By Robert Gilbert, COC, FHFMA

Revenue Integrity

The Importance of a Solid Program

It's well worth the investment to review nine areas in your revenue cycle where integrity may be at risk.

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Revenue integrity is ensuring all charges are captured appropriately, documented sufficiently, and paid correctly. Every organization — whether a private physician practice or a major academic medical center — needs a comprehensive revenue integrity plan. Federal agencies and commercial insurance companies are quick to retract payments for unsupported claims. Providers must be confident that attested claims are accurate and that all charges are supported.

Examine nine key areas to develop an effective, comprehensive revenue integrity plan.

1. Revenue Integrity Self-assessment

The first step to a successful revenue integrity program is conducting a self-assessment to identify the biggest risks to the organization. This self-assessment will shape the foundation of the revenue integrity program.

Keep in mind: Self-assessment is not a one-time reflection. Successful organizations need to be nimble enough to continuously assess and change the needs of the program, as internal and external influences exude pressure on the system.

Consider following these guidelines for a self-assessment audit plan:

a. Maintain a calendar of which departments or areas should be reviewed monthly.

b. Randomly select a minimum of 30 records from those areas to be reviewed.

c. The ideal auditor should be familiar with what is happening to the patient clinically; understand how the account was coded; and understand the organization's charge description master (CDM).

d. When the audit is complete, review findings with the department leader.

e. Develop corrective action plans that reflect the findings.

f. Ensure the department review is not adversarial: department leaders should perceive the review as a positive experience.

g. The auditor should follow up on the corrective action plans and re-audit, if necessary.

2. Charge Assurance

Charge assurance is attesting that all charges on the claim are correct. Charges can easily be erroneous — from selecting the incorrect line, keying an inaccurate quantity, or simply forgetting to enter some or all of the charges.

A great place to start developing a plan is to look at the Office of Inspector General's (OIG) website. The OIG maintains a work plan for healthcare providers, which is updated continuously. Keeping up with changes and documenting action plans will immediately reduce your risk of noncompliance.

3. Routine CDM Reviews

All codes in the CDM should be up to date. Common areas of opportunity to find erroneous charge capture are:

- Missing charge for the service
- Charges are too high or too low
- Improper revenue or procedure codes
- Obsolete charges
- Pricing inconsistency
- Inadequate charge descriptions
- Miscellaneous charge codes
- Markup policies for drugs and supplies

4. Charge Reconciliation

Charge reconciliation is often forgotten or ignored, but when done correctly at the department level, it's the fastest way to identify charging errors and to ensure compliance. Revenue generating departments should "own" this function. Operationally, this can be difficult to enforce, but working collaboratively with the organization's compliance officer can reinforce the importance of the issue.

For more information on charge description masters (CDM), read **Robert Gilbert, COC, FHFMA**, article "Charge Description Master: Use It to Optimize Revenue" on pages 48-50 of the December 2018 issue of *Healthcare Business Monthly*, also in AAPC's Knowledge Center at **www.aapc.com/blog/44984-charge-description-master-use-it-to-optimize-revenue/**.

5. Information Systems

An organization's health information system (HIS) often lends itself to revenue leakage. This risk increases exponentially when there are multiple ancillary systems interfacing with each other. In this scenario, a charge or CDM needs to be built both in the organization's HIS, as well as in the external systems. When systems interface with one another, a check and balance is needed to ensure the system mapping occurs appropriately. A typographical error in mapping could allow the end user to believe they are charging for one service while something completely different is entered on the claim.

6. Charge Entry

Charge entry can range from old fashioned hand-keying of charges to a pick list that clinical or non-clinical staff selects from, which includes charges mapped in the background based on the documentation generated from clinical staff. Clinicians often do not receive proper training on charge entry and accuracy, so attention to detail often is diminished.

7. Price Justification

Healthcare is one of the only products/services where organizations typically are not setting the price as a function of cost. Most healthcare organizations price their services as a function of maximizing reimbursement, rather than the cost to perform the services. Maximizing reimbursement is critical to a practice's livelihood, but it's not the most ideal method for price justification.

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Medicare's paper-based manual section 2202.4 states, "Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient."

8. Medical Coding

Coding reports the medical encounter in a variety of ways. From a revenue integrity standpoint, ICD-10 diagnosis codes tell the story of the patient's clinical presentation and support the medical necessity of the services for payment purposes; whereas ICD-10 procedure codes (inpatient facilities) and CPT® codes (outpatient facilities) tell the story of what services the patient received.

Often, coding accuracy is thought of only when factoring the accuracy of the final claim. This is critical, but what is often overlooked is the accuracy of coding on the order for service.

Providers are responsible for selecting diagnosis codes that define the reasons why services are ordered. These are the codes that hospital staff should look at to see if a diagnosis supports the payer-defined medical necessity guidelines. If the code does not support the payers' policy, then the patient should be made aware that the service is not covered and that they will be financially responsible. Without this step, denials will occur and the organization will be liable for the charges.

9. Denial Management

Organizations often feel payer requirements make it difficult to receive payments for their medical services. To optimize revenue integrity, organizations are turning to fully-integrated, centralized financial clearance center teams. Financial clearance is a concept that, at its very basic element, ensures the patient is aware of their insurance eligibility, benefit coverage, and out-of-pocket expense.

A fully functioning financial clearance center is the most effective way to mitigate denials. It should validate the following four items prior to scheduling a service:

- Verify the patient's insurance *eligibility* for the service.
- Evaluate if the patient's insurance requires a referral or an authorization:
  - If a *referral* is required, the rendering provider must validate that there is a referring provider and that they have initiated and approved the referral.
  - If an *authorization* is required, the facility must validate that the ordering provider has obtained the authorization.
- Establish if the patient's insurance has a *medical necessity* payment policy for the ordered service. If a payment policy exists, validate the order has an ICD-10 diagnosis code(s) that will support the medical necessity for the service.

If at any point one of these four items (eligibility, referral, authorization, medical necessity) fails to be validated, inform the ordering provider and the patient that the service may not be fully covered.

For some items, such as referrals or authorizations, payers may require a timeframe for processing. Providers and patients often do not understand this requirement, and want services provided expediently.

This is the best opportunity for organizations to proactively prevent denials. In any event, the patient should be given a financial liability waiver, or an Advanced Beneficiary Notice of Noncoverage (ABN) for Medicare patients, to assign financial liability to the patient.

Simplify Revenue Integrity

Revenue integrity comes down to three simple tenets: Ensure every dollar going out of your healthcare organization is:

(1) Correct;

(2) Supported and justified in the medical record; and

(3) Reimbursed accurately according to the terms of contracts.

Ensuring revenue integrity can be difficult in an evolving healthcare environment, but the effort is well worth the investment. HBM

Robert Gilbert, COC, FHFMA, is senior manager in the Healthcare Consulting Practice at Baker Newman Noyes. He specializes in operational areas including charge capture, revenue cycle, revenue integrity, charge master, claims, provider reimbursement, and business systems. Gilbert has dedicated his career to assisting healthcare organizations with revenue cycle. He is a member of the Dover-Seacoast, N.H., local chapter.