HFMA New Mexico

It's Not Winter Yet – Fall Conference

A CEO Perspective in Finance and Revenue Cycle

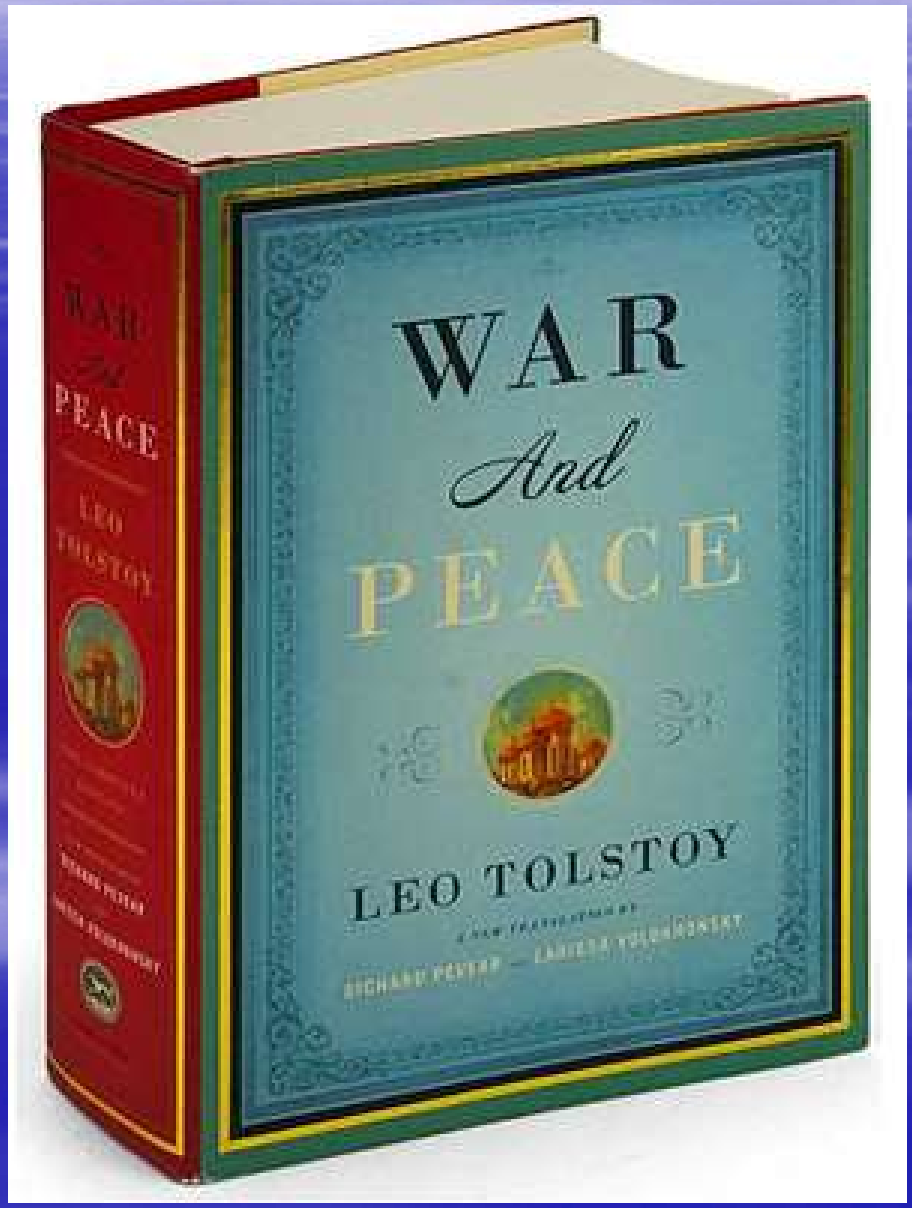
Embassy Suites

Albuquerque, New Mexico

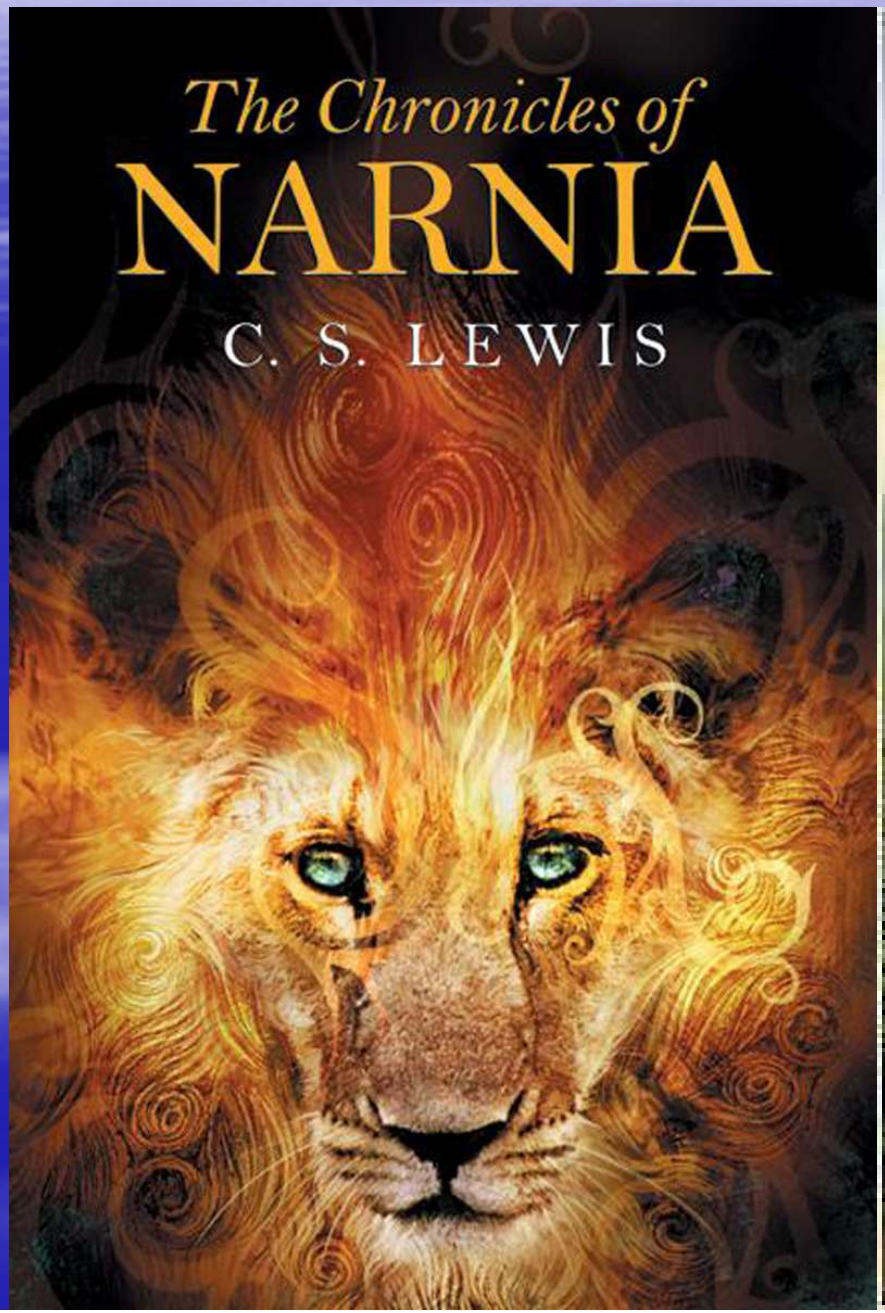
Joe Avelino RN, BSN, MHSA, CPHQ
Chief Executive Officer
College Medical Center
Monday, December 12, 2022

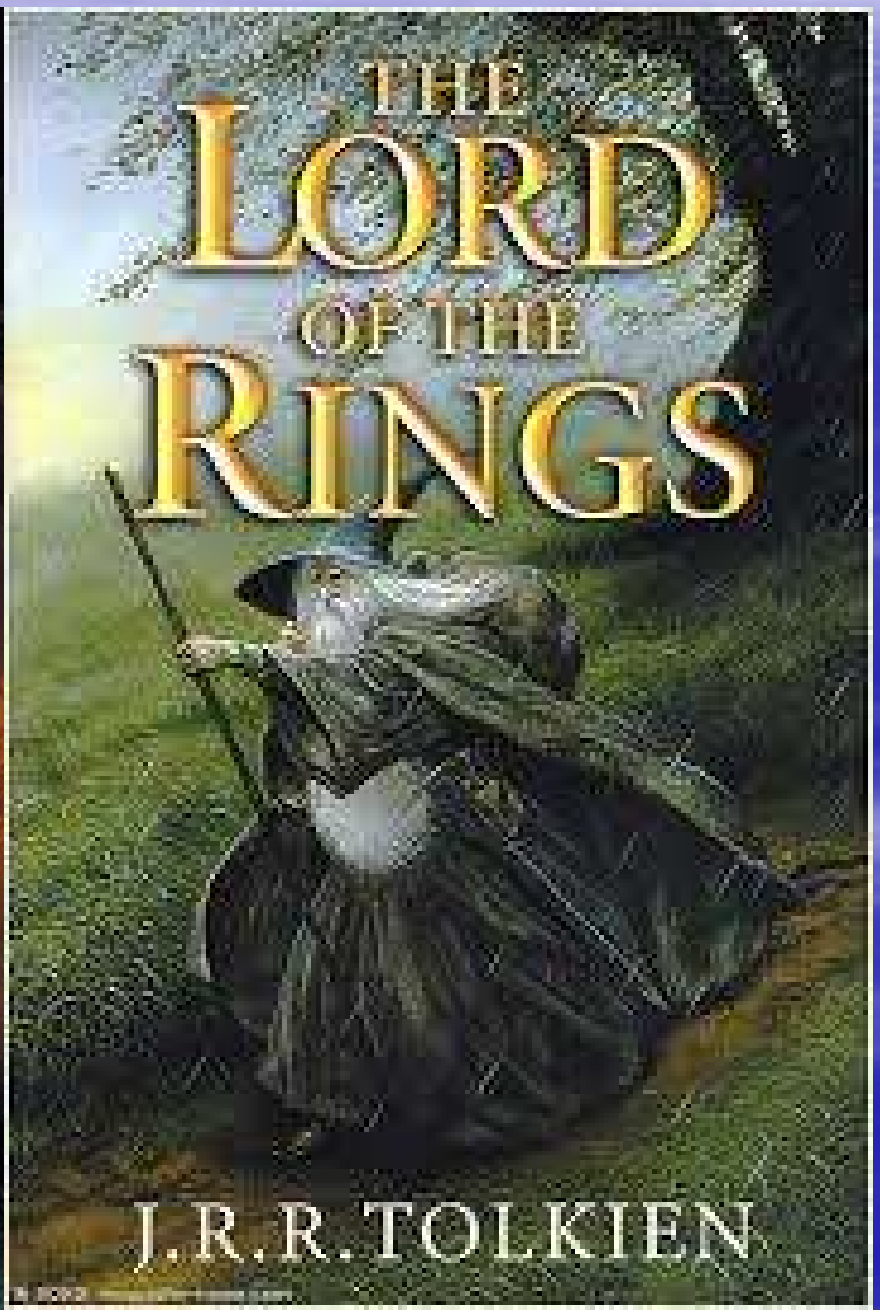
Leonardo da Vinci

Leo Tolstoy



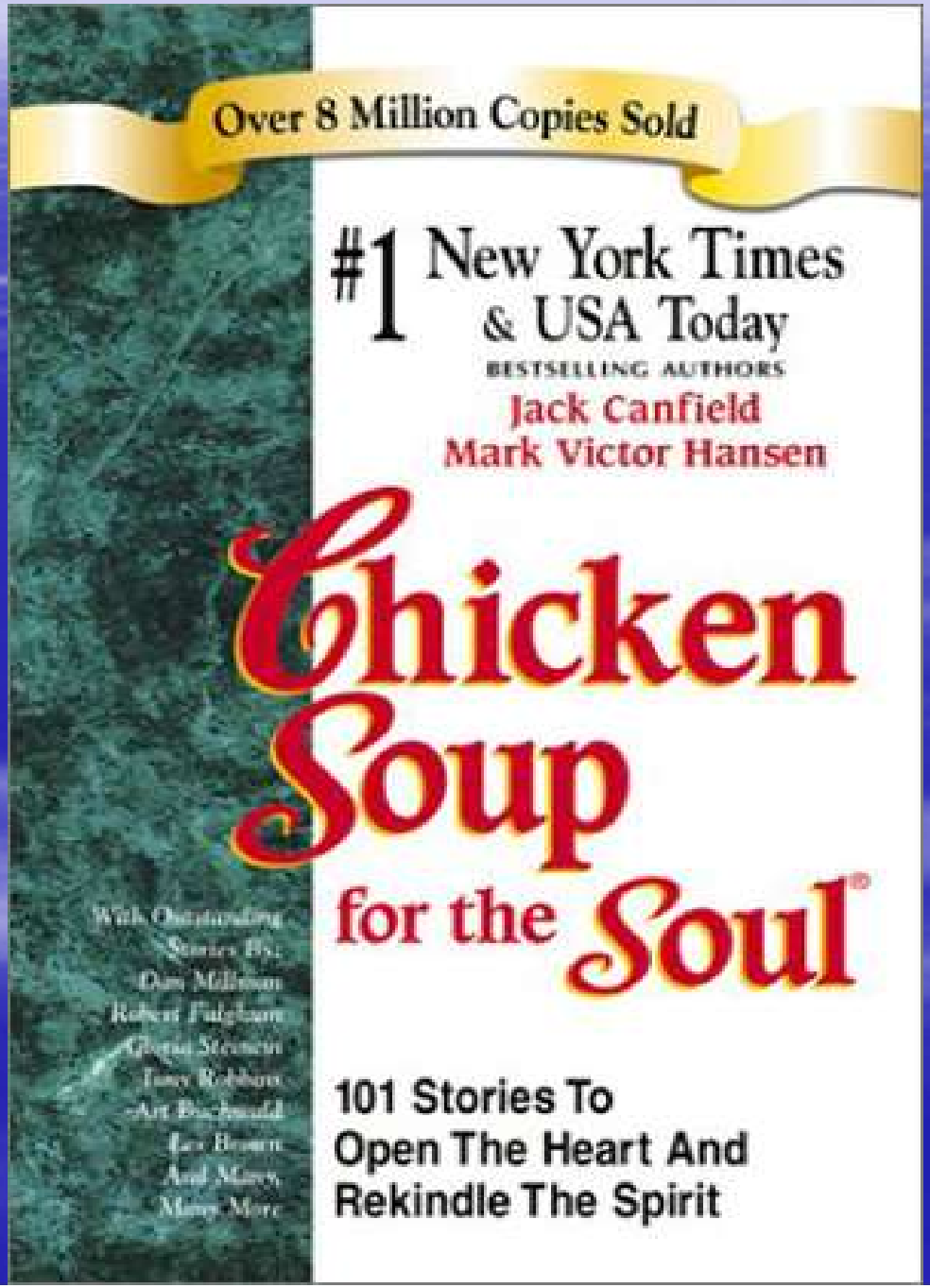
C.S. Lewis


The Chronicles of
NARNIA
C. S. LEWIS


THE
LORD
OF THE
RINGS
J.R.R. TOLKIEN

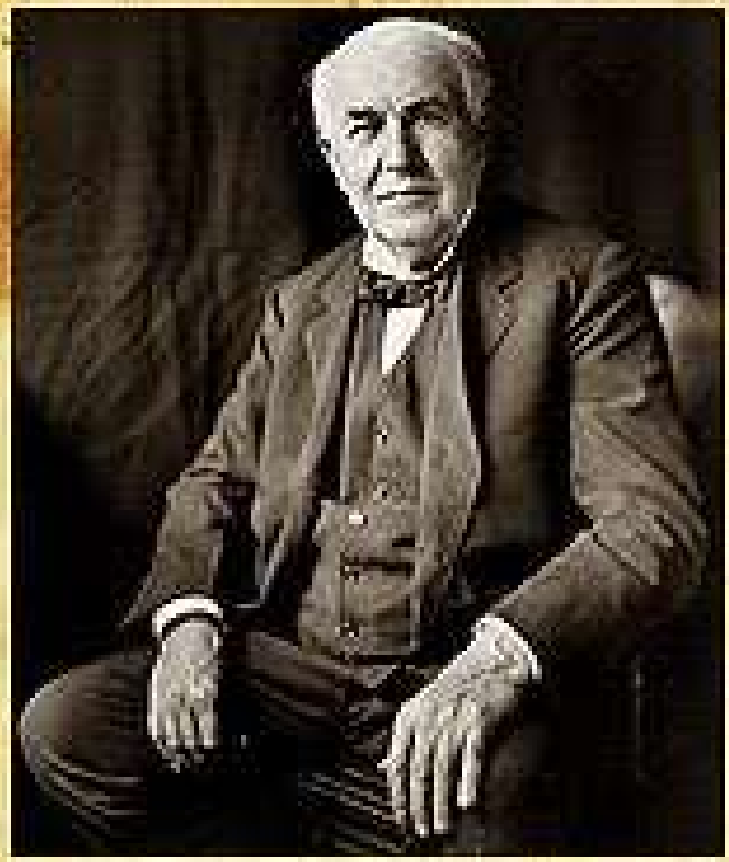
Michelangelo

Jack Canfield



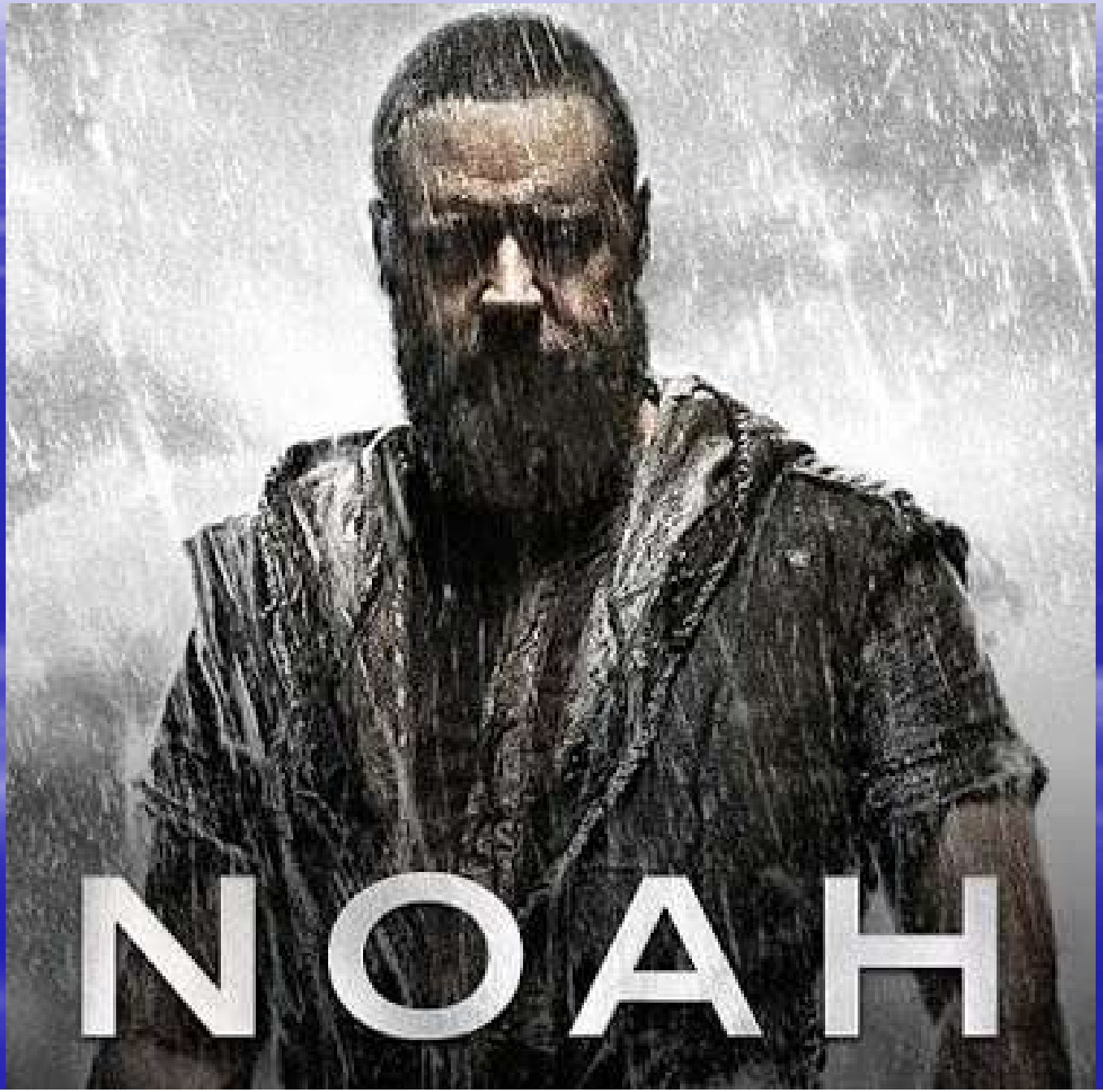
Walt Disney

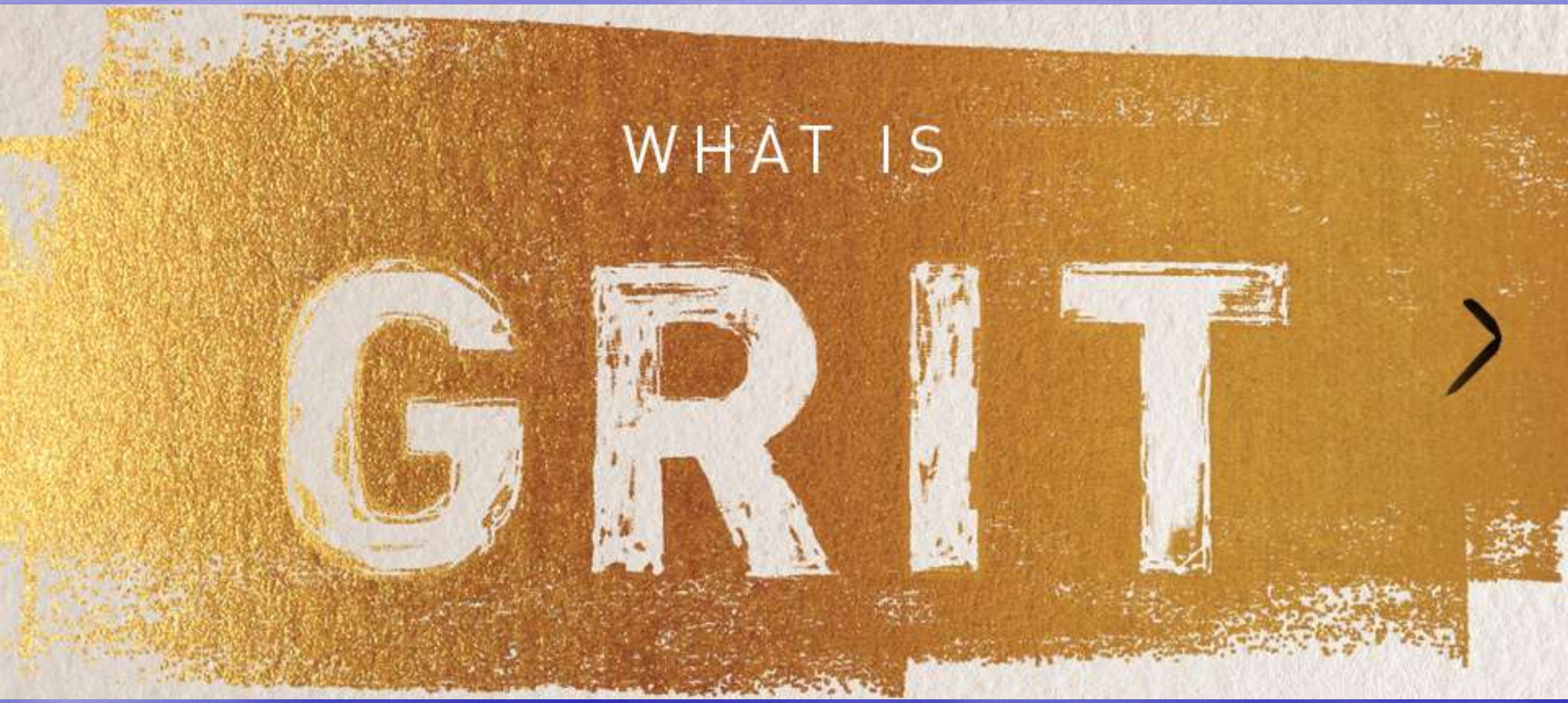
Thomas Edison



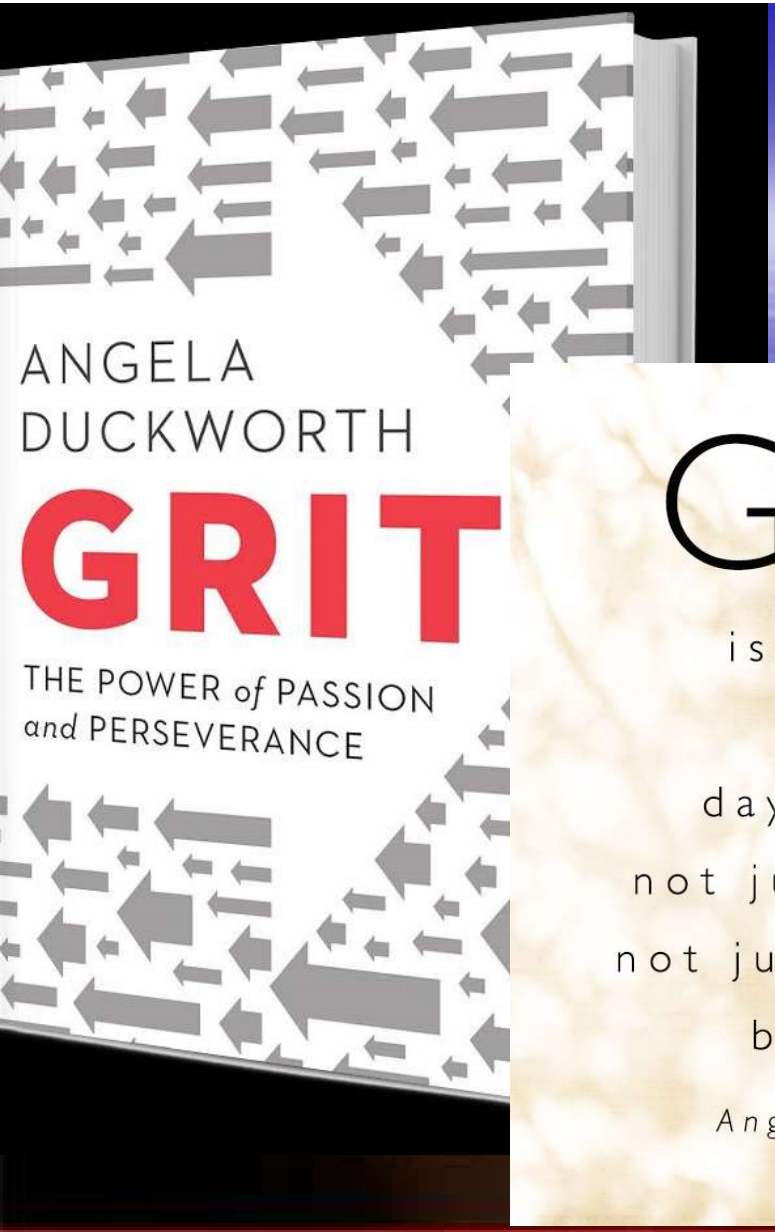
To invent, you need a good imagination and a pile of junk. -Thomas Edison-

Who Built the Ark?




WHAT IS
GRIT

Defining Grit



GRIT

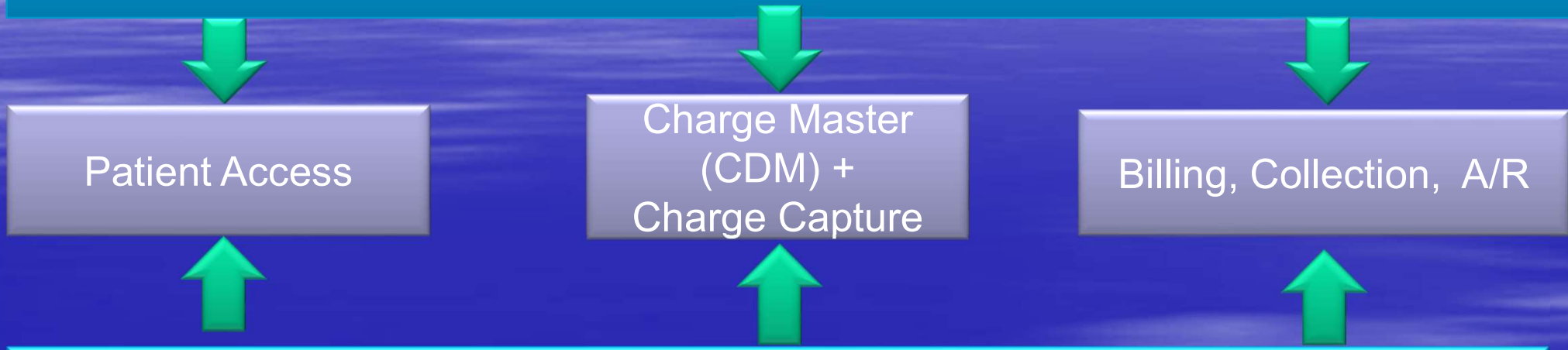
is sticking with
your future
day in, day out &
not just for the week,
not just for the month,
but for years.

Angela Lee Duckworth

feaonline.co.uk

Revenue Cycle and Finance Operations

Process and Components



Categories of Discussion

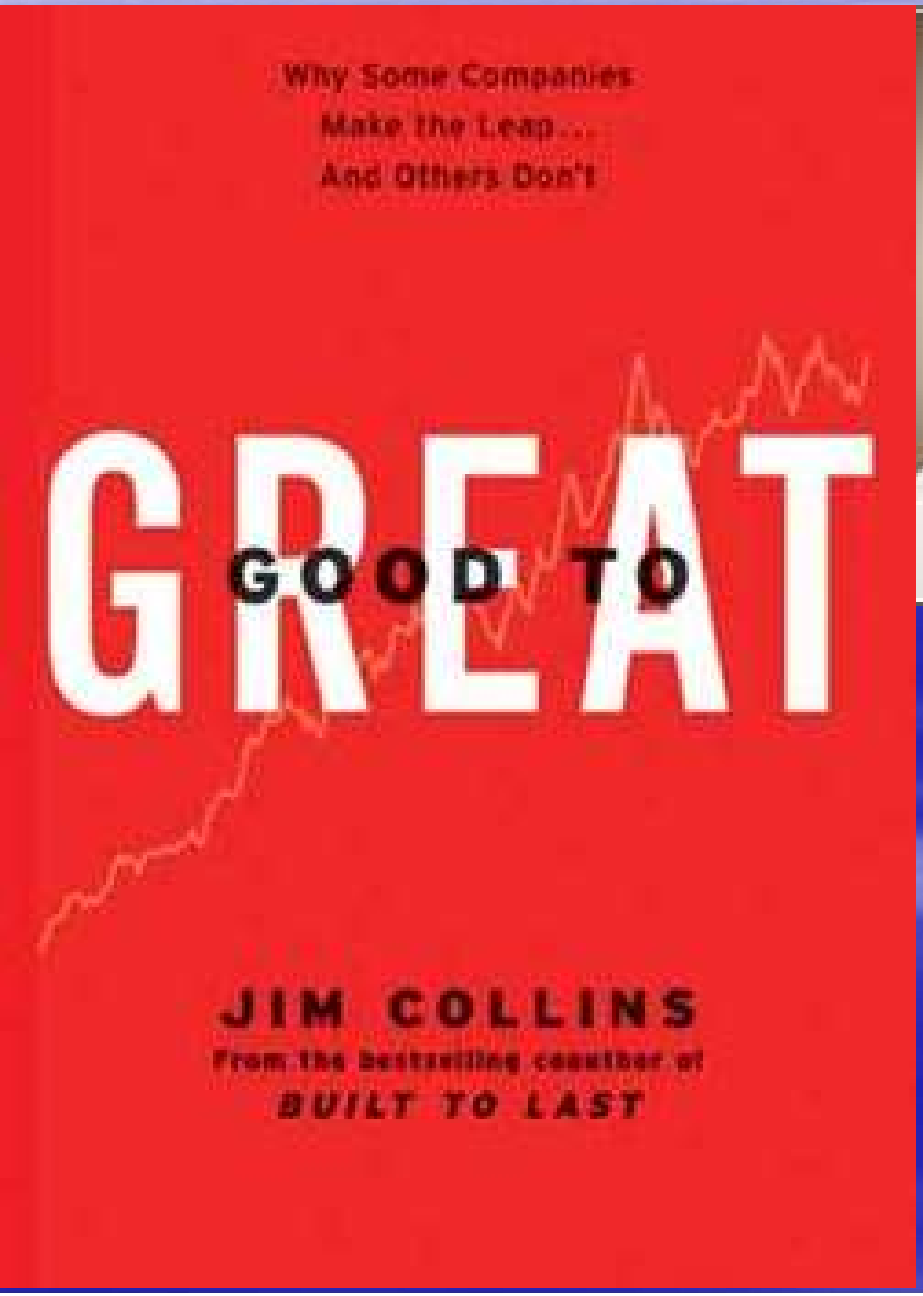
- Authorization Process
- ABN
- Eligibility Enrollment Services
- Upfront cash collection
- Admission vs. Observation

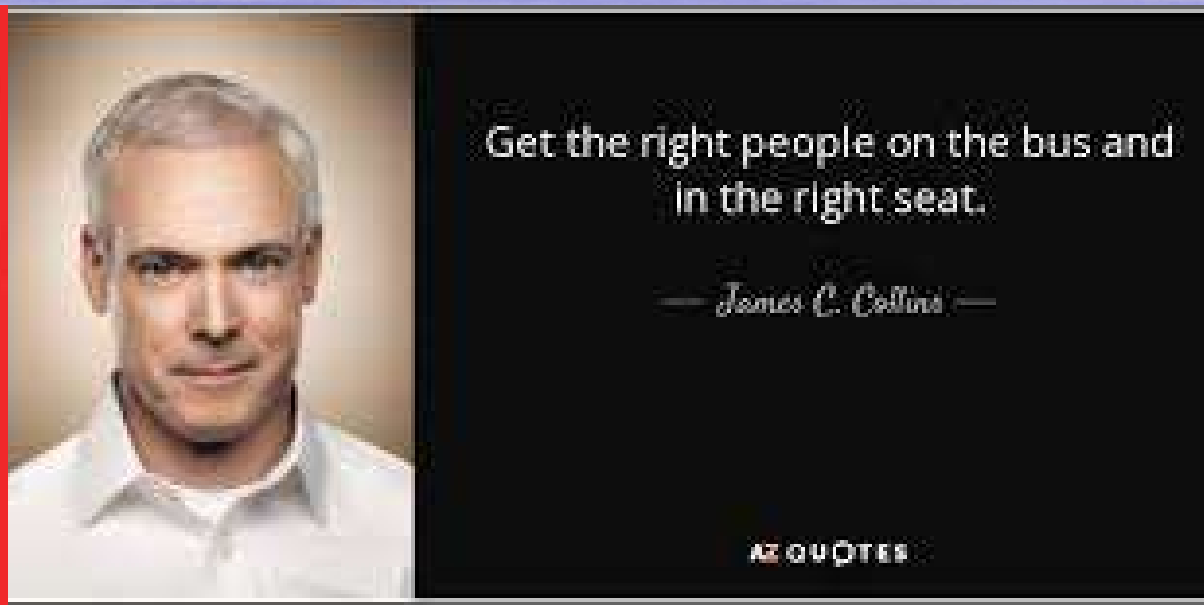
- Charge Master
- Charge Capture
- ED Charges
- ED Metrics Having Financial Impact
- Supply Usage Analysis
- Medication Utilization

- DNFB
- CDI
- MS-DRG

Good to Great

Staffing and Recruitment





BECKER'S
Hospital CFO

Hospitals' 3 biggest revenue cycle mistakes

Written by Brooke Murphy

Here are three of the most common revenue cycle management mistakes physician practices and hospitals can avoid by taking proactive steps, according to NTC Healthcare.

1. Failure to verify eligibility. Nearly 25 percent of medical practices no not verify patient eligibility upfront, according to a report by Caparo. By insisting on eligibility verification early in the registration process, medical providers can decrease future bad debt and help patients avoid unanticipated out-of-pocket expenses.

2. Failure to provide patients with an accurate out-of-pocket estimate. As patients' financial responsibility for medical services continues to grow, it has become exceedingly important practices offer accurate out-of-pocket estimates. This service helps patients prepare mentally and financially for their medical care before treatment is rendered. In many cases, advance notice of financial obligations for care can allow patients to set aside funds or find additional sources of financing. When patients aren't prepared for their medical bills medical providers are often left with unpaid costs and lingering debt.

3. Failure to collect at time of service. Communicating to patients about co-pays and other upfront costs is a simple way to prevent collection problems for medical practices. Failure to warn patients about these financial obligations ahead of time can result in frustration and resentment from patients. Conversations around upfront costs should take place immediately with new patients.

Access Services

Insurance Verification

a) Verifying eligibility and benefits
b) Ensuring authorization “prior” to admission (Pre-authorization)
c) Secure authorization “throughout” the hospitalization

ABN (Advanced Beneficiary Notice)

a) Specifically for Medicare beneficiaries
b) Providor (e.g., radiology and laboratory services) to notify the beneficiary in writing that the test may not be a covered service
c) If the providor does not have proof that the beneficiary was notified (i.e., that service may not be covered) providor may NOT bill the patient

Eligibility Enrollment Services

a) Finding funding solutions for uninsured patients
b) Assists uninsured/underinsured patients enroll into a government program

Financial Counselor

a) Upfront cash collection
(e.g., collection of co-pays, share of cost, and deductible)
b) Refers uninsured patients to an Eligibility Enrollment Company

11/30/20--

Psychiatry - Eligibility Statistics Report

	Total Placed	Open Accounts		Open in TAR/Billing	APPROVAL RATE		CONVERSION RATE		
Month/Year	Num		Gross charges	Num	# Accts	# Days	# Accts	# Days	Cash Collected
2017 Total	362	0	$ -	0	92%	94%	92%	94%	$ 1,399,949
2018 Total	320	0	$ -	0	91%	95%	91%	95%	$ 1,278,408
2019 Total	507	0	$ -	0	85%	92%	85%	92%	$ 2,320,427
2020 Total	438	0	$ -	0	83%	89%	83%	89%	$ 2,002,370
2021 Total	394	0	$ -	14	92%	94%	93%	94%	$ 1,724,593
Jan 20--	17	1	3,661.00		80%	80%	75%	75%	54,720.00
Feb 20--	27				89%	92%	89%	92%	124,560.00
Mar 20--	39	2	5,230.00	3	89%	92%	84%	88%	131,040.00
Apr 20--	26			3	100%	100%	100%	100%	246,950.65
May 20--	32	2	10,460.00	1	97%	97%	90%	88%	141,120.00
Jun 20--	34	1	4,184.00	1	86%	89%	83%	86%	118,100.58
Jul 20--	21			4	79%	79%	79%	79%	78,760.00
Aug 20--	33	1	4,184.00	9	94%	97%	91%	94%	136,935.00
Sep 20--	40	5	17,259.00	17	94%	95%	83%	84%	113,665.00
Oct 20--	25	12	36,087.00	9	91%	92%	43%	42%	7,160.00
Nov 20--	17	12	41,317.00	5	100%	100%	29%	30%	
2022 YTD Total	311	36	122382	52	91%	93%	80%	84%	$ 1,153,011

11/30/20--

Acute - Eligibility Statistics Report

	Total Placed	Open Accounts		Open in TAR/Billing	APPROVAL RATE		CONVERSION RATE		
Month/Year	Num	Num	Gross charges	Num	# Accts	# Days	# Accts	# Days	Cash Collected
2017 Total	**120**	**0**	**0**	**0**	**90%**	**96%**	**90%**	**96%**	**$ 783,443**
2018 Total	**137**	**0**	**0**	**0**	**83%**	**89%**	**83%**	**89%**	**$ 763,662**
2019 Total	**164**	**0**	**0**	**0**	**83%**	**94%**	**82%**	**94%**	**$ 716,446**
2020 Total	**166**	**1**	**8,819**	**0**	**82%**	**89%**	**82%**	**89%**	**$ 825,390**
2021 Total	**129**	**1**	**6,000**	**7**	**84%**	**89%**	**84%**	**90%**	**$ 580,781**
Jan 20--	4				67%	83%	67%	83%	12,902
Feb 20--	9				67%	64%	67%	64%	26,681
Mar 20--	11				64%	80%	64%	80%	53,261
Apr 20--	7				100%	100%	100%	100%	31,311
May 20--	6	1	2,000		100%	100%	83%	94%	20,304
Jun 20--	4			1	100%	100%	100%	100%	25,227
Jul 20--	7				50%	48%	50%	48%	20,288
Aug 20--	7	1	10,000	1	67%	39%	57%	33%	18,662
Sep 20--	8	1	2,000	2	100%	100%	86%	97%	24,732
Oct 20--	11	5	36,000	3	100%	100%	55%	49%	9,522
Nov 20--	8	7	46,000	1	100%	100%	13%	8%	
2022 YTD Total	**82**	**15**	**96,000**	**8**	**79%**	**80%**	**64%**	**66%**	**242,890**

Case Study One

Scenario

- Blue Cross Admission with LOS of 36 days
- Denied for No Authorization
- Claim Denied
- First Level Appeal (45 days turnaround time)

Results

- Denial overturned
  (11 days approved and 25 days denied)
- Revenue Loss of $29,900.00 based on the contracted rate

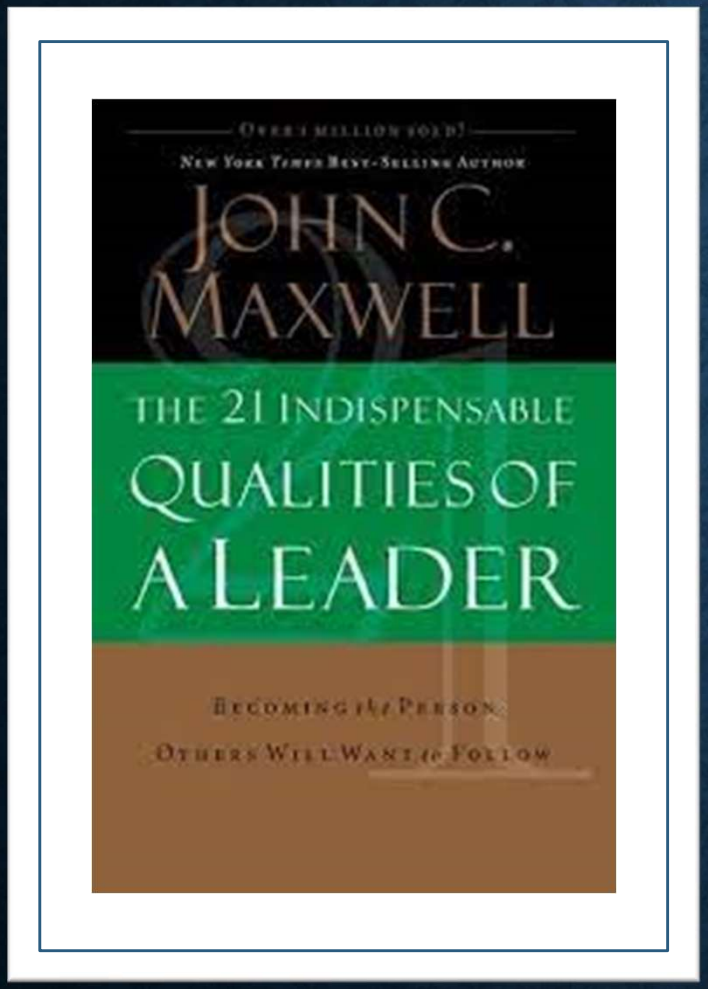
Case Study Two

Scenario

- Patient has surgery claim of $5,000.
- The organization failed to collect the $1,000 deductible.
- Unmet deductibles = the hospital reimbursement will be impacted

Results

- Insurance company will ONLY reimburse the hospital $4,000.
- The hospital should bill or pursue the $1,000 deductible from the patient.
- Lessons Learned: Important to collect the unmet deductible PRIOR to services rendered on elected procedures.



"When they heard enough
that they have to;
when they learn enough
that they want to;
and when they receive enough
that they are able to."

John C. Maxwell

Admission vs. Observation Status

With Medicare, admission status significantly impacts hospital revenues.

Inpatients vs. outpatients

Inpatient (IP) status is not based on staying overnight, or the number of hours a patient is in the hospital.

Also, observation = outpatient.

For IP status, a physician must admit the patient *as an inpatient.*

Physician documentation must include reasons for admission which meet criteria for *medical necessity* for inpatient care:

- **Hospital-specific or InterQual® criteria**
- **Criteria for deciding whether the admission was medically necessary.**

Inpatient

Outpatient

What is Observation Status?

- Recognized by MEDICARE and some HMO
- Allows 48 – 72 hours for tests to be completed to determine if case warrants in-patient admission OR
- MD determines that acute condition will resolve in 24 - 48 hours.

23 HOUR OBSERVATION CRITERIA

A. Patient Condition(s)

ol/Drug intoxication	Spontanious Pneumothorax less than 15%
ic reaction with airway compromise	Syncope/Presyncope
ng, but hemodynamically stable	Smoke Inhalation
ion of toxic substance, but clinically stable	Suspected CNS Infection
Oliguria	Neuro-New or exacerbation of ataxia, incoordination, paresis, weakeness, disorientation, lethargy
ntractable pain, Sickle Cell Anemia , Pyelonephritis, Calculus, Abdominal	Postictal State > 15 minutes with known seizure disorder
a/wheezing with PEF 50-75% after Tx	Vomiting 1-3 hours **unresponsive** to ER treatment
pain	**New** Diabetes with BS>400, lethargy, or postural BP changes
	dyspnea
a with normal initial exam and suspected organ	foreign body unable tot extract in ER

B. Abnormal Vitals

>101	RR 20-28
100.4 per rectum and toxic appearing with skin uspected infectious disease	
0-140	Postural Systolic BP>30 mmhg drop

C. Labs

>15,000	NA-< 120 or > 150
60 or 02 sat <91%	K < 3 or > 5.5
>45 and CRT >3	Urine Specific gravity >1.030
25% and asymptomatic	Blood Sugar < 50* or>400 *requiring ≥ 2 D50% boluses

D. Radiology

ir in mediastinum	Pneumothorax spontaneous >15%

E. ECG

Patient can be observed with normal or unchanged ECG if symptoms warrant

F. Treatments

sments at least Q4H- Arrthymia ing Lab 02 sat Output Psychotic behavior ing/Diarrhea	**IV administration** of at least **two** of the following medication types administered at least twice Analgesics Anti-coags Anti-emetics Anti-infectious Anti-psychotics Corticosteriods Diuretics 50% Glucose Muscle Relaxants Narcotic Antagonists Sedatives/anti-anxiety
uetic thoracentesis	**IV administration** of medications at least once Anti-convulsants Anti-hypertensives Glycosides Vasodilators
ids ≥100	Heparin Administration
t LP in 12 hours	Inspired 02 > 28% and pulse ox monitoring
eutic Thoracentesis	Psychiatric Crisis Intervention/observation Q15 min
n Adjustment ≥3x/24 hours	Kayexalate with an elevated K

12/06 pa

SI/IS Basics - Acute Inpatient Care

To meet the acute care standard, a patient must meet criteria in BOTH 'SI' AND 'IS'

SI = Severity of Illness (Need one)

A. Sudden Impairment:

1. Change in consciousness – disorientation
2. Vision, Hearing, or Speech Disturbance
3. New inability to Move Body Part
4. Loss of circulation in body part
5. Open fracture
6. Inability to Breathe
7. Chest pain suspicious for cardiac or pulmonary embolism
8. Major uncontrolled bleeding
9. Suspected acute bowel obstruction
10. Loss of urine output
11. Major surgical wound disruption requiring closure
12. Intractable pain

B. Abnormal Vital Signs:

1. BP Systolic: < 90 or > 200 mm Hg
2. BP Diastolic: > 120 mm Hg
3. Temp: < 96 F or > 102 F w/ sepsis
4. Pulse: < 50 or > 120/min
5. Resp: > 30

C. Lab Values:

1. Blood PH < 7.30 or > 7.50 [new]
2. Serum sodium < 120 or > 150 with mental status change
3. Serum potassium < 2.5 [or <3 on digoxin]or potassium > 6.0
4. Hgb < 8 or > 19
5. WBC < 2,000 or > 20,000
6. Toxic drug levels
7. Pulse oximetry < 87 on RA
8. Elevated CPK-MB or Troponin
9. BS >500 with Bun>45 and Crt >3.0

D. Radiology [new finding]

1. Pneumothorax
2. Pulmonary edema
3. Pericardial effusion
4. Perforated viscus
5. Bilateral or multilobe infiltrates

E. EKG

1. Acute myocardial ischemia or infarction
2. Atrial fib-flutter w rapid ventricular rate
3. Third degree heart block or symptomatic second degree heart block

IS = Intensity of Service

A. Continuous Monitoring (need three):
Minimum every 4 hours

1. Vital signs
2. Cardiac rhythm
3. Orientation or Glasgow Coma Scale
4. Urine output
5. Central arterial or venous pressure
6. Drug Toxicity Monitoring
7. Glucose monitoring followed by insulin adjustments 3X/day

OR

B. Medications (need one):

1. IV fluids≥100cc/hr with NPO≥48hrs or active vomiting
2. IV medications requiring titration
3. IV chemotherapy requiring inpatient stay and monitoring
4. IV thrombolytic agents

OR

C. Treatments (need one):

1. Ventilatory assistance
2. Intensive Care Unit
3. Chest tube
4. Surgery/Procedure requiring general or regional anesthesia and requiring acute care
5. Protective isolation
6. Treatment of Unstable Arrhythmias
7. Post-resuscitation care
8. Balloon pump
9. New cardiac pacemaker
10. Dialysis - initial

"One of the fundamental aspects of leadership, I realized more and more, is the ability to instill confidence in others when you yourself are feeling insecure"

Howard Schultz

Charge Master (CM)

Charge Description Master

Why change / update your Charge Master?

- Codes no longer in existence / expired.
- Organization would be out of compliance for incorrect coding.
- Codes should be updated with potentially higher reimbursement.

	CDM #	Dept	Mercy CDM Description	Mercy Price	Rideout Quanty	Total Charges	Mercy / Rideout
1	4803391	48	LEFT HEART CATH PERC	$ 16,947.00	2536	$ 42,977,592.00	3.75
	CDM #	Dept	Sutter Memorial Description	Sutter Price	Rideout Quanty	Total Charges	Sutter / Rideout
	3414158	34	Ca Heart Cath Left	$ 15,188.00	2536	$ 38,516,768.00	3.36
	CDM #	Dept	Enloe Description	Enloe Price	Rideout Quanty	Total Charges	Enloe / Rideout
	457081001		ER-Left Heart Catheterization	$ 10,069.00	2536	$ 25,534,984.00	2.23
	CDM #	Dept	Rideout Description	Rideout Price	Rideout Quanty	Total Charges	
			Left Heart Cath	$ 4,522.80	2536	$ 11,469,820.80	
2	CDM #	Dept	Mercy CDM Description	Mercy Price	Rideout Quanty	Total Charges	Mercy / Rideout
	4803433	48	Cor Angio cath placement	$ 13,563.00	3616	$ 49,043,808.00	6.53
	CDM #	Dept	Sutter Memorial Description	Sutter Price	Rideout Quanty	Total Charges	Sutter / Rideout
	3413309	34	CA Coro/graft/ima w/o lhc	$ 12,381.00	3616	$ 44,769,696.00	5.96
	CDM #	Dept	Enloe Description	Enloe Price	Rideout Quanty	Total Charges	Enloe / Rideout
	457081010		ER-Bilat cornary angio Primary	$ 9,769.00	3616	$ 35,324,704.00	4.71
	CDM #	Dept	Rideout Description	Rideout Price	Rideout Quanty	Total Charges	
			Coronary angio	$ 2,076.00	3616	$ 7,506,816.00	
3	CDM #	Dept	Mercy CDM Description	Mercy Price	Rideout Quanty	Total Charges	Mercy / Rideout
	4802161	48	Stent DES	$ 20,504.00	874	$ 17,920,496.00	1.31
	CDM #	Dept	Sutter Memorial Description	Sutter Price	Rideout Quanty	Total Charges	Sutter / Rideout
	3416203	34	CA Stent IC Sngl vsl prc	$ 26,817.00	874	$ 23,438,058.00	1.71
	CDM #	Dept	Enloe Description	Enloe Price	Rideout Quanty	Total Charges	Enloe / Rideout
	457092910		coronary stent Primary	$ 20,804.00	874	$ 18,182,696.00	1.33
	CDM #	Dept	Rideout Description	Rideout Price	Rideout Quanty	Total Charges	
			Drug Eluting Stenting	$ 15,679.50	874	$ 13,703,883.00	
4	CDM #	Dept	Mercy CDM Description	Mercy Price	Rideout Quanty	Total Charges	Mercy / Rideout
	4803359	48	right and left heart cath	$ 22,836.00	324	$ 7,398,864.00	2.70
	CDM #	Dept	Sutter Memorial Description	Sutter Price	Rideout Quanty	Total Charges	Sutter / Rideout
	3414059	34	rhc/lhc	$ 19,908.00	324	$ 6,450,192.00	2.35
	CDM#	Dept	Enloe Description	Enloe Price	Rideout Quanty	Total Charges	Enloe / Rideout
	4570993526		RT/LT Heart cath	$ 10,308.00	324	$ 3,339,792.00	1.22
	CDM #	Dept	Rideout Description	Rideout Price	Rideout Quanty	Total Charges	
			left and right heart cath	$ 8,466.10	324	$ 2,743,016.40	
5	CDM #	Dept	Mercy CDM Description	Mercy Price	Rideout Quanty	Total Charges	Mercy / Rideout
	4801510	48	PACEMK INS/REPLC GEN DUAL	$ 5,701.00	228	$ 1,299,828.00	2.58
	CDM #	Dept	Sutter Memorial Description	Sutter Price	Rideout Quanty	Total Charges	Sutter / Rideout
	3415205	34	insert pacer dual	$ 11,905.90	228	$ 2,714,545.20	5.38
	CDM #	Dept	Enloe Description	Enloe Price	Rideout Quanty	Total Charges	Enloe / Rideout
	457081039		ER-Perm Pacemaker insertion	$ 7,725.00	228	$ 1,761,300.00	3.49

Department of Justice

FOR IMMEDIATE RELEASE
THURSDAY, JUNE 29, 2006
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(202) 514-2007
TDD (202) 514-1888

Tenet Healthcare Corporation to Pay U.S. more than $900 Million to Resolve False Claims Act Allegations

WASHINGTON – Tenet Healthcare Corporation, operator of the nation's second largest hospital chain, has agreed to pay the United States more than $900 million for alleged unlawful billing practices, Assistant Attorney General Peter D. Keisler of the Civil Division and U.S. Attorney Debra Wong Yang of the Central District of California in Los Angeles announced today.

"Today's settlement reflects our continued resolve to hold responsible those who engage in health care fraud in any form," said Assistant Attorney General Keisler, head of the Justice Department's Civil Division. "The Department of Justice will not tolerate fraudulent efforts by hospitals or other health care providers to claim excessive sums from the Medicare program."

Under the agreement, Tenet, which is headquartered in Dallas but operates dozens of hospitals throughout the United States, will pay a total of $900 million over a four-year period, plus interest, to resolve various types of civil allegations involving Tenet's billings to Medicare and other federal health care programs. The settlement amount was based on the company's ability to pay.

"The Medicare program currently faces great challenges, and can ill afford attempts by hospitals to manipulate and cheat the system," said U.S. Debra Wong Yang. "This settlement demonstrates our strong commitment to recovering taxpayer funds from health care companies that break the rules in pursuit of higher profits." Of the $900 million settlement amount, the agreement requires Tenet to pay:

-- more than $788 million to resolve claims arising from Tenet's receipt of excessive "outlier" payments (payments that are intended to be limited to situations involving extraordinarily costly episodes of care) resulting from the hospitals' inflating their charges substantially in excess of any increase in the costs associated with patient care and billing for services and supplies not provided to patients;

-- more than $47 million to resolve claims that Tenet paid kickbacks to physicians to get Medicare patients referred to its facilities, and that Tenet billed Medicare for services that were ordered or referred by physicians with whom Tenet had an improper financial relationship; and,

-- more than $46 million to resolve claims that Tenet engaged in "upcoding," which refers to situations where diagnosis codes that Tenet is unable to support or that were otherwise improper were assigned to patient records in order to increase reimbursement to Tenet hospitals.

MEMORANDUM

Date: **February 25, 20__**

To: **Patient Financial Services**

From: **Director of Patient Financial Services**

Subject: **RATE INCREASE EFFECTIVE April 1, 20__**

It has been approved by the Board of Directors to implement a rate increase bringing the Organization prices up to, but not to exceed market. The rate increase, effective April 1, 20__, will help the Organization address one of the contributors to its current bottom line challenges.

Room rates will increase an average of 30% with the specific rates as attached. Ancillary service charges will increase 30% in the following areas:

* Room and Board
* Operating Room
* Endoscopy
* Respiratory Therapy
* CT
* EKG
* Labor and Delivery
* Medical and Radiation Oncology
* Cardiac Cath Lab
* Recovery Room
* Central Supply
* Emergency Room
* EEG
* Cardiology
* IV Therapy

The room rates are rounded to the nearest dollar and all other charges should be rounded to the nearest ten cents.

ROOM CHARGES EFFECTIVE: APRIL 1, 20--

The full daily rate will be charged for the day of admission regardless of the time of admission (before midnight). No charge will be made for the day of discharge.

Cardiac ICU	6,305.00
Intensive Care Unit	5,772.00
Cardiac Telemetry	3,691.00
Step Down	3,437.00
Pediatrics	2,993.00
Medical/Surgical Units	2,487.00
(Including labor & maternity rooms)	
Private Room	3,042.00
NICU	4,186.00
Nursery (With mother in-house)	1,915.00

February 25, 20__

Regional Director of Provider Contracting
11050 Olson Drive, Suite 110
Rancho Cordova, CA 95670

Dear _____,

This letter will serve as the required 30 day notice to Blue Cross of California of an increase in prices. This notice is pursuant to Exhibit J of the fully executed Third Amendment to the Comprehensive Hospital Agreement between Blue Cross of California and Name of Organization.

Increases to the following areas of the Charge Description Master will take place on April 1, 20__:

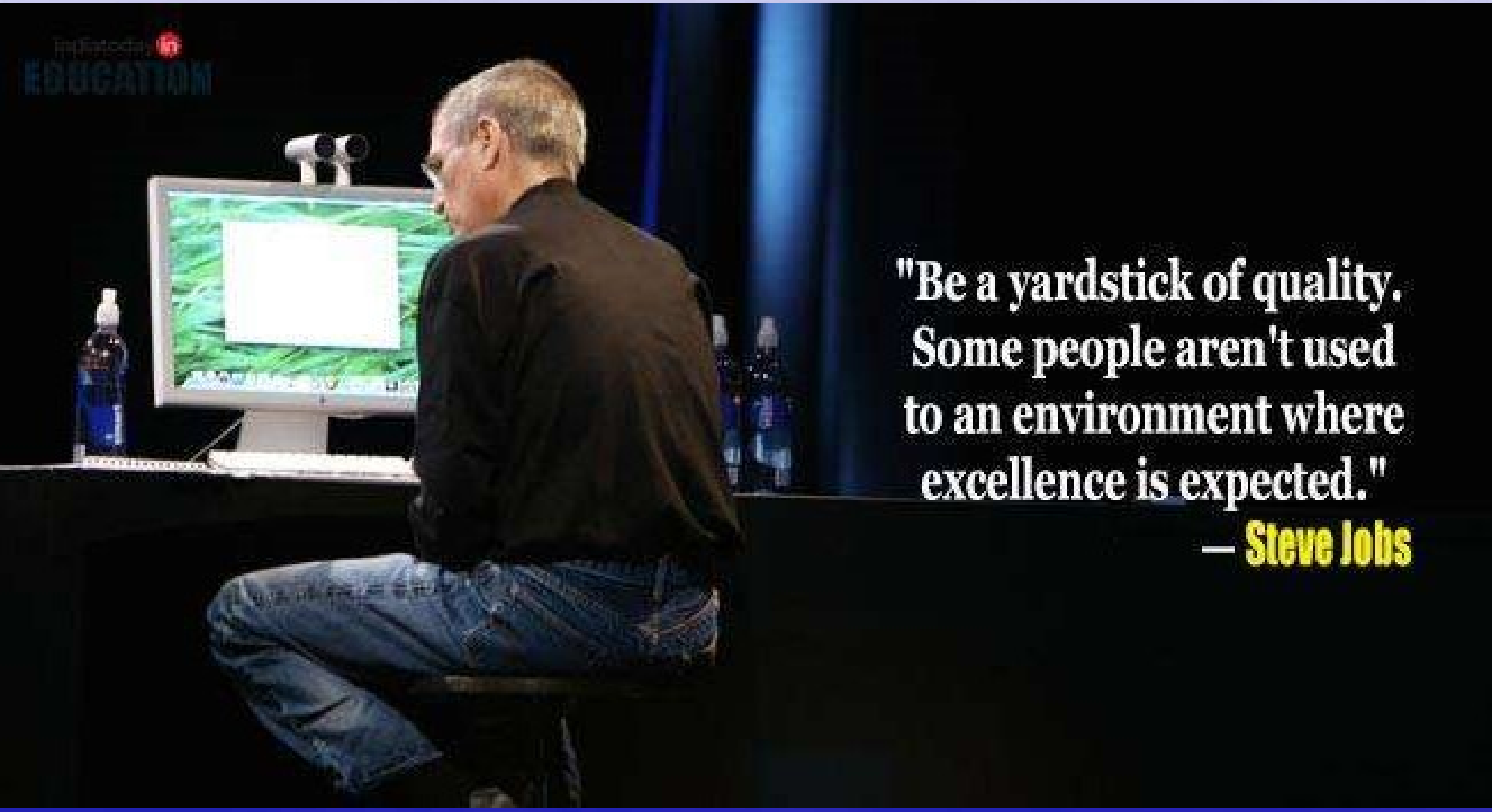
* Room and Board
* Operating Room
* Endoscopy
* Respiratory Therapy
* CT
* EKG
* Labor and Delivery
* Medical and Radiation Oncology
* Cardiac Cath Lab
* Recovery Room
* Central Supply
* Emergency Room
* EEG
* Cardiology
* IV Therapy

So that you may properly calculate the impact of the contract price deflator as described in Exhibit J, I am enclosing our CDM before and our CDM after the changes. If you have any questions regarding this notice, please contact _____, Director of Patient Financial Services at (530) 740-1911.

Respectfully,

Mr. Case
Chief Financial Officer
Name of Organization

Cc Director Patient Financial Services


EDUCATION
"Be a yardstick of quality.
Some people aren't used
to an environment where
excellence is expected."
— Steve Jobs

Charge Capture

Supplies Usage Analysis

High Priced Items

For the month of: Apr-07

Description	CY 06 Actual	Budget	CY 07 Actual	Units Over / (Under) Budget	Unit Price	Range
ADJUSTED Patient Days	4430	4,528	4,458			
Hips	4	4	2	(2)	9,550	9000 - 15,000
Knees	5	5	5	-	9,790	8,000 -10,000
Shoulder	2	2	-	(2)	9,110	7,200 - 10,000
Cervical laminectomies with Fusions		-		-	9,500	5,000 - 9,500
Hip Fracture	3	3	8	5	3,197	3100 - 3500
Troch nail	4	4	3	(1)	1,830	1750 - 1900
General / Vascular Surgeries	58	58	71	13	5,000	
Drug Eluting Stents (Taxus & Cypher)	-	-	-	-	10,382	
				-		
Pacemakers	4	4	2	(2)	8,000	4,800 - 7,000
Misc. Depts:						
Lab						
Blood Bank						
X-Ray & Interventional						
Pharmacy						
Other Non-Medical Supplies						

Case Study

Scenario

- Hospital typically averages 5 single chamber cardiac pacemakers at $7,000 per month and totaling approximately $35,000.
- However the cardiologist working in collaboration with the Sales Rep encourages the insertion of 5 “high end” dual chamber cardiac pacemakers for the following month at $15,000 hence increasing the monthly purchase of pacemakers for $75,000 for the month.

Results

- The Sales Rep and the Cardiologist used 5 new technology high end dual chamber cardiac pacemakers at $15,000 each rather than the $7,000 single chamber cardiac pacemaker.
- Never went through approval through Administration or committee regarding price change.
- Paid in additional $40,000.00 for cardiac pacemaker for the month.
- Recommendation of initiating Value Based Analysis Team (i.e., where all hospital supplies, implants, and devices are approved by a Committee rather than putting you as the executive as the sole decision-maker).

Abstraction of Emergency Department Charges Through a Comprehensive Review of Medical Records

ED Charge Report

Date Period: 01/01/2012 - 07/31/2012

Medical

	January		February		March		April		May		June		July			
	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Total Unit	Total Charge
ER Level 0	4	0	5	0	4	0	3	0	6	0	5	0	10	0	37	0
ER Level 1	26	7800	39	11700	26	7800	46	13800	31	9300	41	12300	54	16200	263	78900
ER Level 2	91	54600	87	52200	119	71400	115	69000	118	70800	111	66600	152	91200	793	475800
ER Level 3	499	449100	403	362700	467	420300	384	345600	402	361800	385	346500	428	385200	2968	2671200
ER Level 4	153	183600	94	112800	119	142800	130	156000	194	232800	138	165600	113	135600	941	1129200
ER Level 5	38	62168	30	49080	27	44172	45	73620	60	98160	26	42536	24	39264	250	409000
ER USE NURSE TRIAGE ONLY	35	6370	10	1820	15	2730	24	4368	25	4550	15	2730	13	2366	137	24934
Total	**846**	**$763,638**	**668**	**$590,300**	**777**	**$689,202**	**747**	**$662,388**	**836**	**$777,410**	**721**	**$636,266**	**794**	**$669,830**	**5389**	**$4,789,034**

Pysch

	January		February		March		April		May		June		July			
	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Units	Charge	Total Unit	Total Charge
ER Level 0			1	0											1	0
ER Level 1			1	300	2	600			1	300	4	1200	3	900	11	3300
ER Level 2	2	1200	4	2400	3	1800	4	2400	6	3600	3	1800	8	4800	30	18000
ER Level 3	17	15300	18	16200	16	14400	12	10800	17	15300	20	18000	15	13500	115	103500
ER Level 4	4	4800	4	4800	4	4800	2	2400	11	13200	9	10800	11	13200	45	54000
ER Level 5	16	26176	23	37628	35	57260	36	58896	41	67076	37	60532	31	50716	219	358284
ER USE NURSE TRIAGE ONLY	2	364	1	182			3	546	4	728	3	546			13	2366
Total	**41**	**$47,840**	**52**	**$61,510**	**60**	**$78,860**	**57**	**$75,042**	**80**	**$100,204**	**76**	**$92,878**	**68**	**$83,116**	**434**	**$539,450**

Legend:

ER Level 0	$0
ER Level 1	$300
ER Level 2	$600
ER Level 3	$900
ER Level 4	$1,200
ER Level 5	$1,636
ER Use Nurse Triage Only	$182

Key Metrics in the Emergency Department Having Financial Impact to Your Bottom-line

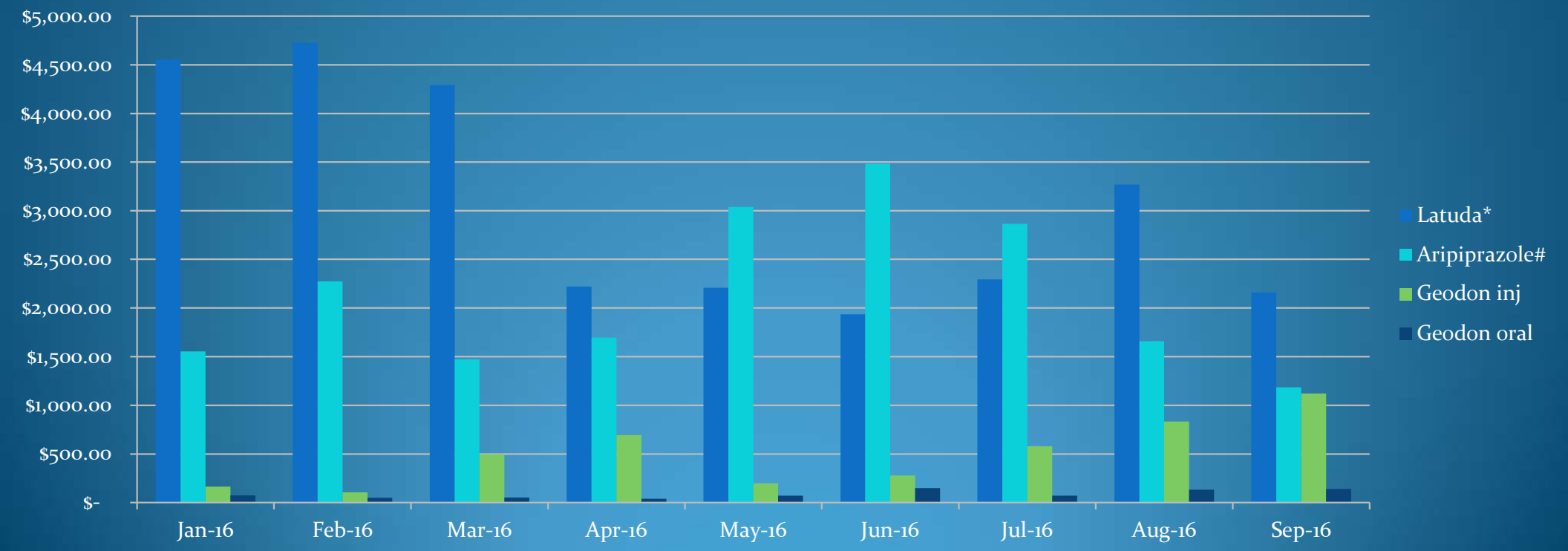
- Door to providor time (Time patients sees MD, NP, or PA)
  1) Must be < 30 minutes to meet CMS benchmarks
- Patients leaving without being seen (LWBS) by providor
  1) % of patients LWBS should be < 2%
  2) Review Reasons for LWBS
- Diversion (Times the facility cannot accept patients)
  1) Decrease in ambulance runs
- Medical Necessity
  1) Interqual Criteria (Case Manager in ED)

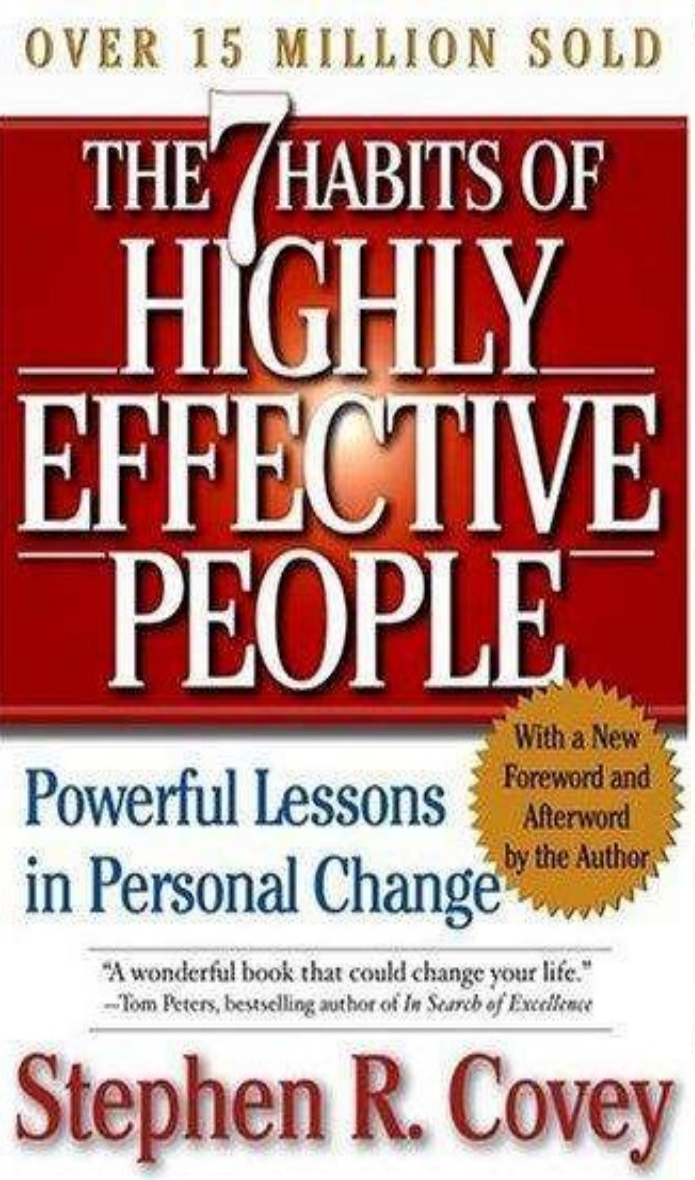
Financial Review of Medication Utilization

Monthly total cost $	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17
Latuda*	$ 2,159.38	$ 3,268.27	$ 2,294.79	$ 1,934.30	$ 2,208.97	$ 2,221.28	$ 4,293.44	$ 4,728.14	$ 4,554.05
Aripiprazole (Abilify)	$ 1,184.91	$ 1,658.81	$ 2,864.17	$ 3,482.37	$ 3,038.01	$ 1,694.44	$ 1,473.93	$ 2,273.18	$ 1,554.00
Geodon inj	$ 1,122.51	$ 832.92	$ 579.42	$ 279.79	$ 198.53	$ 694.85	$ 496.32	$ 104.78	$ 165.44
Geodon oral	$ 138.62	$ 132.80	$ 71.93	$ 149.75	$ 71.08	$ 40.38	$ 52.96	$ 50.59	$ 74.24

*Split Latuda 80mg to 2 x 40mg starting 10/16, potential savings of 30%

#Price decrease starting Aug 16





Manage Yourself	**Habit 1** Be Proactive® The Habit of choice	• See alternatives, not roadblocks • Focus on what you can influence • I am free to choose and am responsible for my choices
	Habit 2 Begin with the End in Mind® The Habit of Vision	• Mental creation precedes physical creation • Define practical outcomes
	Habit 3 Put First Things First® The Habit of Integrity and Execution	• Focus on the important, not just the urgent • Effectiveness requires the integrity to act on your priorities • Plan weekly, act daily
Lead Others	**Habit 4** Think Win/Win® The Habit of Mutual Benefit	• Effective long-term relationships require mutual respect and mutual benefit • Build trust with co-workers
	Habit 5 Seek First to Understand, then to be Understood® The Habit of Mutual Understanding	• To communicate effectively, we must first understand each other • Practice empathic listening • Give honest, accurate feedback
	Habit 6 Synergize® The Habit of Creative Cooperation	• The whole is greater than the sum of its parts • Synergize to arrive at new and better alternatives
Unleash Potential	**Habit 7** Sharpen the Saw® The Habit of Renewal	• To maintain and increase effectiveness, we must renew ourselves in body, heart, mind and soul

Billing and Collection

Discharge Not Final Billed (DNFB Report)

Two Key Statistics

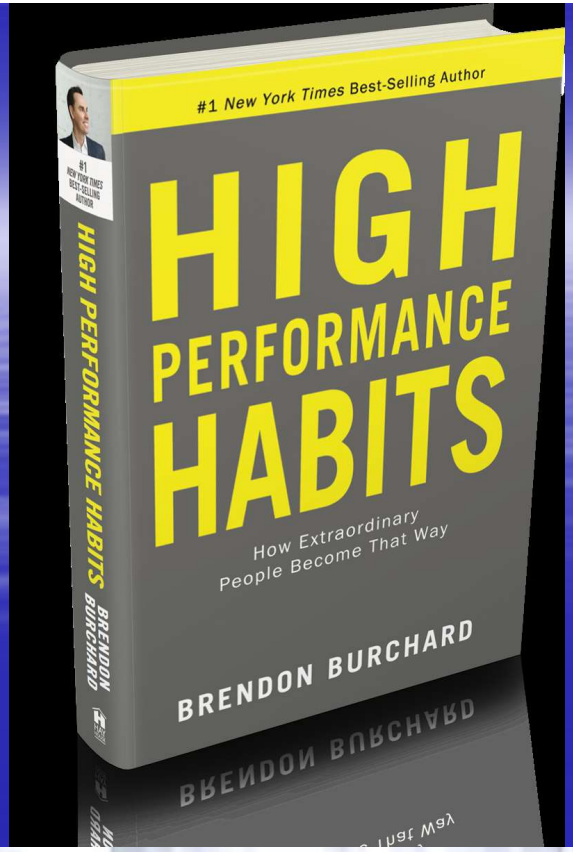
- Dollars in “Scrubber” Waiting to be Billed
- Medical Records Waiting for Coding

DNFB – Medical Records Waiting for Coding By MD and Cost

Dr. Psychiatrist	**Discharge Summary**	**Sign**	**15**	**Name**	**Behavioral Health**	**$ 13,819.00**	**1**	
Dr. Psychiatrist	**Discharge Summary**	**Sign**	**15**	**Name**	**Behavioral Health - South Campus**	**$ 15,824.00**	**1**	
Dr. Psychiatrist	Discharge Summary	Sign	14	**Name**	Behavioral Health	$ 15,509.00	1	
Dr. Psychiatrist	Discharge Summary	Sign	14	**Name**	Behavioral Health	$ 19,987.20	1	
Dr. Psychiatrist	Discharge Summary	Sign	12	**Name**	Behavioral Health - South Campus	$ 10,869.00	1	
Dr. Psychiatrist	Discharge Summary	Sign	11	**Name**	Behavioral Health	$ 24,531.97	1	
Dr. Psychiatrist	**Psychiatric Evaluation**	**Modify**	**11**	**Name**	**Behavioral Health**		**1**	**Missing Adnit DX with AXIS**
Dr. Psychiatrist	Discharge Summary	Sign	11	**Name**	Behavioral Health	$ 10,023.00	1	
Dr. Psychiatrist	Discharge Summary	Sign	11	**Name**	Behavioral Health	$ 29,748.40	1	
Dr. Psychiatrist	Discharge Summary	Sign	11	**Name**	Behavioral Health - South Campus	$ 19,384.00	1	
Dr. Psychiatrist	Discharge Summary	Sign	10	**Name**	Behavioral Health	$ 10,153.00	1	
Dr. Psychiatrist	**Psychiatric Evaluation**	**Perform**	**10**	**Name**	**Behavioral Health**	**$ 20,121.00**	**1**	
Dr. Psychiatrist	Discharge Summary	Sign	10	**Name**	Behavioral Health - South Campus	$ 13,710.00	1	
						$223,165.57	**14**	
Dr. Medical	**Progress Note Physician**	**Modify**	**16**	**Name**	**Behavioral Health**	**$ 11,464.00**	**1**	**Missing Progress Note 7/14/15**
Dr. Medical	Discharge Summary	Perform	14	**Name**	Behavioral Health	$ 9,567.00	1	
Dr. Medical	Long Term Goals	Sign	12	**Name**	Behavioral Health	$ 8,825.00	1	
						$ 29,856.00	**3**	
Dr. Who	**Discharge Summary**	**Modify**	**20**	**Name**	**Behavioral Health**	**$ 12,077.60**	**1**	**Missing D/C Meds**
Dr. Who	Discharge Summary	Modify	13	**Name**	Behavioral Health - South Campus	$ 22,922.00	1	Missing D/C Condition
Dr. Who	Discharge Med List Reconciliation	Modify	13	**Name**	Behavioral Health - South Campus	$ 5,692.97	1	Missing date on paper doc.
Dr. Who	Discharge Summary	Modify	12	**Name**	Behavioral Health	$ 5,553.00	1	**Missing D/C Meds**
Dr. Who	Discharge Summary	Modify	11	**Name**	Behavioral Health - South Campus	$ 12,557.31	1	Missing D/C Follow up
						$ 58,802.88	**5**	

Account Receivables Balance
(181 to 360 Days)
Also known as "Aging Accounts or Safety Net "

Sum of Current A/R Balance	Column Labels							
Row Labels	181-210	211-240	241-270	271-300	301-330	331-365	366+	Grand Total
Commercial Insurance	$149,615.05	$272,961.25	$159,297.27	$130,670.34	$88,028.44	$308,596.48	$365,615.20	$1,474,784.03
Medi-Cal Capitation						$72.00	$62,012.23	$62,084.23
Medi-Cal Managed Care FF	$1,129,175.68	$429,678.01	$154,171.38	$205,560.19	$160,672.13	$412,667.61	$304,516.91	$2,796,441.91
Medi-Cal Traditional	$575,262.07	$311,481.21	$607,985.41	$628,225.75	$1,078,507.02	$856,318.79	$924,428.24	$4,982,208.49
Medicare	$204,157.86	$208,646.44	$558,598.37	$542,583.31	$505,653.63	$381,508.00	$128,315.99	$2,529,463.60
Medicare Advantage	$431,005.60	$570,640.54	$459,959.98	$335,089.44	$289,747.64	$658,703.94	$552,654.28	$3,297,801.42
Medicare Inpt Part B Only	$45,453.78	$34,241.01	$174,213.84	$87,999.30	$322,653.25	$159,414.07	$308,193.68	$1,132,168.93
Other Government	$484,438.43	$57,581.95	$38,366.96	$36,007.63	$34,395.68	$115,762.00	$165,325.20	$931,877.85
Self Pay	$30,748.88	$8,124.33	$34,994.83	$14,401.45	$188,692.98	$98,116.23	$56,271.93	$431,350.63
Worker's Compensation	$2,998.00	$1,365.00		$4,721.04	$3,379.00	$1,649.00	$20,034.65	$34,146.69
Grand Total	$3,052,855.35	$1,894,719.74	$2,187,588.04	$1,985,258.45	$2,671,729.77	$2,992,808.12	$2,887,368.31	$17,672,327.78



MARK OF EXCELLENCE

6 WAYS TO BECOME A HIGH PERFORMER

1. **SEEK CLARITY** on who you want to be, how you want to interact with others, what you want and what will bring you the greatest meaning. High performers consistently seek clarity again and again as times change. This routine self-monitoring is one of the hallmarks of their success.
2. **GENERATE ENERGY** so you can maintain focus, effort and well-being. To stay on your A game, you'll need to care for your mental stamina, physical energy and positive emotions.
3. **RAISE THE NECESSITY** for exceptional performance. This means actively tapping into the reasons you absolutely must perform well (detailed in part above). This necessity is based on a mix of your internal standards (identity, beliefs, values or expectations for excellence) and external demands (social obligations, competition, public commitments or deadlines).
4. **INCREASE PRODUCTIVITY** in your primary field of interest. Specifically, focus on prolific quality output in the area in which you want to be known. You'll also have to minimize distractions (including opportunities) that steal your attention.
5. **DEVELOP INFLUENCE** with those around you. It will make you better at getting people to believe in and support your efforts and ambitions. Unless you consciously develop a positive support network, major achievements over the long haul are all but impossible.
6. **DEMONSTRATE COURAGE** by expressing your ideas, taking bold action and standing up for yourself and others, even in the face of fear, uncertainty, threats or changing conditions. Courage is not an occasional act, but a trait of choice and will.

Clinical Documentation Improvement (CDI)

What is Clinical Documentation Improvement (CDI)

a) Definition One: Clinical Documentation Improvement (CDI) is a collaborative approach to bridge the gap between clinical documentation and coding guidelines and regulatory requirements.

b) Definition Two: Clinical Documentation Integrity (CDI) is the process and effort of preventing and reconciling inconsistent, imprecise, incomplete, conflicting, and/or illegible physician documentation.

The goal is to positively impact physician documentation to concurrently demonstrate severity and acuity for a specific patient population.

Why is CDI Important to Revenue Cycle?

1) CDI Programs generate revenue
2) Typical Results of 4-8% increase in CMI
3) CDI increases coding productivity by ensuring clear and accurate documentation
4) Impact physician documentation to concurrently demonstrate severity and acuity
    a) Medical Schools do not teach CMS required documentation.

Job Description Example of Nurse Cardiac Documentation Specialist

THE HOSPITAL HEALTH GROUP
(Cardiology)
(Nurse Cardiac Documentation Specialist/ Nurse Cardiac Auditor)

POSITION NUMBER:	EFFECTIVE DATE: May 2008	APPROVED BY:

RESPONSIBLE TO:	Director of Cardiology, Cath Lab, and Cardiac Rehab
RESPONSIBLE FOR:	Performing on-site audits of patients' billed charges compared to their medical records, and defending against challenges to the billed charges by insurance payers. Data collection and entree for the ACC for Cardiac procedures. Initiate Supply inventor and par levels. Improving dictation from doctors through concurrent reviews and make recommendations to physicians documentation to maximize reimbursement.
EXEMPTION STATUS:	None
KNOWLEDGE:	Knowledge and ability to tread, understand, and interpret, analyze and apply complex rules and regulations as dictated by various regulatory agencies and third party payers. Knowledge of advanced clinical standards, practices and procedures for adult cardiac settings. Knowledge of signs and symptoms of and reporting mechanism for suspected abuse.
SKILLS:	Excellent oral and written communication skills. Good human relationship skills. Knowledge of and skills in the use of personal computer and related software. Ability to respond appropriately to customer/coworker by projecting a professional, friendly, and helpful demeanor. Skill in time management. Skill in problem solving, assessing, and using alternative approaches. Ability to work independently, takes imitative, set priorities, and use good judgment. Ability to incorporate into practice, advance clinical skills, theoretical concepts and knowledge of health care finances. Ability to deal effectively with constant change and ambiguity.
EXPERIENCE:	At least 2 years recent clinical cardiac experience.
LICENSE:	Current Valid California Registered Nursing License. Current CPR and ACLS.

DEFINITION:
An individual who concurrently reviews medical records of cardiac patients to facilitate appropriate physician documentation to accurately reflect patient severity of illness and risk of mortality. The nurse is also responsible for ensuring and maintaining the cardiac charging methodologies and procedures for the facility. The nurse also reviews charges and practices that are frequently challenged and makes recommendations to management to correct and deficiencies. In addition, the nurse may perform in-serves to the hospital departments regarding cardiac procedures, cardiac charges, and cardiac documentation methodology.

RESPONSIBILITIES:

A. Concurrently review 90% of all cardiac admissions per month
    a. Assigns working DRG
    b. Provides appropriate options and relative weights when more than one DRG may be utilized.
B. Initiates concurrent review with 24-48 hours of cardiac patient admissions.
C. Demonstrates an understanding of the importance of documentation and makes an effort to capture all potential secondary diagnoses for profiling purposes.


21:02:33;14

The Fundamental Breakdown Analysis of CDI

What is an MS-DRG?

"Medicare Severity Diagnosis Related Groups (MS-DRGs) (MS)-DRGs": codes designed to represent patient severity of illness & hospital resource utilization.

Each MS-DRG can be split into three different tiers of severity:

a) With Major Complication or Comorbidity (MCC)

b) With Complication or Comorbidity (CC)

c) *Without* Complication or Comorbidity (WO CC/MCC)

Type of Heart Failure must be specified in order for an MCC or CC to be assigned

DX Code	DX Code Description	Status
428.1	Left heart failure	CC
428.20	Systolic heart failure, unspecified	CC
428.22	Chronic systolic heart failure	CC
428.30	Unspecified diastolic heart failure	CC
428.32	Chronic diastolic heart failure	CC
428.40	Combined diastolic/systolic HF, unspecified	CC
428.42	Chronic combined diastolic/systolic HF	CC

Type of Heart Failure must be specified in order for an MCC or CC to be assigned

MCC – specify an acute exacerbation of CHF

DX Code	DX Code Description	Status
428.21	Acute systolic heart failure	MCC
428.23	Acute on chronic systolic heart failure	MCC
428.31	Acute diastolic heart failure	MCC
428.33	Acute on chronic diastolic heart failure	MCC
428.41	Acute combined systolic & diastolic heart failure	MCC
428.43	Acute on chronic combined systolic and diastolic heart failure	MCC

Heart Failure and Shock

MS - DRG	MS –DRG Title	FY 20-- Average Reimbursement	GLOS
291	Heart Failure & Shock w/MCC 1.4796	$13,041	4.5
292	Heart Failure & Shock w/CC 0.9574	$8,438	3.5
293	Heart Failure & Shock w/o MCC or CC 0.6618	$ 5,833	2.6

Sepsis

MS - DRG	MS –DRG Title	FY 20-- Average Reimbursement	GLOS
870	Septicemia or Severe Sepsis W MV> 96 Hours	$49,000	12.6
871	Septicemia or Severe Sepsis W/O MV >96 Hours W MCC	$13,000	4.9
872	Septicemia or Severe Sepsis W/O MV <96 Hours W/O MCC	$ 8,500	3.8

Psychosis

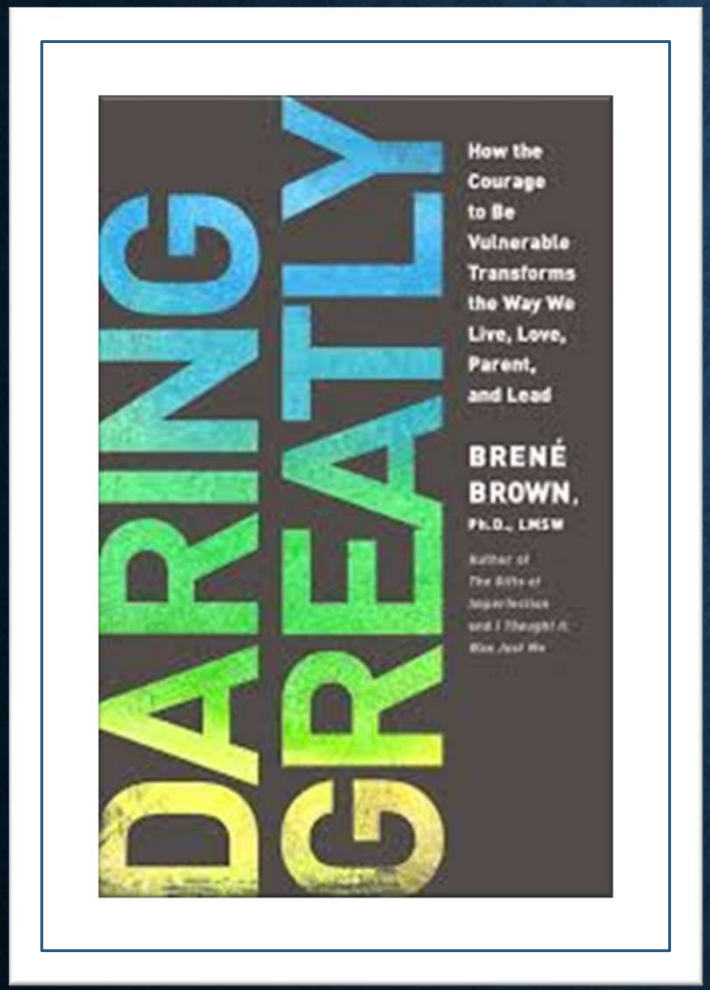
MS - DRG	MS –DRG Title	FY 20-- Average Reimbursement	GLOS
885	Psychosis	$ 10,500	5.8
	Psychosis is not considered CC or MCC and doesn't affect DRG.		

Detox APR-DRG for Opioid Abuse

APR - DRG	APR –DRG Title	FY 20-- Average Reimbursement	GLOS
773-1	Opioid Abuse & Dependence W/O CC or MCC 0.2842	$ 2,132	3.65
773-2	Opioid Abuse & Dependence W/CC 0.3631	$ 2,723	4.21
773-3	Opioid Abuse & Dependence W/MCC 0.6550	$ 4,913	5.22

Detox APR-DRG for Alcohol Abuse

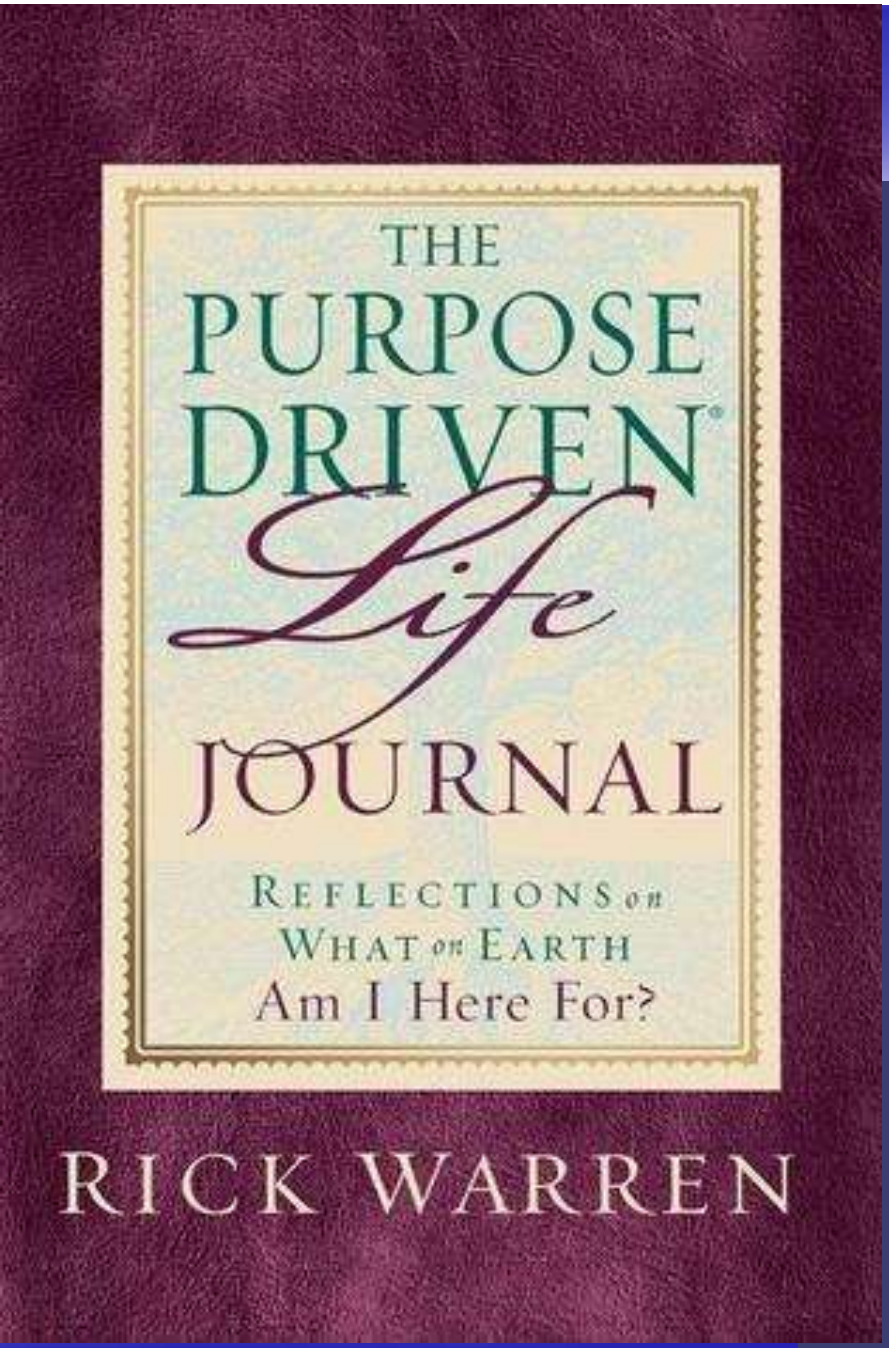
APR – DRG	APR –DRG Title	FY 20-- Average Reimbursement	GLOS
775-1	Alcohol Abuse & Dependence W/O CC or MCC 0.3349	$ 2,512	3.26
775-2	Alcohol Abuse & Dependence W/CC 0.4637	$ 3,478	3.76
775-3	Alcohol Abuse & Dependence W/MCC 0.8502	$ 6,377	5.72



"Daring greatly means the courage to be vulnerable. It means to show up and be seen. To ask for what you need. To talk about how you're feeling. To have the hard conversations."

Brene' Brown

THE FINANCIAL IMPACT OF CONTRACTING



Your most profound and intimate experiences of worship will likely be in your darkest days - when your heart is broken, when you feel abandoned, when your out of options, when the pain is great - and you turn to God alone.

Rick Warren

Case Study: Contract Negotiation with Health Plan

Scenario

- Health Care IPA with over 100,000 lives in the Long Beach area is interested in negotiating an agreement with the hospital.
- Average Reimbursement per patient day (PPD):
  a) Medi-Cal Managed Care = $1,740
  b) Traditional Medi-Cal = $1,055
  c) Health Net = $1,600
  d) Care First = $1,475-$1500
- What is the proposed reimbursement per services by Health Care IPA?

Accountable Health Care IPA Draw Rates

HEALTH CARE IPA
HOSPITAL DRAW RATES

DESCRIPTION

	Rates
Med/Surg/PEDS	$900
DOU	$900
ICU/CCU	$1,050
NICU/PICU	$1,050
Border Baby	$250
Acute Rehab	$650
Sub Acute (no Vent)	$500
Sub Acute (Vent)	$500
CASE RATES - IN-PATIENT	
OB - Vaginal (Upto 2 days)	$1,800
OB - C Section (upto 3 days)	$2,700
OB - Additional Day	$800
OB - C Section (additional Day)	$800
Out Patient	
OP Surgery	100% of M-Cal

Result: Contract Negotiation with Health Plan

Results

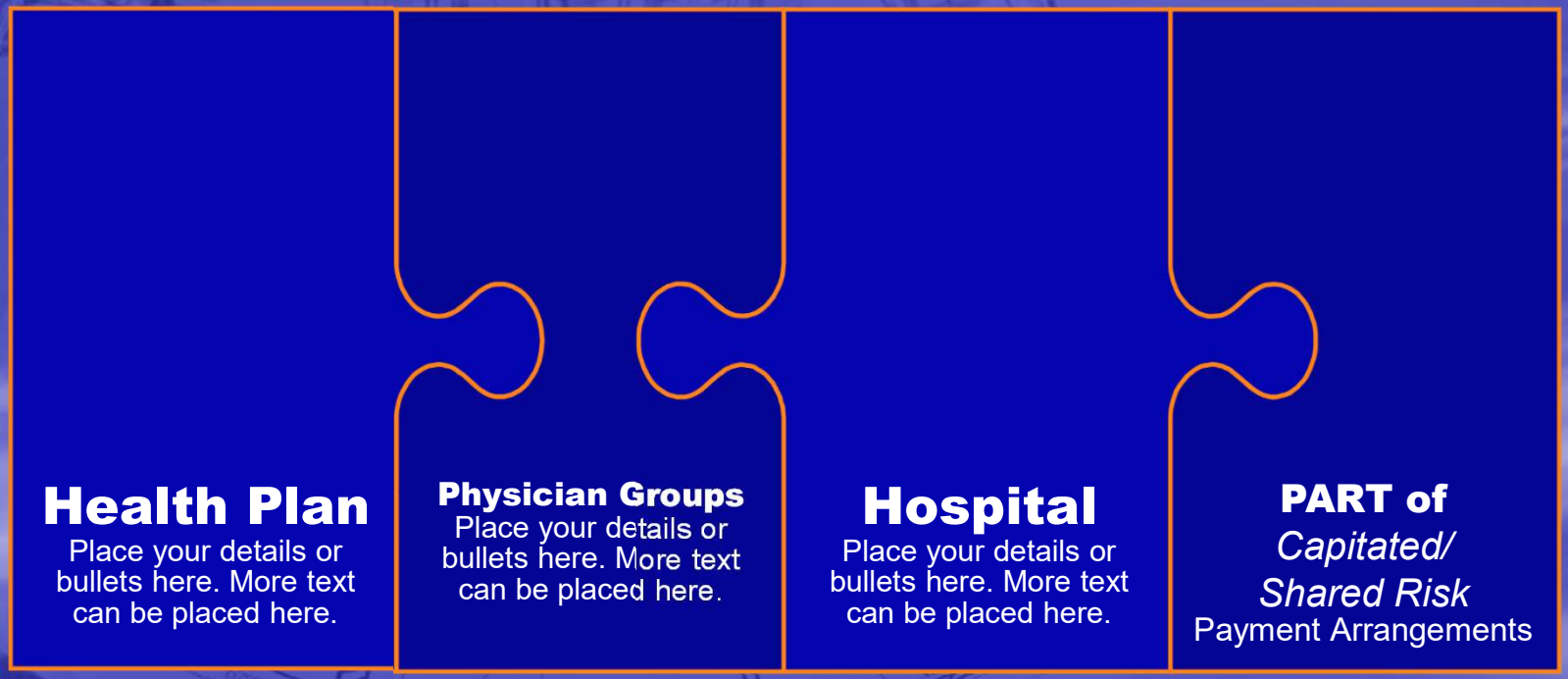
- Health Care IPA rates are very low.
- With a shared risk model, the hospital is responsible for all hospital services, including out of network.
- Out of Network Services also include:
  - Orthopedic Surgeries (No Carve Outs)
  - Oncology Services
  - HIV
  - Cardio/Thoracic Surgeries
- No agreement at this time unless Health Care IPA is willing to agree for a $1,800 PPD reimbursement.
- Lessons Learned: In negotiating with health plans or IPA initiate a cost benefit analysis whether it would beneficial to your organization

Who is paying for it?

DOFR (Division of Financial Responsibility)

DOFR

Is a tool used in the contracting process by health plans, physician organizations and hospitals in capitated or shared risk payment arrangements to define which party is financially responsible for services rendered (e.g., ED, Inpatient Acute, Surgery, Outpatient Ancillary).



DOFR – Division of Financial Responsibility

				PAYER AT RISK					
Health Plan	**Participating Provider Group**	**Capitated Hospital**	**Authorization**	**InPatient-Medical Acute**	**InPatient-Detox**	**InPatient-BHU**	**OutPatient Surgery**	**Emergency Room**	**Outpatient Services (Ancillary)**
LA Care HP	Global IPA	Hollywood Presb	Global IPA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	Hollywood (Conifer Hlth)	Global IPA (MedPoint)
LA Care HP	HealthCare LA	No Cap	HealthCare LA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	LA Care HP	HealthCare LA (MedPoint)
LA Care HP	HealthCare LA	California Hospital	HealthCare LA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	HealthCare LA (MedPoint)	HealthCare LA (MedPoint)
LA Care HP	HealthCare LA	Hollywood Presb	HealthCare LA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	LA Care HP	HealthCare LA (MedPoint)
LA Care HP	MLK IPA	No Cap	MLK IPA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	DHS	LA Care HP	DHS
LA Care HP	Preferred IPA	Hollywood Presb	Preferred IPA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	Hollywood Pres (HSMSO)	LA Care HP	LA Care HP
LA Care HP	Preferred IPA	Valley Presb	Preferred IPA	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	LA Care HP	LA Care HP
LA Care HP	Prospect MG	Alta Hospitals	Preferred IPA	Alta Hospitals	Medi-Cal Traditional	Medi-Cal Traditional	Alta Hospitals	Alta Hospitals	Alta Hospitals
LA Care HP	Prospect MG	Alta Med		Alta Hospitals	Medi-Cal Traditional	Medi-Cal Traditional	Alta Hospitals	Alta Hospitals	Prospect MG (MedPoint)
LA Care HP	Regal Medical Group	No Cap	Regal Medical Group (Heritage Provider Network)	Regal Medical Group (Heritage Provider Network)	Regal Medical Group	Medi-Cal Traditional	Regal Medical Group (Heritage Provider Network)	Regal Medical Group (Heritage Provider Network)	Regal Medical Group (Heritage Provider Network)
LA Care HP	Seaside Health Plan	No Cap	LA Care HP	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	LA Care HP	LA Care HP
LA Care HP	South Atlantic Medical Group	No Cap	South Atlantic Medical Group	LA Care HP	Medi-Cal Traditional	Medi-Cal Traditional	LA Care HP	LA Care HP	LA Care HP

Case Study: Denial of Submitted Claims

Scenario

- LA Care has been initiating denials on submitted claims despite the service being rendered at the hospital.
- They have provided the organization an “authorization number” but nevertheless denied the claims.
- A First Level of Appeal was initiated but denied once again because it was missing “provider data quality.”

Please Note Information Requested to Avoid Denials and Payment Delays

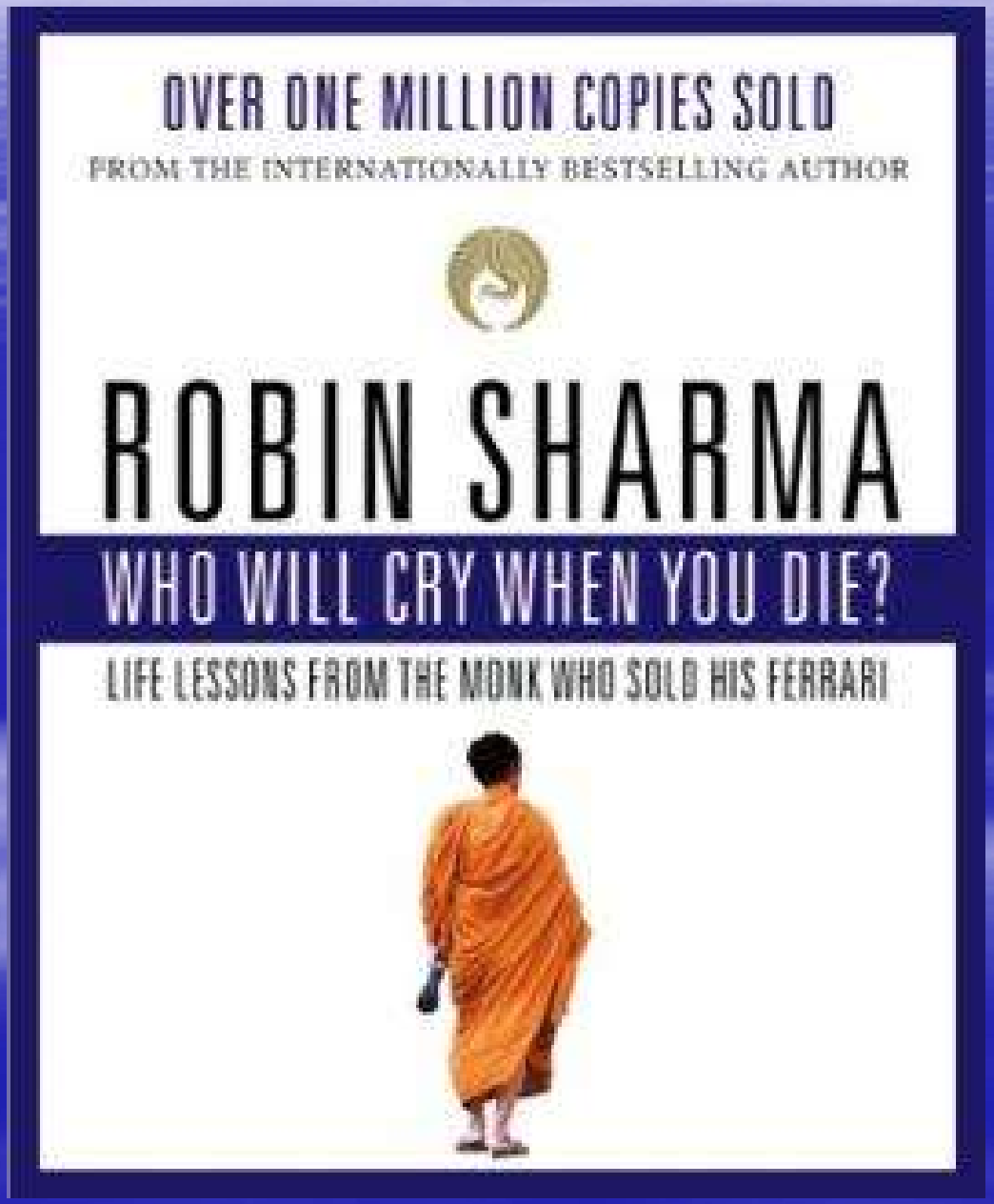
PROVIDER DATA QUALITY

Confirming the following critical Provider data elements:

- NPI
- TIN
- Affiliations & Locations
- Pay-to Entity & Address
- Par / Non-Par
- PaySpan Enrollment & Account Accuracy

L.A. Care HEALTH PLAN

Leave A Legacy



"When you were born, you cried while the world rejoiced. Live your life in such a way that when you die, the world cries while you rejoice."

Robin Sharma

Summary

Action Items

1) Access Services
   a) Competitive Pay Compensation: Collaborate with Human Resources to evaluate Admitting Staff SWB.
   b) Ensure authorization "prior" to admission (Pre-authorization) and "throughout" the hospitalization
   c) ABN (Advanced Beneficiary Notice): Review your Radiology and Laboratory services whether process established to notify the beneficiary test may not be a covered service. (Specifically for Medicare beneficiaries)
   d) Eligibility Enrollment Services: Finding funding solutions for uninsured patients.
   e) Deductibles: What's your process collecting deductibles.
   f) Admission vs. Observation: Criteria for medical necessity (InterQual vs. P&P).

Summary

Action Items

2) Charge Master / Charge Capture
   a) Assess the last time CDM updated.
   b) Pricing Strategy: Don't want it to be the Highest or the Lowest ---- want pricing to be in the median compared to our competitors.
   c) Assess the last time room charges updated.
   d) Get to know your vendors in your OR/Cath Lab/ Radiology, who could potentially approve an implant or your device without your approval.
   e) Know your monthly utilization/cost of implants, stents, pacemakers, where applicable in the OR / Cath Lab Services.
   f) Review your ED Level Charges.
   g) Consider Case Manager in ED.
   h) Identify High Cost / High Drug and collaborate with Medical Staff to Reduce Cost.

Summary

Action Items

3) Billing and Collection
   a) DNFB Report
      - Dollars in "Scrubber" Waiting to be Billed
      - Medical Records Waiting for Coding
   b) Review AR Balance (Aging Accounts - 181 to 360 Days)
      - Consider Outsourcing
   c) Consider implementing a comprehensive CDI program
      - (MS)-DRGs
   d) Consider hiring a CDI Specialist

Summary

Action Items

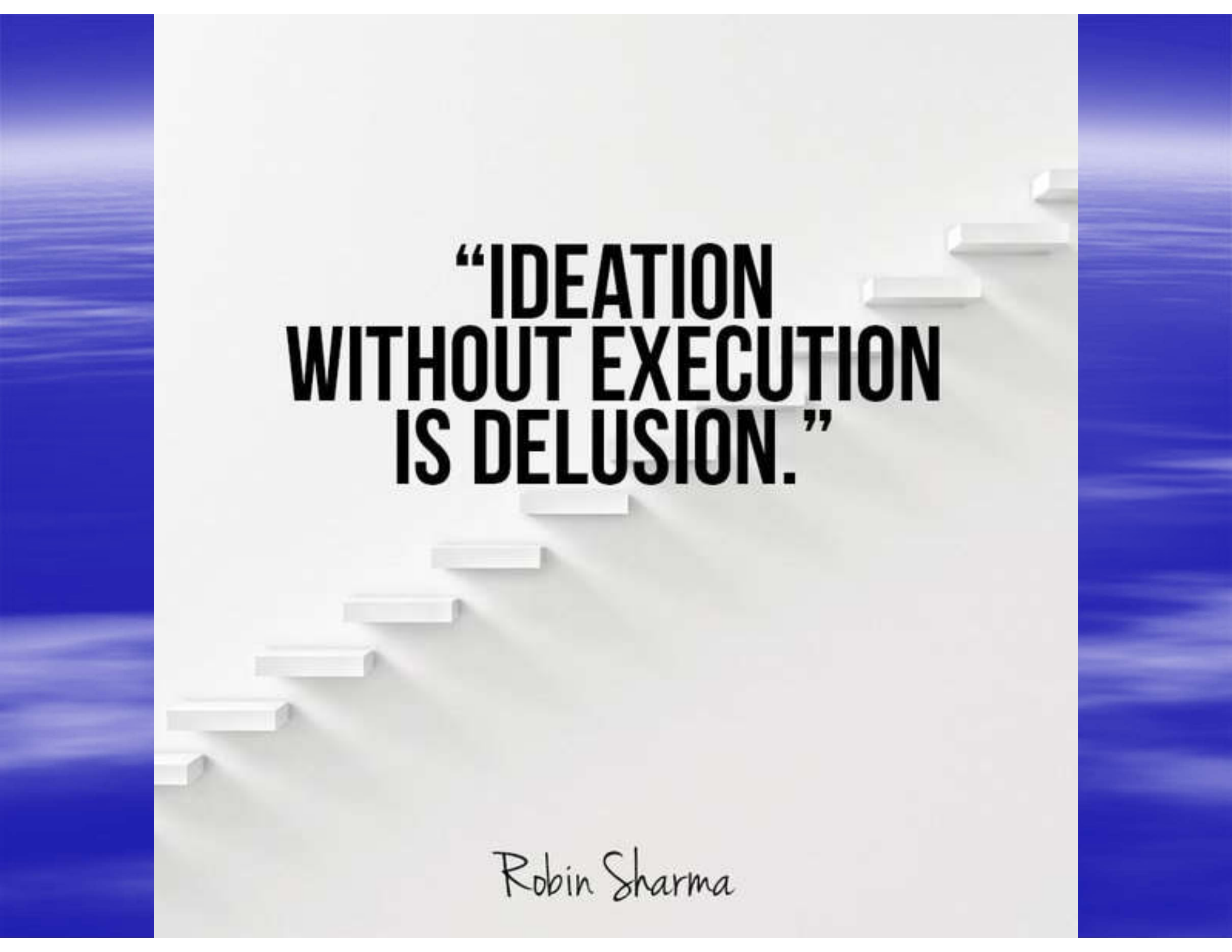
4) Contracting

a) Contract Negotiation with Health Plan

- Assess from other health plans particularly on Average Reimbursement per patient day (PPD).

b) Division of Financial Responsibility (DOFR)

- Who is paying for it?
  i. Health Plan
  ii. Physician Group
  iii. Hospital
  iv. PART of Capitated/Shared Risk Payment Arrangement


“IDEATION
WITHOUT EXECUTION
IS DELUSION.”
Robin Sharma

Questions?

Contact Information for Questions and Speaking Engagement Opportunities

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