Domain VII: Revenue Cycle

RHIT Exam Review Prep

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Disclaimer

Please note that these presentations are designed to serve as a valuable supplement to your overall study plan to prepare for the RHIT certification examination.

Participation in these presentations does not guarantee a passing score on RHIT the examination. For more information on the testing dates and the RHIT credential go to www.ahima.org.
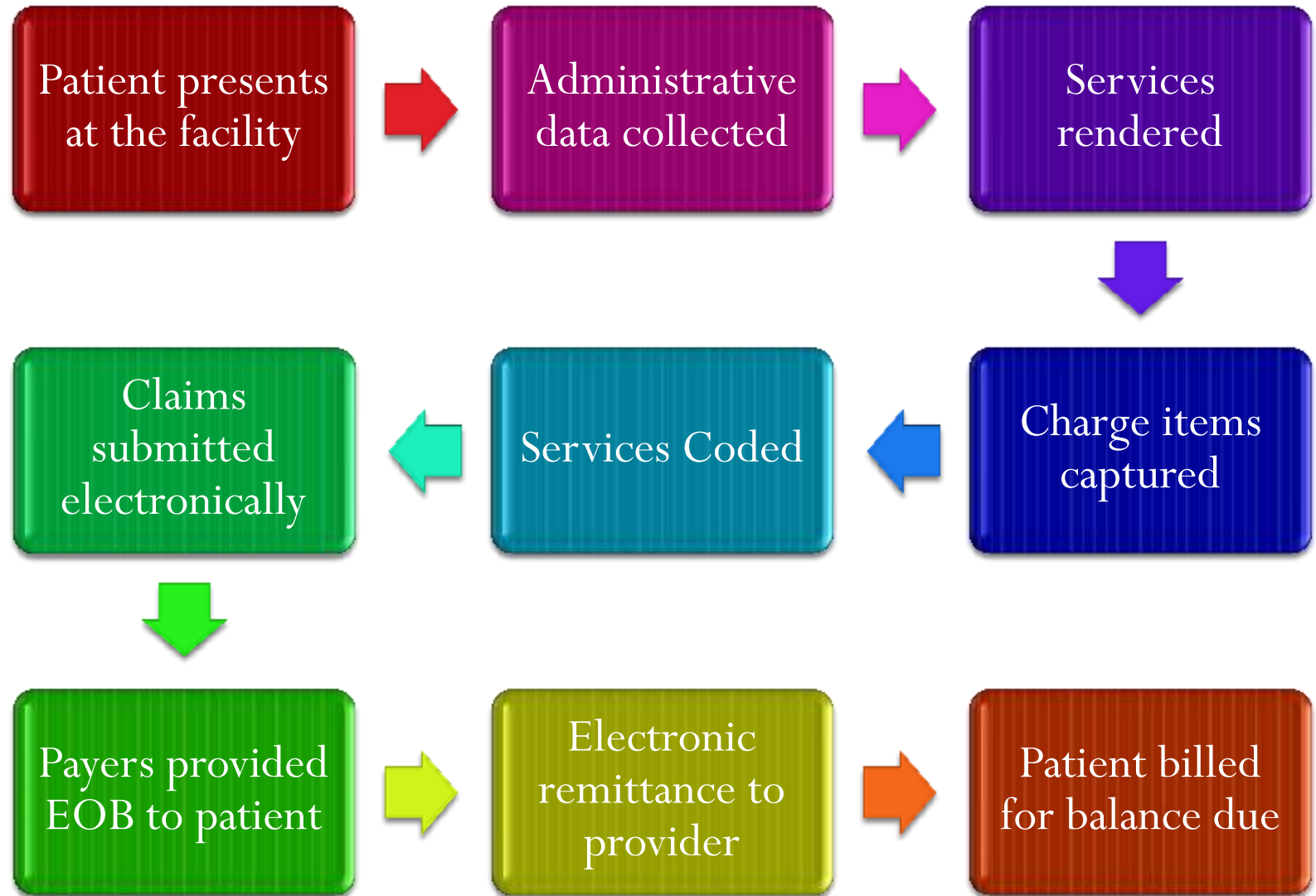
It is suggested that you follow the AHIMA Candidate Guide, Appendix H as a study guide for preparing for your certification exam.

Revenue Cycle (11%)
Knowledge Clusters

1. Communicate with providers to discuss documentation deficiencies (i.e. queries)

2. Participate in clinical documentation improvement programs to ensure proper documentation of health records

3. Collaborate with other departments on monitoring accounts receivable (i.e. unbilled, uncoded)

4. Provide ongoing education to healthcare providers (i.e. regulatory changes, new guidelines, payment standards, best practices, etc.)

5. Identify fraud and abuse

6. Assist with appeal letters in response to claim denials

7. Monitor claim denials/over-payments to identify potential revenue impact

8. Prioritize the work according to accounts receivable, patient type, etc.

9. Distribute the work according to accounts receivable, patient type, etc.

10. Maintain the chargemaster

11. Ensure physicians are credentialed with different payers for reimbursement

Revenue Cycle

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┌────────────────────┐      ┌────────────────────┐      ┌────────────────────┐
│ Patient presents   │ ───► │ Administrative     │ ───► │ Services           │
│ at the facility    │      │ data collected     │      │ rendered           │
└────────────────────┘      └────────────────────┘      └────────────────────┘
                                                                   │
                                                                   ▼
┌────────────────────┐      ┌────────────────────┐      ┌────────────────────┐
│ Claims             │ ◄─── │ Services Coded     │ ◄─── │ Charge items       │
│ submitted          │      │                    │      │ captured           │
│ electronically     │      │                    │      │                    │
└────────────────────┘      └────────────────────┘      └────────────────────┘
          │
          ▼
┌────────────────────┐      ┌────────────────────┐      ┌────────────────────┐
│ Payers provided    │ ───► │ Electronic         │ ───► │ Patient billed     │
│ EOB to patient     │      │ remittance to      │      │ for balance due    │
│                    │      │ provider           │      │                    │
└────────────────────┘      └────────────────────┘      └────────────────────┘
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Coding & Clinical documentation

- Communicate with providers to discuss documentation deficiencies (i.e. queries)

- Participate in clinical documentation improvement programs to ensure proper documentation of health records

Communicating with providers

- The key to accurate coding is physician documentation
  - Coder is the expert in coding
  - Physician is the expert in clinical services
- Query
  - View as less about reimbursement and more about data quality
  - Communicating with providers to clarify and substantiate clinically valid diagnoses supported by the patient's medical record documentation
  - Query should contain
    - Patient name, MR number and Account number
    - Admission date and date of service
    - Date Query initiated
    - Name and contact information of the coder initiating the query
    - State of the issue in the form of a question along with the clinical indicators specified from the chart (e.g. H&P states urosepsis, lab reports WBC of 14,400. ED reports fever of 102) (Sayles 2013)

CDI – Clinical Documentation Improvement

- Need collaboration between coders and physicians
- Complete, accurate, legible and timely documentation should:
  - Address the clinical significance of abnormal test results
  - Support the intensity of patient evaluation and treatment and describe the thoughts processes and complexity of decision making
  - Include all diagnostic and therapeutic procedures, treatment and tests performed, in addition to their results
  - Include any changes in patient's condition,
  - Include all conditions that coexist at the time of admission, that subsequently develop, or that affect the treatment received and the length of stay
  - Updated as needed to reflect all diagnoses relevant to the care or service provided
  - Be consistent, discuss and reconcile any discrepancies in the patient medical record
  - Be legible, written well and authenticated according to best practice standards

Training

- Provide ongoing education to healthcare providers (i.e. regulatory changes, new guidelines, payment standards, best practices, etc.)
- Identify fraud and abuse

Training - Coders

- Periodic and staff appropriate education is a key factor to a successful compliance program
- Areas that should be covered in training sessions
  - The OIG Work Plan
  - Clinical information related to problematic body systems, diagnoses and procures
  - Changes to PPSs
  - Changes to ICD, HCPCS Level II and CPT Codes
  - Application of the ICD Official Guidelines for Coding and Reporting
  - Issues addressed in the Coding Clinics
  - Issues addressed in CPT Assistant (Sayles, 2013)

Training - Physicians

- Examples of documentation problems
  - Inconsistent documentation
  - Incomplete progress notes
  - Undocumented care
  - Test results not addressed in physician documentation
  - Historical diagnoses being documented as current diagnoses
  - Long-standing, chronic conditions that are not documented
  - Lack of documentation of post operative complications
  - Illegibility
  - Documentation not completed on time (Bowman 2008)

Fraud & Abuse

- Prevent key part of any coding compliance program
- 2 Key examples
  - Upcoding
    - Coding medically unnecessary services
    - Practice of assigning a diagnosis or procedure code specifically for the purpose of obtaining a higher level of payment
    - Often found when reimbursement grouping systems are used
  - Unbundling
    - Practice of using multiple codes that describes individual components of a procedure rather than an appropriate single code that groups all steps of the procedure performed.

Denials

- Assist with appeal letters in response to claim denials
- Monitor claim denials/over-payments to identify potential revenue impact

Appeals Process

- Request for reconsideration of denial of coverage/claim
- Show why your service is valid and deserves reimbursement
  - Medical necessity
  - Clinical pertinence
  - Issue of coding
  - Documentation variance
- The appeal must be in writing following the payer's appeal process procedures
- Used as an performance indicator for RCM Team

Difference between Rejected and Denied Claims

- Rejected claims have a mechanical issue that must be corrected and refiled for reconsideration and reimbursement
- Denied claim must be appealed

Recovery Audit Contracts

- Medicare prescription Drug, Improvement & Modernization Act of 2003
  - DHHS conducted a 3 year demonstration program in California, New York and Florida to detect, correct improperly paid claims and recover more than $700 millions of dollars of Medicare funds
- 2006 Tax Relief and Health Care Act created the permanent RAC Program and implemented in all 50 states by 2010
  - 4 recovery audit contracts that divide up the states into 4 areas
  - Conduct 2 types of audits
    - Automated review
      - Occurs when a RAC makes a claim determination at the system level without a human review of the record using data mining. Tend to be incorrect coding or clear non-covered service; variance from coding guidelines
    - Complex review
      - Occurs when a RAC makes a claim determination utilizing human review of the record. Tend to be high probability of non-covered services or no Medicare sanctioned coding guideline exists

Accounts Receivables

- Prioritize the work according to accounts receivable, patient type, etc.

- Distribute the work according to accounts receivable, patient type, etc.

- Collaborate with other departments on monitoring accounts receivable (i.e. unbilled, uncoded)

Accounts Receivable

- Manages the amounts owed to a facility by customers who received services
  - Claims management
  - Billing
  - Account reconciliation
  - Collections
- Maintain statistics as quality indicators
  - Days in AR
    - Calculated by dividing the ending AR balance for a given period by the average revenue per day
  - Aging of accounts
    - maintained in "bucket" as 0-30 days, 31-60 days, 61-90 days and so on

RCM Team

- Purpose
  - To improve the efficiency and effectiveness of the RC Process
- Each organization sets it's own goals but some common examples are:
  - Identify issues to improve AR
  - Communicate issues to key areas within the system
  - Develop educational materials such an a RC Manual
  - Create a map or blueprint on how to bring up new services
  - Review denials and actively discuss the appeal process
  - Discuss key performance indicators

Key Performance Indicators

- *Sample* of key performance indicators
  - Dollar values of discharged, not final billed (NFB), encounters
  - Days from discharge to coded
  - Number of AR days
  - Percentage and amount of write-offs
  - Percentage of non-error claims (clean claims)
  - Percentage of claims returned to providers for correction by third party payers
  - Percentage of late charges
  - Percentage of accurate registrations
  - Percentage of increased POS collection for elective procedures
  - Percentage of increased DRG payment due to improved documentation and coding

Maintain the chargemaster

Chargemaster

- Chargemaster aka charge description master (CDM) contains the organization's about healthcare services and transactions provide to patients.

- As services are ordered and posted, the chargemaster posts the charge to the patient's account

- Automated charge entry for routine services

Chargermaster

- Must be maintained and updated routinely by
  - HIM
  - Clinical services
  - Finance
  - Business office/patient financial services
  - Compliance
  - Information systems
- Improper maintenance can create major adverse impact on a facility's fiscal health
  - Overpayments
  - Underpayments
  - Undercharging for delivery of healthcare services
  - Claim rejections
  - Potential fines and penaltis

Chargemaster

- Line items vary from facility to facility vary but the common elements are
  - Description of services
  - CPT/HCPCS codes that correspond to the services
  - Revenue codes (also called UB-04 codes)
    - CMS required 3 digit codes that describe a classification of a product or service provided to patients
  - Charge amount
    - Amount the facility charges – not necessarily what the facility will receive as reimbursement
  - Charge or Service code
    - Internal code assigned is unique to the facility used to identify each procedure listed an links to the department or revenue center that initiates the charge
  - General ledger key
    - 2 or 3 digit number that assigns a line item to a section in the general ledger in the facility's accounting system
  - Activity/status date
    - Indicates the most recent activity of an item

CDM Uses

- Posting charges into the billing and accounting system
  - Hard-coding – linking services automatically to CPT/HCPCS
- Collect workload statistics to monitor production and compile budgets
- Data on use of bio-equipment, personnel, services and supplies
- Decision support tool on costs related to resources for contract negotiations with managed care organizations

Ensure physicians are credentialed with different payers for reimbursement

Credentialing

- Previously discussion in Domain 3 Compliance

- Insurance carriers

  - Require credentialing of providers to be included on their panels for payment

    - Managed care contracts
    - Participating provider
    - In Network

Examples of questions

Question

When a provider, in order to increase their reimbursement, reports codes to a pair that are not supported by documentation in the medical record, this is called

A. Fraud
B. Abuse
C. Unbundling
D. Hyper coding

Answer

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Question

A new initiative by the federal government to eliminate fraud and abuse and recover over payments involved the use of _____. Charts are audited to identify Medicare overpayment and underpayments. These entities are paid based on a percentage of money they identify and collect on behalf of the government.

  A.   Clinical Data Abstraction Centers
  B.   Quality Improvement Organizations
  C.   Medicare Code Editors
  D.   Recovery Audit Contractors

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This information is used to assign each item to the particular section of the general ledger. In a particular facilities accounting section. Reports can be generated from this information to include statistics related to volume in terms of numbers, dollars, and payer types. What element is this of your charge master?

A. General ledger key
B. Charge code
C. Revenue code
D. HCPC code

Answer

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   A.   **General ledger key**
   B.   Charge code
   C.   Revenue code
   D.   HCPC code

Question

There are times when documentation is incomplete or insufficient to support the diagnosis found in the patient's chart. The most common way of communicating with a physician for answers is by

    A.   E-mailing physicians
    B.   Using physician query forms
    C.   Calling the physician's office
    D.   Leaving notes in the chart

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Accounts Receivable (A/R) refers to

A. Cases that have not yet been paid
B. The amount the hospital was paid
C. Cases that have been paid
D. Now that have been returned to the hospital

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Question

- To monitor timely claims processing, a hospital, a summary report of patient receivables is generated frequently. H. receivables can negatively effect the facility's cash flow; therefore, to maintain the facility's fiscal integrity, the HIM manager must routinely analyze this report. Though this report has no standard title, is often called the

  A. Remittance advice
  B. Periodic interim payments
  C. Discharge no final bill (DNFB)
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Question

The difference between a reject the claim in a denying claim is that

A. A reject the claim is sent back to the provider, errors may be corrected and the claim resubmitted

B. A denied claim is sent back to the provider, errors may be corrected and the claimant resubmitted.

C. A reject a claim may be appealed, but denied claim may not be appealed.

D. If the procedure or service is unauthorized to claim will be rejected, not denied

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Q&A