

Denials Management and Revenue Integrity—Where Does Compliance Fall?

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Learning Objectives

- Defining denials management and revenue integrity
- Identify and correct root causes of denials to keep the claims “clean”-
- Compliance- helping to reduce regulatory risk

Defining Revenue Integrity

- Management of patient accounts/claims pending for billing edits that if not reviewed would cause claim delays, rejections or denials
- Department charge capture auditing for revenue and overall compliance
- Clinical issues that can affect denials, such as a lack of meeting medical necessity

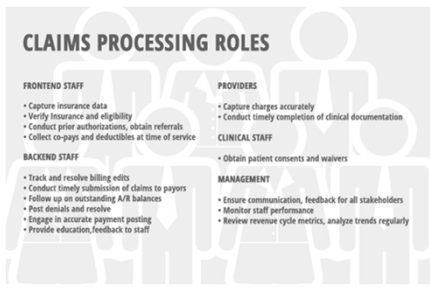
Further Clarification

- The National Association of Healthcare Revenue Integrity (NAHRI) states that 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 Cycle Processes

- **Front-end process:** patient access and provider credentialing
- **Mid-cycle process:** clinical documentation, charge capture and coding
- **Back-end process:** claim production/billing; collections; insurance contracts, denial management and summary of billing edits
- Reference: Core Functions of Revenue Integrity-HCPro

Summary Reference: Xtelligent Media 2016



HFMA Defines Claims

- **Clean Claim:** generates revenue efficiently by monitoring prebill for billing errors; identify reoccurring issues
- **Complete Claim:** ensures that all possible revenue is being captured by monitoring the departmental charges by audits; assuring no late charge entry and possible education for department management
- **Compliant Claim:** should eliminate risk of denials and paybacks by monitoring prebill errors and review of chargemaster updates; monitor billing edits for payor edits of medical necessity, etc.

Identifying if your Hospital/Physician Clinic has “Clean” Claims

- Analyzing Denials
- Time to Paid Claim
- Up to Date and Accurate Charge Description Master (CDM)
- Monitoring new services provided

Identifying if your Hospital/Physician Clinic has “Clean” Claims

- Evaluation of the clinical documentation improvement program
 - How is this performed in your hospital?
 - Is it a compliant process?
 - Do physician’s feel that they are able to adequately document the care they are providing?

Identifying if your Hospital/Physician Clinic has “Clean” Claims

- Is the coding staff required to attend regular coding education?
- Is regular outside coding audit performed?
- What happens with the results of that audit – is it reported to compliance and senior leadership?
- Is education on the findings provided back to the coding team?
- Are findings of insurance audit provided to the coding team?

Example #1: Prebill Process

- **Definitions:**

Medical Necessity:

Services or supplies that:

- are proper and needed for the diagnosis and treatment of a medical condition
- are provided for the diagnosis, direct care, and treatment of a medical condition
- meet the standards of good medical practice in the local area
- aren't mainly for the convenience of the provider

Referral:

A written OK from the primary care physician for the patient to see a specialist or get certain services. Some plans require a referral for care or services from any provider other than the primary care physician. No referral = No payment.

Continues

Pre Determination:

A voluntary, written request for review of treatment or services and includes services that may be considered:

- not medically necessary
- investigational, unproven or experimental
- cosmetic

Pre determination approvals and denial are usually based on provisions within the carrier's medical policy guidelines. A predetermination is not a substitute for a preauthorization.

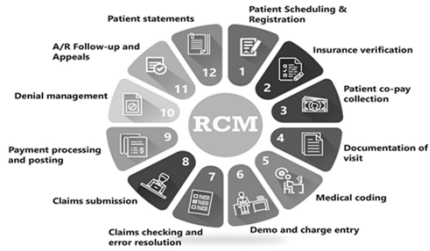
Pre Authorization:

The determination of the medical necessity and appropriateness for treatment as a required part of the utilization review proves for certain covered services. May also be referred to as:

- prior authorization
- prior approval
- Precertification

Failure to obtain these proper permissions may affect claim payment. A preauthorization is not a guarantee of payment.

Summary of Pre-Bill



Example #2: Post Review by External

- Acute Respiratory Failure not supported
 - Does a physician statement as documented actually support the code?
 - Not if it is unclear and inconsistent with the treatment provided to the patient
 - Coding Compliance Issue-

19. **Code assignment and Clinical Criteria**
The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Revenue Integrity Keys



- Clinicians
- Patient Access
- CDI (clinical documentation integrity)
- Case Management
- Coding
- Billing
- Denial Preventions

Revenue Integrity = Compliance

- Validation of staff with appropriate credentials and experience
- Workflow process defined and reviewed annually
- Quality review audits quarterly
- Monitoring of regulatory changes that can affect a facility and it's service lines

Compliance Officer Role

- **Compliance officer:** True revenue integrity depends on strict adherence to all laws and regulations. These can change frequently, so what worked yesterday may no longer be effective today.
- The compliance officer should develop reports that show how new regulatory developments impact the organization's processes and overall revenue cycle, and work with each stakeholder to adjust accordingly.

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