

# *Revenue Cycle Management*

**Audio Seminar/Webinar**

*April 17, 2007*

***Practical Tools for Seminar Learning***

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## Faculty

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### **Staci S. Smith, RHIA, RN, CCS, CHFP**

Ms. Smith has more than 14 years of experience in health care management with both providers and payers. Her expertise is in Health Information Management, Case Management, and hospital finance related to various prospective payment systems (PPS). She is currently the Divisional CDM/Charge Capture Analyst for the Hillcrest Health System which is owned by Ardent Health Services, Nashville, Tennessee.

Before joining the Hillcrest Health System, Ms. Smith was the director of inpatient coding for the largest non-profit health system in Oklahoma, where she developed and implemented a clinical documentation improvement program. Ms. Smith has also worked as a network development consultant in provider relations for the largest insurance company in Oklahoma. Most recently, she was employed as a supervising consultant with one of the top 10 accounting and health care consulting firms.

Ms. Smith is an accomplished speaker and has presented numerous seminars to various health care organizations, including the Oklahoma Hospital Association, Oklahoma Healthcare Financial Management Association, Oklahoma Health Information Management Association and the American Health Information Management Association; all associations of which she is a member.

Ms. Smith is a graduate of East Central University, Ada, Oklahoma, with a B.S. degree in health information management and a graduate of Oklahoma City Community College with an associate degree in nursing.

### **Karen G. Youmans, MPA, RHIA, CCS**

Ms. Youmans is Executive Vice President of YES HIM Consulting, Inc. She has over 25 years of experience as manager, teacher and consultant in the field of health information management (HIM). She has previously held such positions as HIM Product Consultant, Practice Manager of Coding Products and Services, Director of Medical Records and Assistant Director of Medical Records. In addition, Ms. Youmans was an Assistant Professor in an HIM program, as well as Program Director in Health Information Technology.

As a volunteer in her profession, Ms. Youmans has lent her services in many capacities to the American Health Information Management Association (AHIMA) and Florida Health Information Management Association (FHIMA). She served on the AHIMA Board of Directors, as Chairman of the Council on Accreditation and as a Director on the Assembly on Education Board. Ms. Youmans also served as President of FHIMA and received a Distinguished Member Award from the organization.

Ms. Youmans has written numerous articles on health information topics and authored the book *Basic Healthcare Statistics for Health Information Management Professionals*, published by AHIMA.

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## ***Objectives***

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- ♦ Provide the purpose of revenue cycle management
- ♦ Identify keys to a successful reimbursement model
- ♦ Identify best practices for the revenue cycle
- ♦ Discuss the role of HIM in the revenue cycle

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## ***Polling Question #1***

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What is your current position?

- \*1 HIM Director
- \*2 Coding Manager
- \*3 Coding professional
- \*4 Billing professional



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## ***Definitions of the Revenue Cycle***

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***“The processes and associated suite of software applications required to manage the registration, charging, billing and payment collections tasks associated with a patient encounter.”***

***\*2007 HIMSS Analytics Report***

***“All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.”***

***\* HFMA Glossary***

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## ***Revenue Cycle: Major Processes***

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- ◆ **Generate Demand**
- ◆ **Deliver Care**
- ◆ **Manage Revenue**
- ◆ **Research and Educate**

**Core processes are a chain of tasks or other sub-processes that deliver value to the organization and/or its customers**

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***Importance of Revenue Cycle Management***

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♦ **External and Internal Forces**

- **OIG workplan**
- **OIG audits**
- **Payer rules**
- **Uninsured patients**
- **Decreasing budgets**
- **Increasing costs**

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***Revenue Cycle: Major Processes***

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♦ **Generate Demand**

- **Customer Inquiry**
- **Scheduling**
- **Registration**
- **Authorization**



♦ **Deliver Care**

- **Orders**
- **Documentation**
- **Charge Capture**

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## *Revenue Cycle: Major Processes*

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### ♦ **Manage Revenue**

- Coding
- Billing
- Collections Follow-up
- Cash Posting
- Customer Inquiry

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## *Revenue Cycle: Major Processes*

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- ♦ **Encompasses core business process that cross administrative, financial and clinical department boundaries**
- ♦ **Inter-related with quality: clinical and administrative**
- ♦ **Begins and ends with the patient**

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## ***Typical Departments in the Revenue Cycle***

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- ◆ **Admitting/Access Management**
- ◆ **Case Management**
- ◆ **HIM/Medical Records**
- ◆ **Business Office/Patient Financial Services**
- ◆ **Finance**
- ◆ **Compliance**
- ◆ **Information Systems**

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## ***Other Functions within Revenue Cycle***

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- ◆ **Charge Capture / Charge Description Master (CDM)**
- ◆ **Unbilled Management**

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***Polling Question #2***

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**Where is the charge capture and/or CDM function within your facility?**

- \*1 Nursing**
- \*2 PFS**
- \*3 Business office**
- \*4 Separate department**



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***Admitting / Patient Access / Registration***

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- ♦ Decentralized
- ♦ Referrals/pre-certs at time of encounter (for nonemergent)
- ♦ Co-pays/Deductibles collected after discharge
- ♦ No deposits for elective procedures
- ♦ No payment plans offered or agreed upon
- ♦ Valid order requirement not enforced

**VS.**

- ♦ Centralized
- ♦ Referrals/pre-certs prior to encounter (for nonemergent)
- ♦ Co-pays/Deductibles collected upfront
- ♦ Deposits for elective procedures
- ♦ Payment plans offered and agreed upon
- ♦ Valid order required
  - Diagnosis
  - Test ordered
  - Physician signature
  - Date

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## Case Management (CM)

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- ◆ Does CM utilize admission criteria?
- ◆ Is CM supported by administration when notifying a doctor that patient(s) do not meet admission or continued stay criteria?
- ◆ Is length of stay monitored?
- ◆ Is ancillary utilization monitored?
- ◆ When does discharge planning begin?

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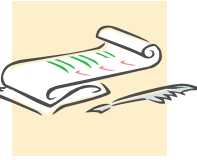
## Business Office

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- |  |                   |   |
|--|-------------------|---|
| <ul style="list-style-type: none"><li>◆ No denial tracking</li><li>◆ No reconciliation process</li><li>◆ No ancillary accountability</li><li>◆ Edits/denials "fixed" in business office or sent to HIM</li><li>◆ AR/Aging not tracked</li><li>◆ Appeals not followed</li></ul> | <b><u>VS.</u></b> | <ul style="list-style-type: none"><li>◆ Denial Tracking</li><li>◆ Denial Trending</li><li>◆ Edits/Denials sent to respective departments for reconciliation</li><li>◆ AR/Aging tracked</li><li>◆ Appeals – CM/HIM/BO/Compliance are involved in appeals</li></ul> |
|--|-------------------|---|

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## Finance Contracting



- ◆ Contract specifications communicated to
  - Registration
  - Case management
  - HIM
  - Business office
  - Compliance
- ◆ Develop template for summary of key terms
  - Start date/expiration date
  - Payment mechanism for inpatients/outpatients
  - Specific code assignment requirements
- ◆ Denials monitored and tracked?
  - Inpatient and outpatient
- ◆ Payments monitored?
  - Are DRGs changed?
  - Are penalties applied for no pre-auth, etc.

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## Information Systems

**“Effective Revenue Cycle Management (RCM) strategies will depend on next generation clinical and financial information systems to address RCM from a care-based perspective in order for organizations to fully realize their revenue potential as the paradigm of reimbursement continues to shift towards payment based on quality and performance.”**

**\* 2007 HIMSS Analytics Report**

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## Charge Capture/CDM

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- |   |                   |   |
|---|-------------------|---|
| <ul style="list-style-type: none"> <li>◆ No CDM Coordinator</li> <li>◆ No reconciliation process</li> <li>◆ No ancillary accountability</li> <li>◆ Edits/denials "fixed" in business office or sent to HIM</li> </ul> | <b><u>VS.</u></b> | <ul style="list-style-type: none"> <li>◆ CDM Coordinator</li> <li>◆ Reconciliation reports</li> <li>◆ Ancillary designee for lab, radiology, ED, surgery, etc.</li> <li>◆ Edits/denials go back to ancillary department to correct</li> </ul> |
|---|-------------------|---|

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## Charge Capture/CDM —Charging Variations

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- ◆ **Examples:**
  - Room and Care – ICU
    - Low \$1,704.12
    - High \$9,330.48
    - Variation 548%
  - CPT 80048 Basic Metabolic Panel
    - Low \$14.69
    - High \$259.92
    - Variation 1,769%

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### ***Polling Question #3***

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**Where is the unbilled management function within your facility?**

- \*1 HIM / Coding department**
- \*2 PFS / Business Office**
- \*3 Separate department**
- \*4 Combination of departments**



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### ***Revenue Cycle Performance Indicators***

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- ♦ **Define, measure, and interpret indicators that go beyond gross receivables, cash and A/R days**
- ♦ **Develop a comprehensive set of key indicator graphs to communicate revenue cycle performance**
- ♦ **Relate indicators to one another and understand processes that support achievement of results**

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## Revenue Cycle Performance Indicators

- ◆ Understand best practice goals, upper and lower control limits, and the importance of managing trends
- ◆ Perform a mini-assessment of your revenue cycle operations using an improved financial indicators checklist as well as related process steps
- ◆ Use a rigorous set of metrics to help drive continuous improvement

\*HFMA 2005

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## Medicare Cost Report Indicators Definitions & Benchmarks

**Case Mix Index:** CMI provides a measure of case mix intensity for the hospital's inpatient population. Changes in case mix are not necessarily good or bad. The key objective is to conduct a profitable operation at whatever the case mix happens to be.

	2004	Percentile Values	
		75 <sup>th</sup>	90 <sup>th</sup>
Urban	1.3418	1.5572	1.7472
Rural	1.0955	1.2061	1.2982
All	1.2375	1.4357	1.6710

Source: The 2006 Almanac of Hospital Financial and Operating Indicators; Ingenix, Inc. 2005

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## Client Example—CMI

Indicator	2001	2002	2003	2004
<u>Client's Medicare CMI</u>	1.2720	1.2300	1.2130	1.4575
<u>Industry</u>	1.2387	1.2484	1.2323	1.2375

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## Medicare Cost Report Indicators Definitions & Benchmarks

**Length of Stay:** LOS measures the average time an inpatient spends in the hospital. In today's environment of fixed payment per case, a reduction in LOS is usually desirable.

	2004	Percentile Values	
		25 <sup>th</sup>	75 <sup>th</sup>
Urban	4.3	3.8	4.9
Rural	3.5	3.1	4.1
All	3.9	3.3	4.6

Source: The 2006 Almanac of Hospital Financial and Operating Indicators; Ingenix, Inc. 2005

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### Client Example—LOS

Indicator	2001	2002	2003	2004
<b>Medicare Average LOS</b>				
Medicare Patient Days (Excluding SNF)	17,800	21,250	19,750	22,550
Discharges	3,100	3,300	3,500	3,500
<b>Client's Medicare Average LOS</b>	<b>5.7</b>	<b>6.4</b>	<b>5.6</b>	<b>6.4</b>
Industry	4.4	4.3	4.3	3.9

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### Medicare Cost Report Indicators Definitions & Benchmarks

**Days in A/R** is defined as the average time that receivables are outstanding, or the average collection period.

	2004	Percentile Values	
		25 <sup>th</sup>	75 <sup>th</sup>
Urban	51.7	44.2	60.7
Rural	57.8	49.2	68.1
All	54.7	46.2	64.7

Source: The 2006 Almanac of Hospital Financial and Operating Indicators; Ingenix, Inc. 2005 26

## Client Example—A/R

Indicator	2001	2002	2003	2004
<b>Days Charges in A/R</b>				
Patient Accounts Receivable	\$8,000,000	\$7,700,000	\$8,250,000	\$7,150,000
Daily Patient Service Revenues	\$106,000	\$115,000	\$125,000	\$130,000
Client's Days in A/R	75.5	67.0	66.0	55.0
Industry	68.8	63.8	62.3	54.7

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## Medicare Margin Analysis Bad, Good, Better?

### CASE STUDY: Medicare Margin Analysis - Inpatient

	Scenario A			Scenario B		
	2002	2003	2004	2002	2003	2004
<b>Acute Beds</b>	42	42	42	31	31	31
<b>Inpatient Days</b>	2,290	2,300	2,350	3,071	2,613	3,200
<b>Discharges</b>	570	525	500	780	726	880
<b>Average LOS</b>	4.0	4.4	4.7	3.9	3.6	3.6
<b>CMI</b>	1.0109	0.9255	0.8702	1.0982	1.2106	1.3407
<b>Charges</b>	\$5,600,000	\$5,900,000	\$6,100,000	\$7,600,000	\$7,800,000	\$9,000,000

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## Case Study

### Medicare Margin Analysis – Inpatient

	Scenario A			Scenario B		
	2002	2003	2004	2002	2003	2004
<b>Inpatient</b>						
Charge/day	\$2,400	\$2,565	\$2,595	\$2,467	\$2,990	\$2,800
Cost/day	\$1,000	\$1,300	\$1,400	\$810	\$959	\$900
Reimbursement (Gross)	\$2,800,000	\$3,300,000	\$3,400,000	\$3,840,000	\$3,835,000	\$4,300,000
Cost	\$2,290,000	\$2,990,000	\$3,290,000	\$2,485,000	\$2,500,000	\$2,880,000
Margin	\$510,000	\$310,000	\$110,000	\$1,355,000	\$1,335,000	\$1,420,000
Margin %	22%	10%	3.0%	35%	34%	38%

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## Case Study

### Medicare Margin Analysis – Outpatient

	Scenario A			Scenario B		
	2002	2003	2004	2002	2003	2004
<b>Outpatient</b>						
Charges	\$1,600,000	\$1,700,000	\$1,800,000	\$1,500,000	\$1,600,000	\$1,800,000
Reimbursement (Gross)	\$650,000	\$650,000	\$700,000	\$760,000	\$850,000	\$950,000
Cost	\$700,000	\$650,000	\$725,000	\$800,000	\$875,000	\$875,000
Margin	(\$50,000)	0	(\$25,000)	(\$40,000)	(\$25,000)	\$75,000
Margin %	-7.0%	0%	-3.0%	-5.0%	-3.0%	10%

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## ***Typical Measurements/Indicators***

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- ♦ DNFB \$ (Discharged Not Final Billed)
- ♦ A/R days
- ♦ Bill hold days
- ♦ % and \$ of write-offs
- ♦ % of clean claims
- ♦ % of RTPs (Return to Provider)
- ♦ % of denials
- ♦ % of accounts missing documents
- ♦ # of query forms
- ♦ % of late charges
- ♦ % of accurate registrations

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## ***Example Best Practice Standards***

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- ♦ Overall pre-registration rate of scheduled patients  $\geq 95\%$
- ♦ Overall insurance verification rate of scheduled patients  $\geq 95\%$
- ♦ Average registration interview duration  $\leq 10$  minutes
- ♦ Data quality compared with pre-established dept standards  $\geq 98\%$
- ♦ Master patient index duplicates created daily as a percentage of total registrations  $\leq 1\%$
- ♦ Collection of elective services deposits prior to service 100%

*\* July, 2005 Healthcare Financial Mgmt*

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## ***Example Best Practice Standards***

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- ♦ Late charge hold period 2–4 days
- ♦ Late charges as a percentage of total charges  $\leq 2\%$
- ♦ Chargemaster duplicate items 0%
- ♦ Chargemaster revenue code lacks necessary HCPCS/CPT-4 code 0%
- ♦ Chargemaster item price less than hospital OPPS APC rate 0%

*\* July, 2005 Healthcare Financial Mgmt*

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## ***Example Best Practice Standards***

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- ♦ HIPAA compliance electronic claim submission rate 100%
- ♦ Bad debt write offs as a percentage of gross revenue  $\leq 3\%$
- ♦ DNFB A/R days (includes late charge hold period)  $\leq 5-6$  A/R days
- ♦ Overall denials rate  $\leq 4\%$
- ♦ Medicare return to provider denials rate  $\leq 3\%$
- ♦ Appeals overturned rate 40 – 60%

*\* July, 2005 Healthcare Financial Mgmt*

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## ***HIM Role Examples in Revenue Cycle***

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- ♦ Great knowledge base
- ♦ Liaison between all areas
- ♦ Coding a common focus
- ♦ Coded data experts
- ♦ Coding accuracy and consistency
- ♦ Case mix analysis
- ♦ DRG/APC experts
- ♦ Education / presentations / trainings
- ♦ Documentation experts
- ♦ Holder of the "rework" effort

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## ***Processes within HIM to target***

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- ♦ Demographic collection and MRN
- ♦ Medical information collection
- ♦ Compliance
- ♦ Documentation enhancement
- ♦ Coding
- ♦ Coding education
- ♦ Data quality review
- ♦ Failed claims review
- ♦ Third-party coding and billing audits

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## ***Polling Question #4***

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**Does HIM have an active role in RCM in your facility?**

- \*1 Yes, HIM represented as a major player**
- \*2 Yes, HIM represented as a minor player**
- \*3 Yes, but HIM is represented by administration**
- \*4 No**



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## ***Sample Monitors of HIM Effectiveness***

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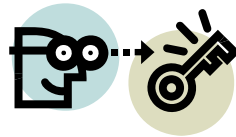
- ♦ **Case Mix Index**
- ♦ **DNFB**
- ♦ **Accounts Receivable**
- ♦ **Failed claims**
- ♦ **Internal benchmarks examples**
  - **Completion of coding within 3 days**
  - **Total routine outpatients with missing dx at 5 % or less**
  - **Error rate of less than 4% for duplicate MRN**

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***HIM Factors for Successful Lower DNFB***

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- ◆ Coding experience
- ◆ Document imaging support
- ◆ Physician involvement in coding policy
- ◆ Newsletter communications
- ◆ HIM credentials
- ◆ Automated workflow management



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***HIM Factors for Successful Lower DNFB***

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- ◆ Formal cross-departmental groups
- ◆ Informal cross-departmental communication
- ◆ HIM participation
- ◆ Established HIM coding expectations
- ◆ Cross-training of HIM coders
- ◆ Availability of coding talent
- ◆ Education in RCM processes for staff

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## ***HIM Role within the Revenue Cycle***

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- ♦ Be responsible for our portion of the revenue cycle “pie”
- ♦ Many times if an account appears on the DNFB report, it is assumed that it is “due to coding”
- ♦ Differentiate what’s in your bucket, and what’s not, using unbilled “reason codes” via your abstracting system

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## ***Outpatient Margin APC Assignment***

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### **Things to Monitor**

- ♦ Multiple APCs per outpatient encounter possible
- ♦ Payment status indicators
- ♦ Inpatient only list
- ♦ Pass-through codes
- ♦ Packaged/Fee schedule
  - Payment can be packaged, paid by fee schedule, discounted or not eligible for separate reimbursement

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## ***Are You Getting Reimbursed Appropriately?***

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- ◆ **Compare cost of care to APC reimbursement**  
Cost report worksheet E, Part B
- ◆ **Denial management**  
RTP letters
- ◆ **Remittance advice review**  
Noncovered services

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## ***Are You Getting Reimbursed Appropriately?***

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- ◆ **Prepare estimated reimbursement logs**
  - Use 2006 vs. 2007 payment rates from Addendum B for impact analysis
  - Use 2007 Addendum B to estimate
  - Use of software to compute
  - Identify top 25 CPT codes
    - Pull & recap UB92 for each of the 25

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## Analyze Data

- ◆ Compare individual service charges to reimbursement

Example: CPT 51992

- ✓ Charge = \$180
- ✓ Medicare APC reimbursement = \$2,676
- ✓ Commercial fee schedules = \$3,000, % of charge, etc.

- ◆ Compare itemized statement to UB 92

Example:

- ✓ 22 PT units billed
- ✓ 22 PT units shown on I-bill
- ✓ 1 PT unit shown on UB
- ✓ Potential for lost reimbursement
- ✓ % of charges

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## Common Reasons for Lost Reimbursement



### 1) CDM

- Invalid CPT/HCPCS codes
- Illogical revenue code assignments
- CDM description inconsistent with AMA standards
- CPT/HCPCS codes not in CDM
- New items & services not on CDM
- Surgical codes
- Explosion codes

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## ***Common Reasons for Lost Reimbursement***

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### **2) Billing**

- Inconsistency between CDM & charge screens/charge tickets
- Inaccurate charge entry
- Routine supplies
- Noncovered services (ABN not obtained)
- Not using payer-specific CPT codes
- Modifier assignment
- ER mapping system

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## ***Common Reasons for Lost Reimbursement***

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### **3) Coding**

- Documentation lacking
- Documentation does not support medical necessity
- Modifiers - appropriate/inappropriate use
- Modifier assignment - accommodated in CDM or assigned at time of billing
- LCD

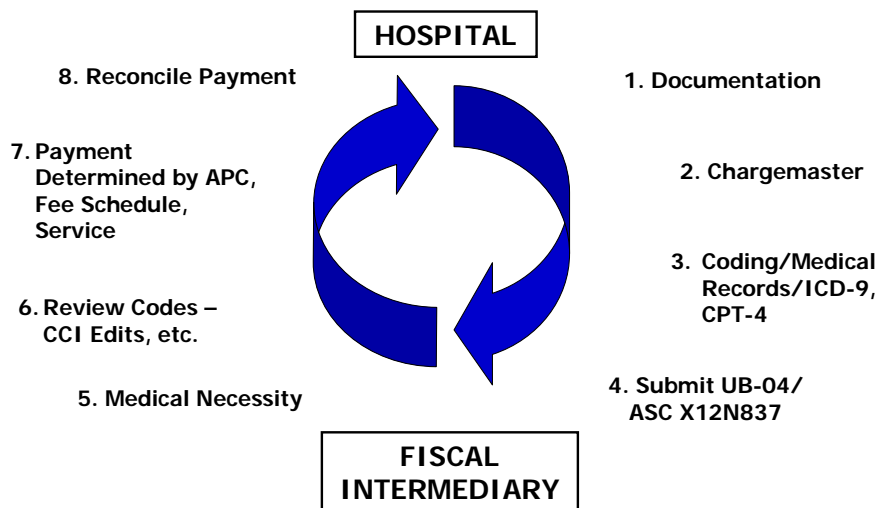
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## Identify Patterns & Trends

- ♦ Organize data into a spreadsheet to track status of denials
- ♦ Categorize denials by
  - Reason for denial
  - Payer specific
  - Service area (lab, X-ray, surgery)
  - Modifier errors
  - CPT/HCPCS code
- ♦ Review patient record in denial case
- ♦ Address specific denial reasons through process improvement or education

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## Outpatient Process Summary



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## ***Inpatient Margin DRG & Case Mix Index***

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- ◆ The DRG assigned to each inpatient stay relates to the case mix
- ◆ Case Mix indicates the types of patients the hospital treats
- ◆ The CMI is determined by dividing the sum of all DRG relative weights for every DRG utilized by Medicare patients by the total number of Medicare cases

$$\text{CMI} = \frac{\text{Sum of all DRG weights for Medicare patients}}{\text{Total number of Medicare cases}}$$

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## ***DRG & Case Mix Index***

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- ◆ Why is Case Mix important?
  - Medicare computes the case mix adjustment each fiscal year based upon the case mix data received (by all Medicare providers)
  - This Case Mix Index is then used to adjust your hospital base rate – which is a contributing factor in computing your DRG payment

$$\text{DRG weight} \times \text{Base Rate} = \text{DRG payment}$$

*(unadjusted)*

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## ***DRG & Case Mix Index***

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### **Why is Case Mix important?**

#### **A fall or rise in CMI could indicate**

- Change in the type of patients being admitted
- Physician admission or patient management pattern
- Change in utilization of services lines
- Undercoding
- Upcoding

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## ***Monitoring CMI***

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- ◆ Develop a relationship between HIM & CM
- ◆ Concurrent vs. retrospective review
- ◆ Have coders review high dollar/extended LOS cases concurrently to review for complete documentation (CCs)
- ◆ Query concurrently – involve CM
- ◆ Identify DRGs/physicians that routinely need more specific documentation and have CM trigger coding

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## ***Monitoring CMI***

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### **◆ Inpatient Denials**

- Trend by physician and educate as appropriate
- Trend by floor/unit and educate case managers, nursing and medical staff as appropriate
- Provide documentation examples
- Meet with QIO/FI to discuss reason for excessive denials

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## ***Monitoring LOS***

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- ◆ CMS's standard average length of stay (ALOS) by DRG is published in the Federal Register annually (August)
- ◆ Benchmark ALOS based on peer groups
- ◆ Set LOS target for your facility
- ◆ Monitor actual LOS compared to target LOS compared to Medicare LOS
- ◆ Identify diagnoses, physicians, service lines that exceed ALOS benchmarks/targets

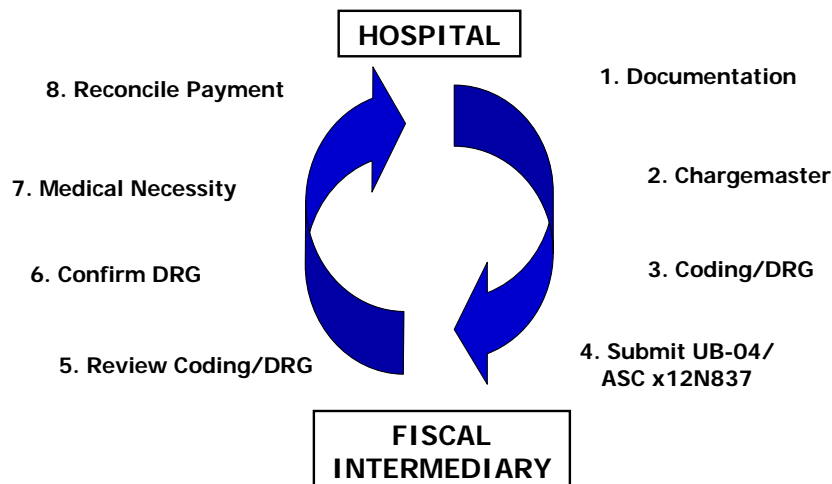
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## Why Document?

- ◆ Not documented = not done
- ◆ Length of Stay (LOS) falls within benchmarks due to accurately reflecting severity of illness
- ◆ Most often, CMI improves
- ◆ Specificity of code assignment leads to better report cards & outcomes analysis
- ◆ Hospital & physician profiling
  - Public access to report cards/profiling
  - Ratings (currently) based on diagnosis & procedure codes submitted on billing forms
- ◆ Competition
- ◆ Accurate long-range financial planning

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## Inpatient Process Summary



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## ***Revenue Management: Keys to Success***

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- ◆ Awareness at all levels
- ◆ Good documentation
- ◆ Accurate procedures
- ◆ Staff education
- ◆ Internal/external audits
- ◆ Concurrent monitoring
- ◆ Retro reviews



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## ***Disclaimer***

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Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. The information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.

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## Resource/Reference List

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- **AHIMA Communities of Practice (CoP)** at [www.ahima.org](http://www.ahima.org)
  - Charge Master CoP
  - HIM Revenue Cycle Management CoP
- **AHIMA online course, "A Guide to Revenue Cycle Management"**. Part of the "Coding Assessments and Training Solutions" distance education program:
  - [http://campus.ahima.org/campus/course\\_info/CATS/CATS\\_newtraining.html](http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html)
- **FORE Library HIM Body of Knowledge (BoK) Articles**
  - *AHIMA Journal* article, "HIM Spin on the Revenue Cycle" by Karen Youmans, 3/2/04  
[http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1\\_022536.hcsp](http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_022536.hcsp)
  - Research study, "Best Practices in Revenue Cycle Management" by Margret Amatayakul, 8/1/05  
[http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_032056.pdf](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_032056.pdf)
  - *AHIMA Journal* article, "Benchmarking RCM: Best Practices to Enhance the HIM Role in Revenue Cycle Management" by Margret Amatayakul, 3/2/06  
[http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1\\_030859.hcsp](http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_030859.hcsp)

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## Audience Questions

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## ***Audio Seminar Discussion***

***Following today's live seminar  
Available to AHIMA members at  
[www.AHIMA.org](http://www.AHIMA.org)***

*"Members Only" Communities of Practice (CoP)  
AHIMA Member ID number and password required*

Join the [Revenue Cycle Management Community](#)  
from your Personal Page. Look under Community  
Discussions for the ***Audio Seminar Forum***

You will be able to:

- discuss seminar topics
- network with other AHIMA members
- enhance your learning experience

## ***AHIMA Audio Seminars***

Visit our Web site

<http://campus.AHIMA.org>

for information on the  
2007 seminar schedule.

While online, you can also register  
for seminars or order CDs and  
Webcasts of past seminars.



## ***Upcoming Audio Seminars***

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- ♦ **Benchmarking:  
Coding Productivity**  
**April 19, 2007**
- ♦ **EHR: Authentication of Entries**  
**May 15, 2007**
- ♦ **Benchmarking:  
HIM Processes**  
**May 22, 2007**

## ***AHIMA Distance Education***

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Anyone interested in learning more about HIM should consider one of AHIMA's **web-based training courses** including "[A Guide to Revenue Cycle Management](#)" – a focused course in the "Coding Assessments and Training Solutions" program.

For more information visit  
<http://campus.ahima.org>

***Thank you for joining us today!***

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**Remember – visit the  
AHIMA Audio Seminars Web site  
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**Each person seeking CE credit must complete  
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**Certificates will be awarded for AHIMA  
CEUs and ANCC Contact Hours.**



# Appendix

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CE Certificate Instructions	

### Resource/Reference List

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- Numerous other articles on Revenue Cycle Management are available in the BoK; find them using the "search" function available there.



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