# Closing the Revenue Cycle Loop – an integrated UM,HIM, Provider Model Approach

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# Step 1: Concurrent Coding Model

- UM departments struggle to meet all CDI needs within their systems which ultimately impacts CMI, ROM, Quality, & Denials.
- Creation of a Concurrent Coding & Query Model helps to streamline efforts & efficiencies
- Application of the model must be founded by a strong working relationship between the UM CDI RN's and HIM coding counterparts

# Where to Begin

- Data Analysis
  - Review of Service Line CMI data
  - Identification of High Impact Service Lines
    - ? High CMI Areas
      - EI: NICU and Heart Transplant Service Lines
    - ? High Volume Areas
      - EI: Medical Admissions
    - ? Targeted Areas
      - EI: PSI or HAC rates

# Identification of Focused Service Areas

- After review and summarization of data – identify Target DRG's vs. General Areas of Focus for Concurrent Review
  - **Target DRG** EI: Heart Failure DRG's 293, 292, 291 – important to facility r/t Heart Failure Bundle reporting
  - **General Area of Focus** EI: Medical DRG's w/o CC & LOS 5+ days
  - **General Area of Focus:** Expiration Charts w/ ROM <4
  - **General Area of Focus:** All potential PSI/HAC codes
    - **Goal** of adding to concurrent coding model – HIM concurrently codes and communicates back to UM CDI those cases coded & either not coded to potential highest DRG or in need of PSI/HAC clarification. UM reviews for further documentation improvement opportunities.

# Creation of UM-HIM Concurrent Coding Inclusion List

- Summarization of Target DRG's and Areas of Focus
  - After identification of target documentation areas – creation of a shared inclusion list
  - Inclusion List -
    - Communicates to HIM staff what DRG's and Areas of Focus should be communicated back to UM for further documentation & query opportunities PRIOR TO BILLING
    - For EPIC Users - Can build Inclusion List into Workque Criteria
    - For Non-Epic Users – Can build as a Stand alone Communication tool

# Sample UM – HIM Inclusion List

| | | UM - HIM INCLUSION LIST | | UM - HIM INCLUSION LIST |
|---|---|---|---|---|
| | **SMH Target APR DRG's - SOI Review 1-3** | | | **SMH PSI/HAC Complication Clarification Needed** |
| APR DRG | 001 | Liver Transplant | | Post-op PSI's- as defined by AHRQ software |
| APR DRG | 002 | Heart &/or Lung Transplant | | HAC's- Falls & Trauma |
| APR DRG | 003 | Bone Marrow Transplant | | Pressure Ulcer 3 & 4 |
| APR DRG | 004 | Tracheostomy w/ long term mechanical ventilation w/ extensive procedure | | |
| APR DRG | 005 | Tracheostomy w/ long term mechanical ventilation w/o extensive procedure | | **Medical Admissions** |
| | **SMH Target MS DRG's - CC/MCC Review** | | | Medicare Medical DRG w/ LOS 5+ days w/o CC |
| MS DRG | 002 | Heart Transplant or Implant of heart assist system w/o MCC | | Medicare Medical DRG w/ LOS 15+ days w/o MCC |
| MS DRG | 006 | Liver Transplant w/o MCC | | APR Medical DRG w/ LOS 5+ days with SOI 1 |
| MS DRG | 012 | Tracheostomy for Face, Mouth & Neck Diagnoses W CC | | APR Medical DRG w/ LOS 15+ days with SOI 2 or 3 |
| MS DRG | 013 | Tracheostomy for Face, Mouth & Neck Diagnoses W/O CC/MCC | | |
| MS DRG | 017 | Autologous BMT w/o CC/MCC | | |

# Summary Step 1: Concurrent Coding Model

- Process so far:
  - Working Communication/Relationship between UM/CDI and HIM/Coding established
  - Data Analysis Performed
  - Identification of Focused Documentation Areas Pertinent to Your Institution
  - Creation of UM-HIM Inclusion List
- Next Steps:
  - UM/CDI review, concurrent coding, & query efforts
  - Monitoring - Focus Service CMI & ROM Rates, PSI/HAC Rates, & Denial Trending

# STEP 2: HIM Identifies CDI Opportunities

- After concurrent coding, based off of Inclusion List – HIM identifies a visit in need of CDI review by UM
- UM reviews the chart for Clinical Documentation Improvement Opportunities &/or Clarification of Documentation; EI: PSI/HAC clarification
  - Concurrent Query sent off to Provider for further documentation clarification OR
  - Chart/Communication returned to HIM with no further changes after concurrent review

# STEP 3: CMI Monitoring per Service Line

- URMC watches each individual service's CMI monthly for any trends
  - For downward trends – UM Program Coordinator does a deeper dive into why CMI dropping
    - UM Program Coordinator will request service specific data from Decision Support group for time period in question
    - Review of visits completed to identify cause of CMI drop
      - EI: Provider left URMC, Procedure dropped off IP only list, Provider on vacation, CDI opportunities missed, Payor Mixes & Contracting Implications
    - UM Program Coordinator will also request Vizient comparison data from our Quality group (as the Vizient admin)
      - Reviews the service in questions' top volume DRG's compared to same DRG's at like Academic Centers for potential CDI opportunities those facilities are capturing that URMC may not be

*Vizient is a national company that is member driven. They are a good source for comparative data & analytics. Vizient is the leader in this industry with ~95% of academic med centers & >50 % of acute care hospital systems participating. If your hospital is not a member – other resources for similar data include The Advisory Board or Conifer if used as a vendor OR your state's advocacy group. EI: HANYS – Healthcare Association of NYS or THA – Tennessee Hospital Association.

# Service Line Data Analysis Example

CMI Request
January - February 2018
Thoracic Surgery
Report Run: 3/8/2018

| Patient Account Numbe | Jan CMI | Feb CMI | Program | Sub Specialty | Attending Physician | Payor Group | Multi DRG Code & Name | CMI | LOS | Check-in | Discharge | APR DRG SOI | Final Bill Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABC1234 | | 1.5044 | SURGERY | THORACIC SURGERY | RABBIT, PETER | MEDICARE A & B | MS 328 - STOM/ESOPH/DUOD PRC WOCC | 1.5 | 11 | 2/12/2018 | 2/23/2018 | 1 | 2/28/2018 |
| DEF4567 | 17.6245 | | SURGERY | THORACIC SURGERY | BUNNY, BENJAMIN | AETNA MEDICARE | MS 003 - ECMO/TRACH MV 96+ W MJOR | 17.62 | 44 | 12/4/2017 | 1/17/2018 | 4 | 1/25/2018 |
| GHJ89101 | | 1.2027 | SURGERY | THORACIC SURGERY | BOBTAIL, LILY | EXCELLUS | APR 220- 1 - MJ STOM/ESOPH/DUODEN PRC | 1.2 | 5 | 2/23/2018 | 2/28/2018 | 1 | 3/6/2018 |
| KLM3456 | 1.9353 | | | THORACIC SURGERY | WHISKERS, SAMMY | MVP | APR 220- 2 - MJ STOM/ESOPH/DUODEN PRC | 1.2 | 3 | 1/12/2018 | 1/15/2018 | 1 | 1/21/2018 |

# STEP 4: Meet With the Providers/Service

- After Review of service specific data & Vizient comparison data when there are CDI improvement opportunities identified – next steps
  - UM meets with the service and discusses findings plus potential ways to improve via creation of documentation tools within the electronic record
    - EI: EPIC smart lists and smart phrases built out for provider easy use & efficiency
  - UM also regroups with internal staff to review findings via creation of Service Specific Documentation Improvement Opportunity Resources
    - EI: Vascular Surgery Service Documentation Improvement Guidelines Include:
      - Electrolyte Imbalance
      - Hypocalcemia
      - Acidosis
      - Thrombocytopenia
      - ESRD
      - Gangrene
    - UM front end staff uses these Documentation Guidelines as tips for what to look for, what potentially impacts the DRG when concurrently coding, and what to query for ultimately

# STEP 5: CDI Opportunities post-discharge but pre-bill – wrapping it up

- If after all concurrent UM and HIM coding and query efforts have failed to clarify or move the DRG to its target assignment then for Target DRG's on the Inclusion List (high volume/high revenue) HIM will send the visits to UM one last time for CDI opportunities after they have final coded but before the bill has gone out.

- UM will review for CDI opportunities one last time
  - If documentation improvement opportunities are identified then they UM will message the Provider for clarification and possible chart note addendum

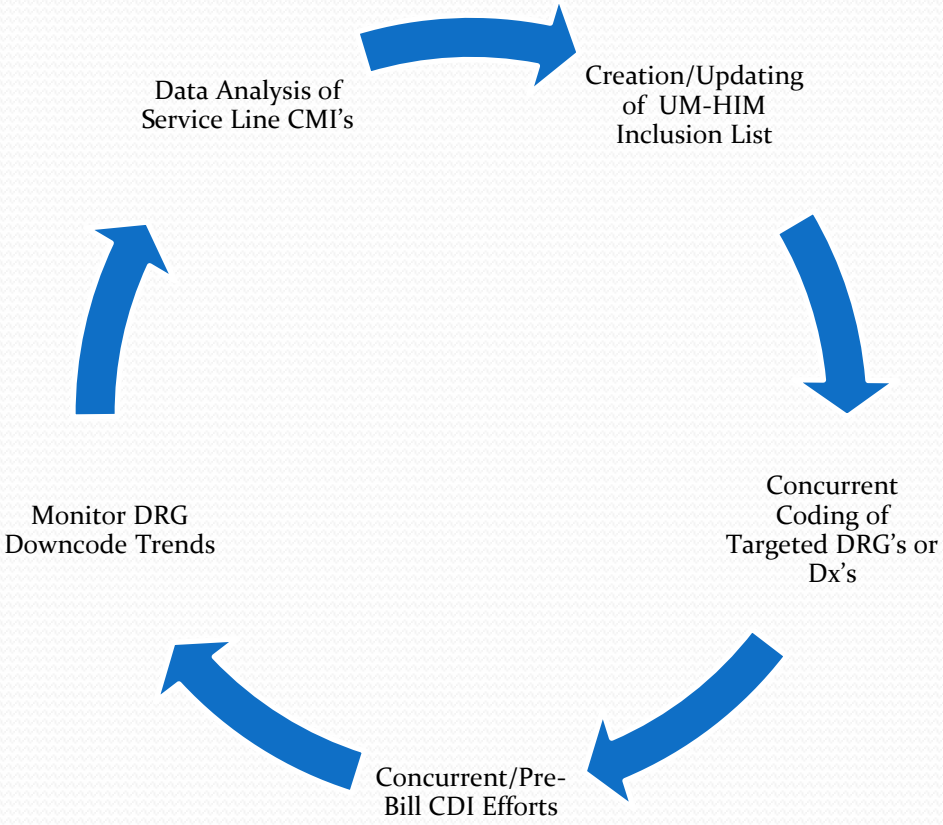
# STEP 5a: Incorporating Denials Management Trends/Findings into CDI Efforts

- Part of this process also includes HIM sending back to UM those visits that include a Targeted DRG Denial Diagnosis; those diagnoses that are seen throughout the industry as targets for coding denial as well as those DRG Denial Diagnoses seen in higher volumes at our institution specifically
  - EI: Sepsis/AKI/Malnutrition/etc.
  - UM reviews & ensures the documentation is clear and consistent throughout the chart in preventing a DRG Denial retrospectively
- Denials Management – reporting from this group should identify DRG Downcoding trends
  - Feedback related to targeted or high volume DRG Downcode Diagnoses should be given to front end for potential inclusion list add

# Model Summary

- Working Communication/Relationship between UM/CDI and HIM/Coding established
- Data Analysis of all Facility Service Lines
- Identification of Focused  Documentation Areas/Services
- Creation of UM-HIM Inclusion List
- UM/CDI review, concurrent coding, & query efforts
- Monitoring - Focus Service CMI Rates & PSI/HAC Rates
- Post Discharge/Pre-Bill CDI Opportunity Review
- Monitor DRG Downcode Diagnosis Trends via Denials Management; add diagnoses to inclusion list as applicable

# Closing the Revenue Cycle Loop



# PAYER MATRIX – ADDN'L RESOURCE

| HEALTH PLAN | PLAN TYPE | CONTRACT IN PLACE | UM CRITERIA | DRG | SURGICAL LIST REFERENCE | IP NOTIFICATION/ AUTHORIZATION | INTAKE-IP NOTIFICATION CONTACT | UM REVIEW EXPECTATIONS | MED NEC DEFINITION | ALC RATE (Y/N)(SKILLED/ CUSTODIAL) | ALC AUTH REQUIRED (Y/N) | ACUTE TO ACUTE TRANSFER REQUESTS | DISCHARGE APPEAL ENTITY | CONCURRENT DENIALS/ P2P'S | RETROSPECTIVE APPEAL GUIDELINES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| What is the name of the Health Plan? UM should look at & start to think about what Payer and Plan Type does this patient have? | What type of plan is this? Knowing the type of plan can assist UM to think - Medicare regulation vs State Regulation vs Commercial contractual obligations vs. Corpoarte policy adherance in the absence of a contract | Is there a Contract with this payer/plan? A Yes vs No can prompt UM to think Contract specific rules at play vs. having to adhere to Plan's Corporate Policies | What UM Screening Tool does the Payer/Plan Use? Interqual, Millimen, CMS 2 MN Rule? Any other guidelines - IE: Medicare C list, Plan Specific Surgical Lists? Etc. | What DRG System is used - APR, MS, AP, Per Diem? | For Surgical Preadmissions - what does the plan reference for surgical bookings. EI: Medicare C-List, Medicaid IP Only list, Interqual, etc. | Who is responsible for the initial Notification of an IP Admission & Authorization Set-up? Financial Counseling, Patient Accounts, Business Office, Social Work, UM? *This information is important when retrospective denials occur for the technicality of"No Authorization Secured"; helps to get the visit back to the responsible party to attempt to rectify/update | If UM is responsible for any Inpatient Admission Notifications & Initial Auth Requests then who is the contact & how do they reach them? | When is a UM review &/or Clinicals Requested due? IE: On admission, then every 3 days, & at D/C? Is this information in a contract or a corporate policy? If no then what is your facility's rule of thumb r/t UM Review & Clinical Requests? Also, conversely as important - what are the payers expectation for turnaround of UM review/authorization decisions? This is great info to have on hand when dealing with payers who may be lagging in review turnaround times. | Does the Payer/Plan specify what criteria/definition they use for Medical Necessity? Is it in a contract or corporate policy? Is it in line with your facility's definition(s) of medical necessity? *Watch here for payers reference to federal, state, or commercial guidelines IE: Use of 2MN rule on their MA population or strict adherance to Millimen Criteria | Does your state recognize Alternate Level of Care, Skilled or Custodialor , or equivalent SNF Rate when the patient is medically stable but awaiting dispo? *Important information to know - for states with ALC rates set by their Medicaid programs, Managed Medicaid plans must abide by the state requirements; plans will often deny this rate & ultimately deny continued stay of the patient unless challenged. Some Commercial Plans may also have ALC rates negotiated in contracts (not Medicaid Specific) so it is important to know who offers ALC vs. who does not which is the difference between IP stay still covered at a lower rate to the hospital vs. financial liability shift to patient potentially | If the plan has an ALC rate for Skilled does it require a separate authorization? Some plans require an IP auth & an ALC auth | When UM is asked if a patient is OK to transfer to an outside hospital, OSH, UM should review. Is there acute to acute contract specific language? Does the plan have a Corporate Policy on this? Is there an internal Hospital policy or Medicare Regulation that should be followed? Also should define what is UM's role & responsibility in these transfers IE: UM secures the OK to transfer from a Payer while Social Work secures the transport authorization | When a patient wants to dispute their discharge order & instructions then who do they contact? Is it a QIO vs. the plan itself? Are there forms associated with the d/c appeal rights? IE: CMS IMM form states QIO contact for D/C appeal | When a visit is concurrently denied & UM disagrees then what is your UM recourse for P2P? When can it be conducted? Who can Conduct it? What should UM do to prep/assist provider for P2P - does your facility have a P2P template? | This may be the most utilized information on your grid. For Retrospective Appeals - What is in your contract or the corporate policy for Reconsiderations, Appeal Levels, External Appeal, &/or ALJ rights? What are the timelines for appeal the hospital must abide by? What are the payer turnaround times for appeal responses? * Mnay payer representatives can be unclear on appeal levels allotted to facilities via their contracts - important to know your rights! Many payer reps may not be familiar with state specific guidelines that ensure external levels of appeal on managed Medicare or Medicaid products - important to know your rights! |
| MVP Gold | Medicare | YES | Interqual | MS-DRG | Medicare C-List | Financial Counseling - responsible for Notification of all ED Inpatient Amissions. UM - responsible for Notification of all Obs to IP upgrades occuring on Floor Units | For Obs to IP upgrade occuring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679 | NOTHING IN CONTRACT- Hospital RULE OF THUMB TO PROVIDE AT ADMIT, WHEN CLINICAL ISREQUESTED/ SHOULD BE NO MORE FREQUENT THEN Q3 DAYS, & AT D/C | This plan recognizes CMS's definition of Medical Necessity & has adopted use of CMS's 2 MN Rule Expectations for Medcial Necessity | NO - Medicare does not recognize ALC | NA | Managed Medicare plan; UM to review & confirm pt still at an Acute LOC. Pts. Still meeting Acute LOC are OK to transfer - no prior auth needed. Custodial pts. Should not be approved for transer to an OSH. | UM to Deliver IMM LIVANTA = D/C Appeal Entity Conact # 800-234-5678 | Contract states MVP to offer Medical Director availability for P2P within 24 hrs of concurrent denial notification. P2P must be conducted by an attending Provider. | MVP contract - 2 internal levels of appeal and then may go to "External Entity" for external appeal. Of note- contract guidelines prevail here & timelines are binding for denials - Level 1 appeal received - hopital has 32 days to respond/Level 1; MVP receives Level 1 and has 23 days to turn around; Level 2 appeal - hospital receives Level 1 response - 32 days to file Level 2; MVP has 23 days post level 2 received to submit to hospital a Final Adverse Determination. External Appeal - MA plan to forward on to Independent Review Entity, IRE per NYS guidelines |
| Excellus Commercial | Commercial | YES | Interqual | APR-DRG | Excellus OP & Preauth Surgical Lists | Financial Counseling - responsible for Notification of all Inpatient Admissions | NA | NOTHING IN CONTRACT - Hospital RULE OF THUMB TO PROVIDE AT ADMIT, WHEN CLINICAL ISREQUESTED/ SHOULD BE NO MORE FREQUENT THEN Q3 DAYS, & AT D/C EXCELLUS UM EXPECTATIONS: Decision, verbal notification & written notification to the member and provider must be completed within 24 hours. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. | Services will be deemed medically necessary only when all the following criteria are met: A. They are appropriate and consistent with the diagnosis and treatment of the patient's medical condition; B. They are required for the direct care and treatment or management of that condition; C. If not provided the patient's medical condition would be adversely affected; D. They are provided in accordance with standards of generally accepted medical practice; E. They are not primarily for the convenience of the patient, the patient's family, the provider of services, or another provider; F. They are the most appropriate service(s), rendered in the most efficient and economical way, and at the most economical level of care which can safely be provided; and G. When the patient is an inpatient, the medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided in any other setting (e.g., outpatient, physician's office or at home). | Skilled ALC Only | NO new auth required | Contract states acute to acute transfers to affiliates do not require prior auth approval. For non-affiliate or out of state transfers; sending hospital UM to secure transfer approval & receiving hospital secures the new authorization | UM to Deliver D/C Notice Excellus = D/C Appeal Entity Contact # 800-987-6789 | Contract states Excellus to offer Medical Director availability for P2P within 48 hrs of concurrent denial notification. Any Provider may conduct the P2P. | Excellus Contract (all commercial lines) Level 1 appeal – must file within 15 days of denial receipt; Excellus to respond within 180 days of receiving appeal; level 2 appeal- must file within 15 days of denial receipt; final adverse from Excellus to be received within 60 days of level 2 appeal receipt; External Appeal can be filed with "External Entity" – 20 days from final adverse to file |
| Fidelis | Medicaid | NO | Millimen | APR-DRG | Medicaid IP List | Financial Counseling - responsible for Notification of all Inpatient Admissions | NA | NOTHING IN CORPORATE POLICY- RULE OF THUMB TO PROVIDE AT ADMIT, WHEN CLINICAL ISREQUESTED/ SHOULD BE NO MORE FREQUENT THEN Q3 DAYS, & AT D/C | A service/treatment provided or the patient condition that warrants a specific service to be provided as inpatient care. Care that is essential and consistent with standards of care for diagnosis and treatment; provided in the most appropriate setting; and is cost effective. | Skilled & Custodial ALC (Managed Medicaid Plan) | YES - Secure new ALC Auth for ALC dates of service | Requires prior auth for non-emergent acute to acute transfer requests (Receiving Hospital to prior auth - Sending Hospital UM to call for OK to transfer --see Acute to Acute Transfer Protocol) Call Your UM Contact | UM to Deliver D/C Notice IPRO = D/C Appeal Entity Contact # 888-456-6785 | Corporate Policy states P2P with a Medical Director to be available within 24 hrs of concurrent denial. No specification r/t who can or cannot conduct the P2P. | Corp[orate Policy - RETRO DENIAL - Level 1 appeal received-hospital to respond within 60 days & Fidelis 30 days after receipt of Standard Appeal. External Appeal. No External Appeal Rights |
| United Behavioral Health | Medicare - Inpatient Behavioral Health Specific Plan | LETTER OF INTENT, LOA, TO CONTRACT | Interqual | Per Diem | NA | Financial Counseling - responsible for Notification of all Psych ED Inpatient Amissions. Social Work - responsible for Notification of all Obs to IP upgrades occuring on Floor Units | NA | In accordance with UnitedHealthcare policy, all initial clinical reviews must be received by the Health Plan within one business day of notification of the admission. Failure to provide clinical review within one business day of notification may result in an administrative denial. | LOA Specifies Medical Necessity defined by Interqual Inpatient Behavioral Health Criteria for the adolescent, adult, and geriatric patient. | NO - Medicare does not recognize ALC | NA | Managed Medicare plan; UM to review & confirm pt still at an Acute LOC. Pts. Still meeting Acute LOC are OK to transfer - no prior auth needed. Custodial pts. Should not be approved for transer to an OSH. | UM to Deliver IMM Office of Mental Health = D/C Appeal Entity | Corporate Policy states ask your UM contact for a Peer to Peer. Payer will provide reasonable access by the Health Care Provider to the clinical peer reviewer within one business day of receipt of the appeal. | Corporate Policy - Reconsideration Level - must submit within 180 calendar Days of the initial claim decision. Payer to respond within 30 business days of receiving request for reconsideration Level 1 - must submit within 60 calendar days of the previous decision. Payer to respond within 60 calendar days of receiving the request. If additional information is needed they will then respond within 60 days of receiving that info. External Appeals - Cannot file an External Appeal under NYS law. NO EXTERNAL APPEAL OPTIONS |


QUESTIONS