# Complete Revenue Cycle Assessments

It has been our experience that the maximum leakage and loss of revenue occurs during the clinical charge capture process. During our revenue cycle assessments we evaluate charge capture processes and mechanisms in place from the front-end i.e. registration, through to the back end, i.e. billing at the Facility. A detailed department by department assessment of current charge capture processes, reporting support and performance statistics for clinical operations that represent the greatest return on investment (ROI) is completed. We work with our clients to select a set of targeted departments based on our collective experience and the investigation of client data. Our past results highlight that 80% of the improvement gains come from 20% of the clinical services. Our assessment includes:

- a detailed on-site process clinical practice and revenue management analysis for inpatient ancillary and outpatient charge capture processes for the major revenue producing clinical services ; and,
- an investigation of the contracted charge capture contract provisions, the CDM, supportive chart analysis, regulatory research and charge capture enabling tools for these same major clinical services.

After the assessment is completed, we remain available to assist the Client as it implements the recommendations associated with improving clinical charge capture. This phase combines an experienced team with Client departmental leadership in process review, redesign and infrastructure support. We concentrate our efforts on supporting the redesign of clinical charge capture processes on a subset of clinical departments that represent the greatest potential for improvement.

# RAC Audit Preparation

RevCys is one of the few consulting organizations that have been advising clients in the original RAC Demonstration Project areas of New York and Florida. Based on our experiences we have developed a comprehensive methodology to assist our clients with a response to these audits from assessment to appeal. Our approach is targeted to provide solutions for long-term financial performance improvement rather than a short-sighted reaction to the audit leading to process improvements that endear. Our solution includes:

- Assessment of Current HIM Operations:
- Initiate a documentation integrity review and identify gaps.
- Review process for documentation compilation.
- Provides specific recommendations for sustained improvements
- Review of issues targeted by RAC Audits:
- Initiate a concurrent review of all observation and one day stays.
- Review documentation and DRG assignment for excisional debridement
- Review documentation for respiratory with ventilator coding
- Set-up RAC Response:
- Identify key staff and set-up a cross functional team of patient access, patient accounts, HIM, Risk Management and Finance.
- Set up process to receive and respond to RAC claim requests.
- Establish database to match requests against claims already reviewed.
- Set up process to review each record requested and process to file rebuttals with the RAC sub-contractor and the FI.
- Assess if client has work-force to manage the volume of audits and identify extended resources by outsourcing some or all RAC audits to ensure timely response and appeal
- Calculated estimated financial impact based on current error rates in documentation to allow creation of financial reserve

Our professionals our involved with educating clients in Virginia, DC and Pennsylvania on the amended CMS guidelines for the RAC sub-contractors and designing strategies to respond to the impending claim audit requests. Our expertise and approach for revenue integrity allows us to serve as a strategic partner to help assess and resolve your RAC and Medicare reimbursement issues.

# Denial Management

While the objective for any hospital is to maximize the percentage of first time 'clean' claims, denials are a fact of life given the multiplicity of regulations from State and third-party payers. According to the Laurel Financial Resources, "Of over 15 billion claims, 25% to 40% are either rejected or denied ... only 50% of these rejected or denied claims are followed up and resubmitted." The Zimmerman Best Practice Report states that, "Evidence shows that 90% of denials are preventable and 67% are recoverable."

Our denial-management solution toolkit incorporates two parallel processes: a prospective-prevention process to avoid claims denials and a claims-recovery process to address claims that have been denied. The toolkit is designed to take advantage of the standardization provided by HIPAA transaction sets for electronic reimbursement. This allows our clients to identify denials in real time, prioritizing these for resolution and mitigating the root causes to prevent future denials. The prospective-prevention process includes identification of scope of services being provided and charging and billing guidelines around them. This is followed by establishing a point-of-service accountability by setting up a communication process down to clinical department level for denials received for incorrect charging and billing.

The claims recovery process includes setting up a denial appeal coordinator function. Minimizing denials due to untimely submission of medical documentation, focusing on denials with most likelihood of being reversed, setting up a template for appealing denials and developing a database to track denials received, appealed and overturned.

# Billing / Coding Audits

Healthcare organizations need to ensure that they comply with government regulations in investigating fraud and abuse. A good way to do this is by establishing an audit program and conducting regular audits of the coding and billing of services. An effective audit program should be designed to minimize potential risk to the organization by recognizing areas of vulnerability.

At RevCys, we follow the 80/20 rule: 20 percent of the organization's activity represents 80 percent of its risk. For example, 20 percent of the insurance carriers representing outstanding accounts receivable typically represent 80 percent of total outstanding dollars due to the organization. Likewise, 20 percent of clinical activity typically represents 80 percent of the organization's compliance risk.

Upon identification of the significant risk areas, RevCys conducts probe audits with a small sample size to evaluate the existence and the extent of the errors. The result of the probe audits determines specific areas to perform detailed audits with a statistically valid sample as defined by the 2009 OIG workplan.

Our audits are designed to support an effective billing compliance program for our client organizations. The need to minimize regulatory risk related to claims submissions is just as important as the need for working capital. The potential for devastating financial consequences in the event of a government investigation or qui tam action more than offsets the cost of operating an effective compliance program.

# Charge Master Optimization

For those organizations that treat their charge master as more than a price list of services, our Charge Master Optimization program helps to align the charging and pricing functions with your coding and billing functions. The program helps ensure that every bill meets every coding compliance standard, assists in separating cost data for reporting purposes and is configured for automatic revisions of changing regulations, codes, and costs.

Our charge master coding analysis takes advantage of our automated methodologies to map the Hospital's charge master to RevCys' standard charge master which has current coding and charge structures embedded into it. That allows us to quickly and accurately review all clinical areas. This review will be performed in order to identify missing, inaccurate, and outdated codes and will be performed in compliance with National Medicare guidelines. The following areas are included in the review as appropriate, based on the services provided by the Hospital:

CPT, HCPCS, and Revenue Code Exceptions

- Outdated CPT Codes – Identifies CPT Codes on the CDM that have been deleted or replaced.
- CPT/Revenue Code Mismatches – Identifies charge codes that have incorrectly matched CPT and/or Revenue Codes.
- HCPCS/Revenue Code Mismatches – Identifies charge codes that have incorrectly matched HCPCS and/or Revenue Codes.
- CPT Codes Not Typically Assigned in the CDM – Identifies charge codes that should not have "hard coded" CPT Codes in the CDM (i.e., these codes are typically assigned by Health Information Management).
- Physician Only CPT Codes Found in the CDM – Identifies charge codes that have CPTs that should only be used by Physicians.
- Revenue Codes Requiring a CPT or HCPCS Code – Identifies charge codes that do not have a CPT or HCPCS where one is applicable.
- Assigned CPT Code Different from RevCys' database– Identifies charge codes with a different CPT Code than the mapped item in the RevCys' database
- Assigned HCPCS Code Different from RevCys' database- Identifies charge codes with a different HCPCS Code than the mapped item in the RevCys' database
- Assigned Revenue Code Different from RevCys' database– Identifies charge codes with a different Revenue Code than the mapped item in the RevCys' database

The Charge Master Optimization Program also assists in identifying other coding and charging issues such as:

- Non-reportable CPT or HCPCS Level II Codes;
- Non-covered CPT or HCPCS Level II Codes;
- Deleted CPT or HCPCS Level II Codes;
- Unlisted CPT or HCPCS Level II Codes;
- Duplicate charge line items;
- Line items which have remained unused for at least 12 months; and
- CPT and HCPCS Level II Code modifiers, as required by Medicare beginning July 1, 1998.

# Observation Status Assessment

The Medicare Claims Processing Manual Section 290.1 defines observation services as a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Billing for outpatient observation services has been an ongoing issue for many providers, particularly since the advent of the hospital outpatient prospective payment system (OPPS). There is no shortage of confusion, both with the issues involve billing problems or dealing with medical staff members that have their own definition of the appropriate use of observation services. Add this to the fact that besides providing very little reimbursement and that the Office of the Inspector General has increased scrutiny in this area, many providers have decided that coding and billing for observation services is not a worthwhile endeavor.