Transforming Mid-Revenue Cycle in Hospitals

Presented on August 5th 2024 By:

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Learning Objectives

- To identify successful strategies to transform mid revenue cycle.
- To analyze various strategies to optimize the revenue cycle performance.
- To Underline the importance of a good CDI program, interdepartmental collaboration, a strong denials management team.

Agenda

- Introduction to Mid Revenue Cycle(RC)
- Why do we need to transform Mid-revenue Cycle?
- Identifying successful strategies to transform RC
- Analyze specific strategies to optimize RC performance
- Analyzing Strategies of an effective CDI program

Agenda

- A Case study of a successful transformation
- Analyzing UR/CM strategies through interdepartmental collaboration
- Creating a strong denials management team
- Summary

Introduction to Mid-Revenue Cycle

- The mid-revenue cycle encompasses a series of processes and activities to accurately capture patient data, document clinical procedures, code diagnoses and treatments, and ensure compliance with regulatory requirements.

- It Connects the front-end (Patient Access) to the back-end (billing and collections by CBO)

- Plays a crucial role in improving revenue cycle efficiency, which ultimately impacts a hospital's bottom line.

Key Components

Coding and Charge Capture

Clinical Documentation Integrity

Case Management

Utilization Review

Denials Prevention*

Why do we need to transform Mid-RC?

Rising Costs of Care

Staffing Shortage and increase in Contract labor

Rising Denials

Burden from Health insurer policies for prior authorizations

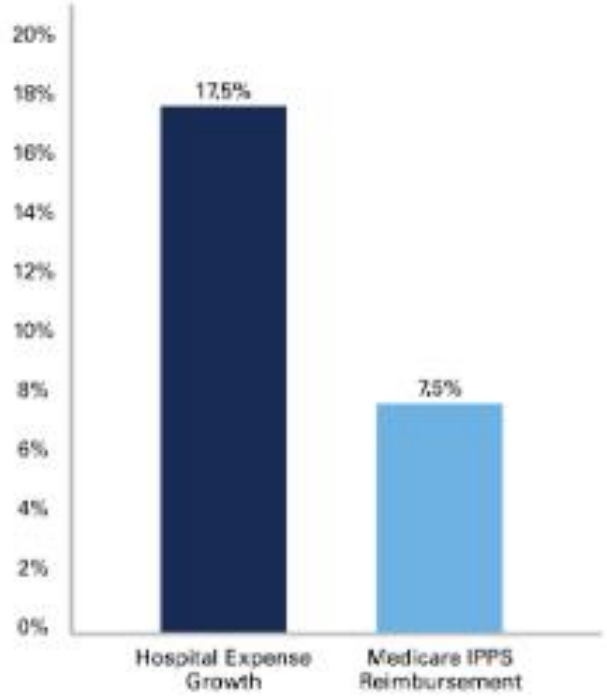
Rising Costs of Supplies and contract labor

As per AHA, The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise.

Hospital total expense per patient rose 22.5% from 2019 to 2022

2022 was the most challenging year for hospitals since the pandemic!

Figure 1. Cumulative Hospital Expense Growth is More Than Double the Cumulative Increases in Medicare IPPS Reimbursement, 2019-2022



Source: FY 2020-2022 IPPS Final Rule

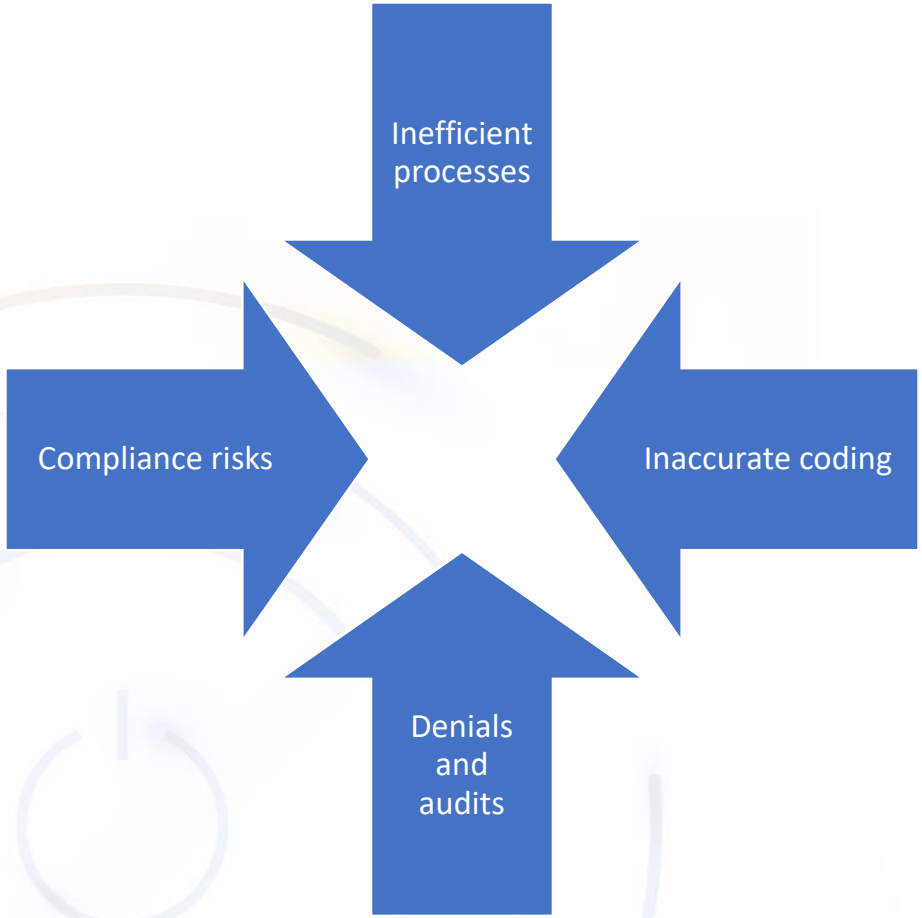
Growing Denials

450 Millions claims per year were subjected to denials

With over 54.3% overturned!

Providers 'Wasted' 10.6B $ in 2022 overturning claims denials.

Common issues in Mid-RC?



- *Factors contributing to revenue loss in the mid-cycle included the expansion of audits ($1.7—$3.3 million) and coding inefficiencies ($1–$2.5 million).
- Average of $4.7–$11.3 million in estimated revenue loss for the average 250-bed hospital

(* report by Advisory board)

Key Transformation strategies

Process Optimization:

- Streamlining workflows
- Implementing best practices

People Integration:

- Integrating mid-revenue cycle clinically
- Collaborative EHR systems

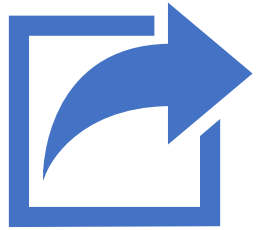
Data Analytics:

- Using data to drive decisions
- Identifying trends and areas for improvement

Process Optimization

Identify the The broken workflow.

Fixing the process



Utilizing the Benefits of the new workflow, filling the process gaps e.g. short stays.

People Integration

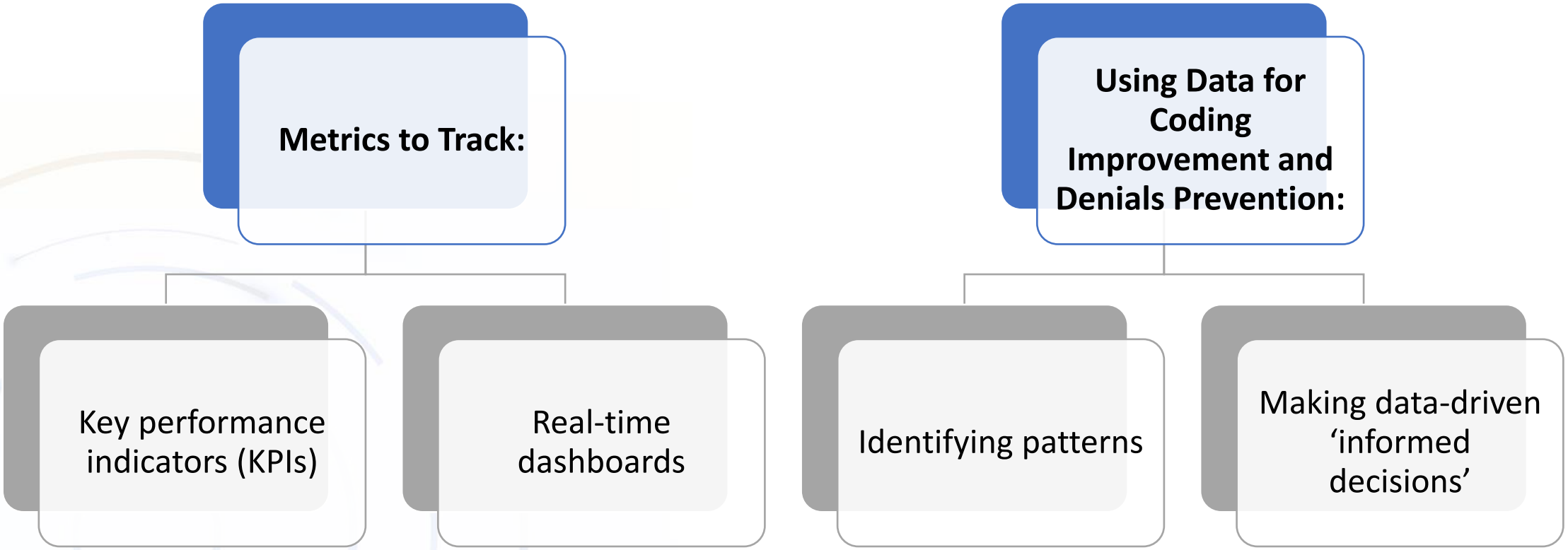
No working in silos

Collaborative systems/dashboards that talk to each other

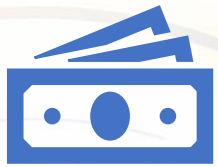
Transparency & maximum visibility

CDI in Patient access, CDI & coding, CDI & Quality, CDI & CM/UR

Data Analytics



Revenue Optimization Strategies



CMI Improvement

Limit UR losses via Improved Communication

Cost reduction- LOS

Denials/DRG Downgrades Prevention

Analyzing Strategies

Clinical Documentation Improvement

Strategies to Improve CMI

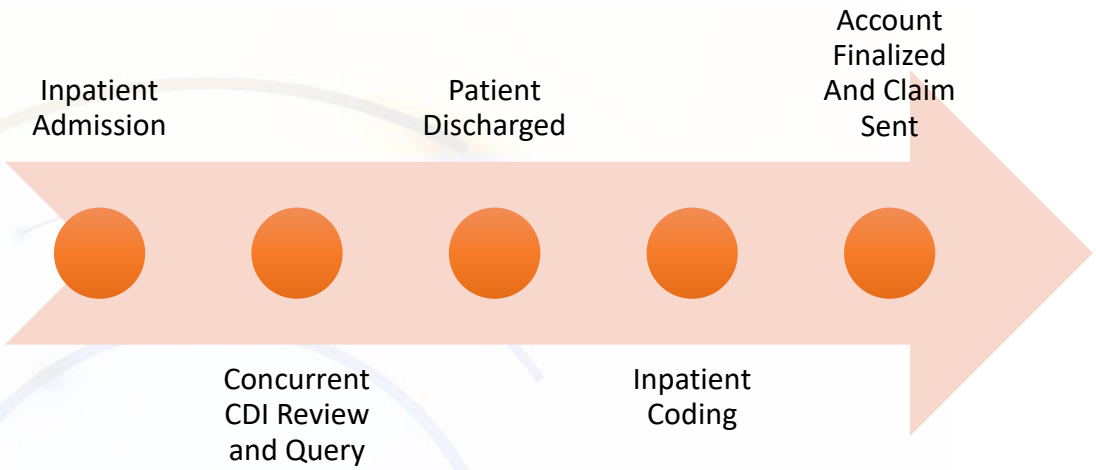
In House Highly Efficient Physician CDI Program with revised workflows

Physician Auditors feedback system based on coding guidelines

Face to Face Provider CDI education and daily meetings

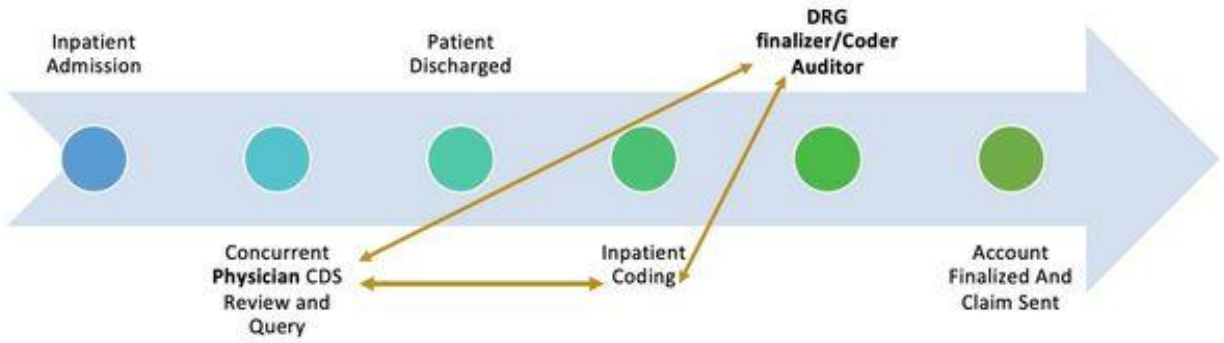
Working with the CMO to update clinical query criteria!

Revising 'Obsolete' Workflows



- Simple linear Workflow
- Obsolete CDI Model
- No Communication between Coding and CDI team
- Coders are not usually clinically savvy and have the final say.
- Lack of reconciliation process for the CDSs to ensure that the improvements achieved concurrently are reflected in final coding.
- No CDI/Coder Audit Process

Transformative CDI Workflow



- Robust design with Multidirectional Communication
- Interdepartmental Multidirectional Communication Model
- Concurrent Querying and Coding done by a physician CDS
- DRG Finalizer/ Coder Auditor is also a physician with Certified coding specialist certification
- 100% audit of Inpatient Coding and CDS work
- Open communication between Coding and CDS, Coding and Auditing, Auditing and CDI

Physician CDI and Auditor CMI Impact

- Direct impact through queries
- Example of DRG optimization

Medicare			
Version	DRG	Weight	Total
41.1	066	0.6875	$5184.95

- Capturing clinically supported MCC

Medicare			
Version	DRG	Weight	Total
41.1	064	2.003	$15106.12

- Indirect impact through code sequencing
  - Patient with acute respiratory failure and aspiration pneumonia
  - Both present on admission with equal thrust of care
- PDx: Acute respiratory failure
- SDx: Aspiration pneumonia

Medicare			
Version	DRG	Weight	Total
41.1	189	1.232	$9291.43

- PDx: Aspiration pneumonia
- SDx: Acute respiratory failure

Medicare			
Version	DRG	Weight	Total
41.1	177	1.6964	$12793.83

Is it unethical/illegal to do any of this?

ABSOLUTELY NOT

- In 2008 Inpatient Prospective Payment System final rule, CMS stated that " There is nothing inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payments.. Supported by documentation in the medical records."

Case Study: Successful Transformation

Michele Vanoni

- A successful Senior Revenue Cycle Director at Lawrence Memorial Hospital in KS who transformed her revenue cycle through her vision and successful partnerships.

Lawrence Memorial Hospital ,KS

Founded in 1921, LMH is a 174-bed hospital located in Lawrence, Kansas.

LMH Health continues to be a community-owned, not-for-profit hospital that serves the health care needs of the community regardless of an individual's ability to pay.

Dedicated to improving the health of the community, LMH invests all excess revenues in services, equipment and facilities which further that mission.

Challenges

- Low CMI
- Lack of coding auditing
- Mismatch between level of care given, Quality scores and clinical documentation.
- LOS and Transfer DRG Issues

Steps Taken to transform revenue Cycle

- Implementing Physician CDI program
- Introducing Physician auditors
- Revising workflows to include real time communication between coding, CDI and auditing teams
- Interdepartmental collaboration

Results

- Increase in CC/MCCs
- Improved Risk Profile and Quality Scoring
- Increased CMI
- Improved bottom line

Analyzing Strategies

Transforming Utilization Review and Case Management through an interdepartmental collaboration

CM Impact: LOS

CM is often unaware of the exact GMLOS of the patients

An open & a collaborative interaction between CDI team and discharge planning team can reduce the gap between LOS and GMLOS

UR Impact : Transfer DRG

"Under the post acute transfer rule, certain DRGs are subject to reduced payment if a patient is discharged early and receives qualifying post-acute care"

Rounds/LOS meeting, directly discussing opportunity of clinically supported additional diagnosis.

Query for acute respiratory failure with agreement will adjust GMLOS

Increased total reimbursement and GMLOS from DRG optimization

If patient discharged prior to new GMLOS, it would result in an underpayment

SEPTICEMIA OR SEVERE SEPSIS WITH MV >96 HOURS	6.9678	6.9678	13.5	16.0
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	1.9795	1.9795	5.1	6.9
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	1.0260	1.0260	3.6	4.3

UR impact : Mechanical Ventilation

Ex. Patient diagnosed with Sepsis due to pneumonia with acute respiratory failure requiring mechanical ventilation

1 min can make a substantial difference

Open communication with Providers/UR/Nursing and CDI

Mechanical ventilation 95 hours and 59 min.

Mechanical Ventilation 96 hours

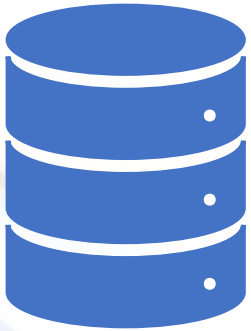
Medicare			
Version	DRG	Weight	Total
41.1	871	1.9826	$14952.26

Medicare			
Version	DRG	Weight	Total
41.1	870	6.9649	$52527.52

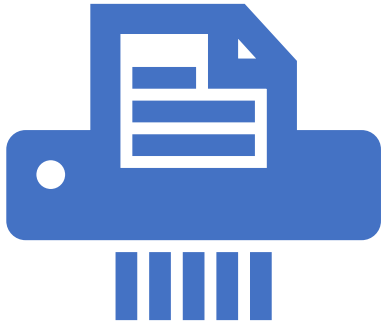
Analyzing Strategies

Denials Prevention

Root Cause Analysis



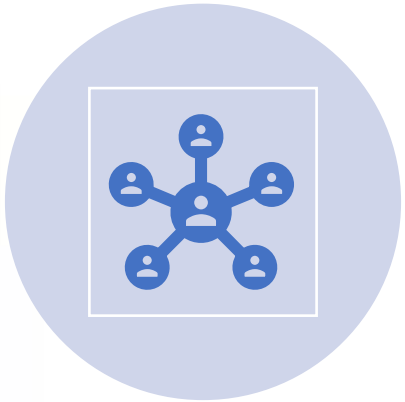
Analyze denials data and categorize it to identify common denials patterns.



Data can be sorted by account type, by service, by payor or by denial reason.

Prevention Strategies

IMPROVING DOCUMENTATION TO SUPPORT CODING AND CHARGE CAPTURE.



ENHANCING INTER-DEPARTMENTAL COMMUNICATION.

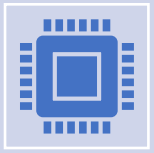
EDUCATING THE CLINICAL AND NON-CLINICAL STAFF ON DENIAL PATTERNS AND POSSIBLE PREVENTIVE MEASURES.

Summary

- Mid-revenue Cycle plays a crucial role in improving revenue cycle efficiency, which ultimately impacts a hospital's bottom line.
- Rising costs of supplies, contracted labor and growing denials have made it imperative to transform the mid-revenue cycle.
- Key Transformation Strategies can be categorized as process optimization, people integration and effective use of data analytics
- An effective physician CDI model improves KPIs like CMI, GMLOS and optimizes workflows and use of manpower to radically improve the revenue impact.

Summary

Visionary revenue cycle leaders when align with right partners can successfully transform the mid-revenue cycle.



An open and collaborative interaction between various stakeholders is the need of the hour to improve CM and UR performance.

An effective denials prevention/management begins working at the mid-revenue cycle to reduce potential denials through adaptive learning and provider education.

References

- Cost-of-Caring-2023-The-Financial-Stability-of-Americas-Hospitals-and-Health-Systems-Is-at-Risk.pdf (aha.org)
- Providers 'wasted' $10.6B in 2022 overturning claims denials (fiercehealthcare.com)
- https://acdis.org/articles/news-largest-mid-cycle-revenue-loss-linked-inadequate-documentation-according-new-report

Questions & Answers

For additional information or details of the Physician transformation:

Email me at Admin@RevCureConsultants.com

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