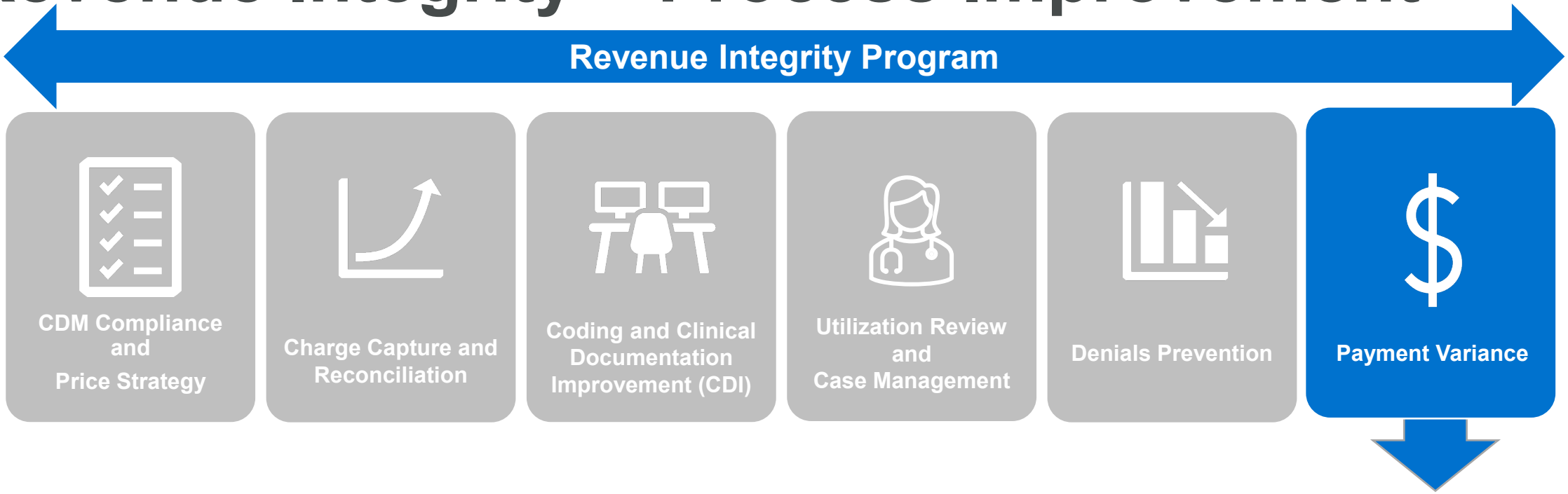
Revenue Integrity – Process Improvement



- **Ownership of the contract management program including payment variance**
  - Coordinate with Managed Care Team on current and future contract management
  - Coordinate with Denials Management Team on variances due to denials management
  - Invest in contract modeling software and or electronic tool to estimate payments/ receivables
  - Analyze and research payor specific overpayments and underpayments
  - Engage with payors monthly to support timely payment variance resolution
- **Develop and maintain policy and procedures for:**
  - Managed Care Contract Maintenance
  - Payment Variance Management – Net revenue monitoring, trending, actioning and reporting

Revenue Integrity – Process Improvement



- **Owner: Revenue Integrity Department (RI) – Analyst/ Manager/ Director or Revenue Cycle Management (RCM) reporting up to the Finance Team via the Chief Financial Officer and or Managed Care Team via the President or Vice President**
- **Process Improvement Opportunities:**
  - Lack of up-to-date contracts including supplemental documents (i.e. fee schedules)
  - No contract management software or electronic tool to estimate payments/ receivables (payor specific)
  - No monitoring or trending of payments/ receivables variances for high-cost, high-volume services or payors
  - No integration with the Denials Management/ Prevention Teams
  - Non-compliant MRF and or SSF/ estimator tool

02

Claim Creation Process

Claims Creation Process: KPI Clean Claim Rate Leading Practice >95%

Patient Discharged/ encounter coded	Bill Hold	Claim Final Billed	Claim Sent to Scrubber	Claim Edits Corrected	Claim Sent to Payor	Claim Accepted/ Rejected
Post discharge, the patient's service information is compiled (i.e., all charges are posted to the account from the EHR and/or ancillary systems and are based on clinical documentation and coding)	It is typical to have a lag between discharge and final bill to allow for charges to post to the claim (best practice is 3-5 days). This is known as the Bill Hold or Suspense Days	After the Bill Hold, the claim information will typically pass through bill edits on its way to the billing system These claims are housed in the claim scrubber and have not yet been sent to the payer (DNSP)	Claim "scrubbers" are typically 3rd party systems that have current insurance carrier information to identify potential errors or conflicts	Any billing edits shown by the claim scrubber are corrected in order to submit a clean claim. Claims are then transmitted via an 837 to a clearinghouse or direct to a payer	Claims are sent to payors electronically (837) or via hard copy. • Electronically submitted claims are transmitted via an EDI or Clearinghouse and are processed faster than paper claims	Claims not accepted by the insurance company for adjudication must be corrected by the provider and resubmitted. There are time limits set forth by payers for providers to resend corrected claims

03

Key Takeaways

Key Takeaways

Revenue Integrity improves Clinical Outcomes, Physician and Patient Satisfactions and Net Margin!

- The Charge Description Master requires on-going maintenance to be compliant and to reflect patient services performed
- Vital Elements of the annual budgetary Price Strategy should include: Market Position, Contract Optimization and Acquisition Cost Management
- Daily, weekly, monthly charge capture reporting and monitoring reduces revenue leakage
- Coding plays a crucial role in accurately reflecting patient conditions and risk factors, which is essential for risk adjustment in healthcare
- The Utilization Review (UR) and Case Management (CM) processes are essential for ensuring that all services are thoroughly documented and comply with payor specific requirements.
- Denials Prevention ensures that healthcare providers receive the payments they are entitled to for the services rendered.
- Payment Variance Management requires frequent engagement with Managed Care and Denials Prevention Teams along with Payors

Thank You!