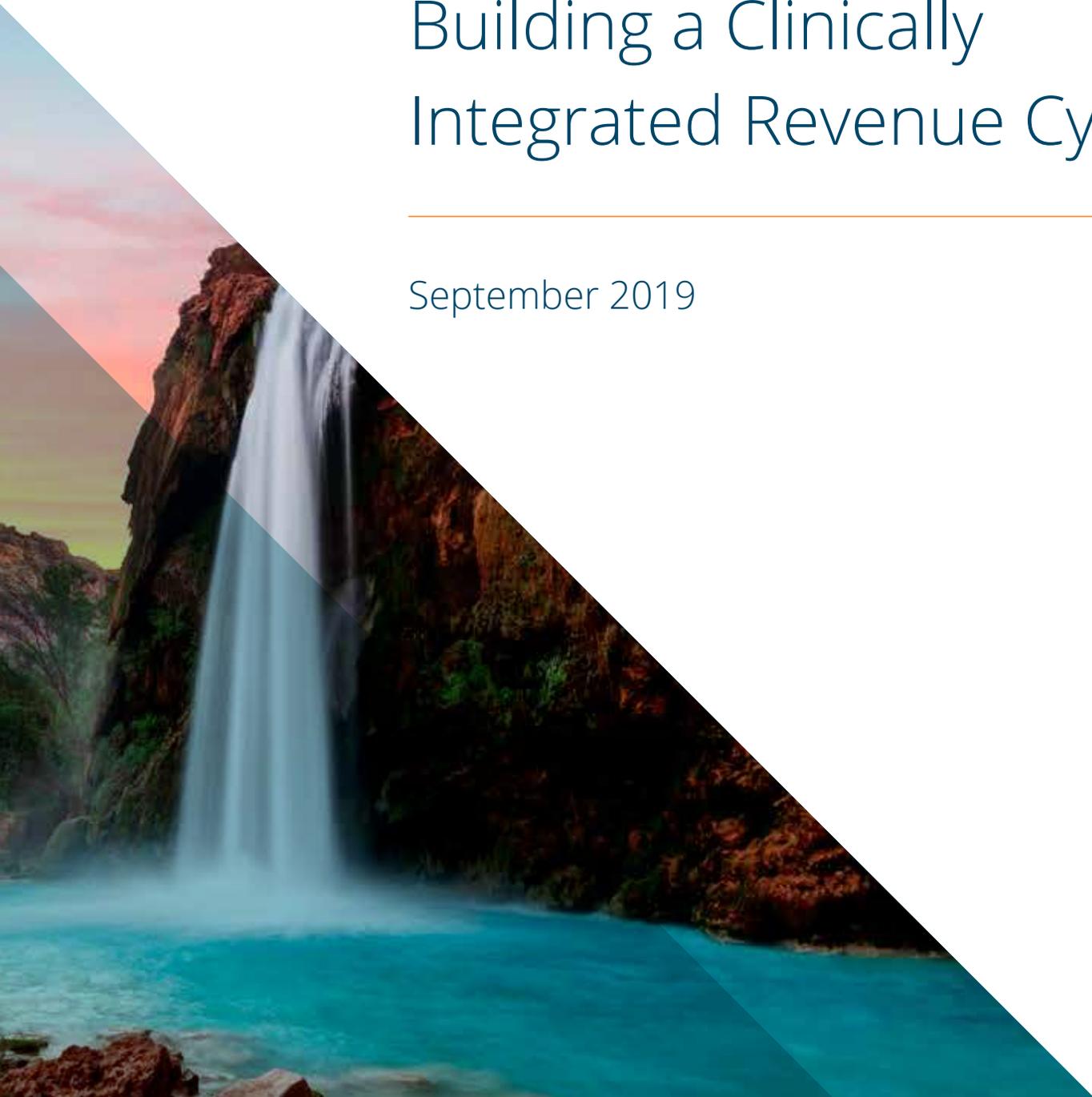


WHITE PAPER



Better Together: Building a Clinically Integrated Revenue Cycle

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For many years, healthcare organizations operated exclusively under fee-for-service reimbursement models. As such, the more services they provided, the more they were paid. A pretty simple equation, to be sure. But the model was allowing costs to spiral out of control and quality to suffer – and that, in turn, created a complex problem.

Value-based healthcare is now poised to address this cost-quality challenge. Under such models, healthcare provider organizations are reimbursed based on the quality of care delivered and the clinical outcomes achieved. As such, patients benefit from lower costs and better clinical outcomes; providers experience higher patient satisfaction rates and better care efficiencies; payers are able to control costs and reduce risks; suppliers can better align prices with patient outcomes; and society is rewarded with reduced healthcare spending and better overall health.

The growth of value-based care is evident in both federal and commercial settings. For example, the number of Accountable Care Organizations (ACO), which are a key component of the move to value-based care, have increased by an average of 63% annually from 2011 to 2018.¹

A study conducted by the American Medical Group Association (AMGA)² similarly shows that provider organizations are moving toward risk-based contracts and away from fee-for-service models.

- AMGA found that between their 2015 and 2018 surveys, federal fee-for-service payments declined by 20% and commercial fee-for-service payments declined by 8%.

- According to the 2018 survey of 75 medical group practice leaders, 56% of revenues were risk-based in the federal setting, and 28% of revenues were risk-based in the commercial setting.

- Furthermore, the survey also found that leaders are doing what it takes to prepare their organizations for risk arrangements with 74% of respondents answering that they would be ready to participate in downside-risk payment models within two years.

Addressing Risks with a Clinically Integrated Revenue Cycle (CIRC)

Taking on more risk under value-based arrangements, of course, brings a bevy of challenges. Among the most pressing: Healthcare provider organizations need to make significant changes to their revenue cycle operations to meet the requirements of a value-based world and from a denials management and prevention aspect. Denials have always been part of the organizational risk, but the landscape related to denials continues to change and organizations must shift from retrospective processing to ongoing prevention throughout the organization.

To start, organizations need to move away from traditional revenue cycle models and systems, which kept clinical and financial activities separate and contributed to denials in some cases. Under these long-standing models, roles were clearly and simply defined. Doctors and nurses, for instance, focused on the health of their patients. So, clinical pathways ruled the day. Financial professionals, likewise, zeroed in on financial pathways. Historically, the clinical

side and the financial side have traveled down separate roads but now the clinical and the financial must meet – and merge. Denials management and prevention is one of the main reasons that the clinical and financial side of the organization must collaborate and partner closer than ever before, especially as part of the CIRC.

Defining the Clinically Integrated Revenue Cycle

The Clinically Integrated Revenue Cycle captures a holistic view of the patient experience, which is required to support value-based care models. Clinical and financial resources, processes and technology are no longer siloed, but instead are integrated. Under such models, when a patient begins their healthcare journey, clinical and financial pathways alike are opened up, and their relationship is far more interwoven.

Clinical and financial professionals do not move along two separate pathways but instead traverse along a merged “clinancial” pathway.



As a result, under these integrated models, the formerly separate health information management (HIM) and revenue cycle management (RCM) departments come together and work in unison toward common goals – delivering quality patient care and capturing the True Clinical Picture through:

- Comprehensive, accurate documentation
- Accurate patient information and charge capture
- Concurrent clinical documentation improvement (CDI) programs
- Timely coding and billing processes that ensure that the initial information released to the payers is accurate

To effectively build a CIRC, these goals must be clearly defined, driven across the organization, and interwoven with both clinical and financial processes.

HIM professionals have the knowledge and skillsets, as well as an understanding of the connectors that are required to support a CIRC. For this reason, HIM professionals are well positioned to serve as change agents to move organizations from the “traditional” to the “clinancial” pathway.

Why? Because HIM professionals have always operated in the “middle” between clinical and financial and are experts in the requirements, rules, and regulations for complete and accurate billing.

Best Practices for Establishing a Clinically Integrated Revenue Cycle

HIM leaders working together with organizational leaders can take the following steps to establish and maintain a CIRC model:

Generate some buzz.

To build a foundation for a CIRC, healthcare systems and facilities must create awareness throughout the organization. It’s important to get people on board and urge them to start thinking outside of their traditional area. Implying clinicians to think about the financial piece of the equation and getting finance folks to think about the clinical documentation piece is critical.

Stack your team.

The value-based care revenue cycle team needs to look much different than the fee-for-service squad. Indeed, the clinically integrated team needs representation from multiple departments across the healthcare system – nursing, case management, quality, ancillary departments and others. It cannot just be a backend or business office-driven team.

Seek the truth.

HIM professionals understand that accurate clinical documentation serves as the foundation of a CIRC. Since data from medical records are aggregated, omissions, errors and incomplete documentation can be magnified by the various creators, systems, and aggregators. The key components can affect the patients, providers, facilities and other users of that data and lead to denials, which will take the organization away from the care of the patient, cause rework and potentially have a financial impact. To mitigate the risk of downstream errors, it is imperative that the medical record reflect the “True Clinical Picture.” Clinicians and HIM professionals both play an important role in ensuring that the medical record accurately and thoroughly reflects the care provided to the patient so the data can be utilized for effective future care, diagnoses, and treatment, as well as accurate reimbursement.

TRUE CLINICAL PICTURE: A complete and comprehensive record that serves as the source of truth by accurately reflecting the care provided. The True Clinical Picture allows healthcare organizations to make meaningful use of health information and achieve positive outcomes for both patients and the organization.

Assess RCM and HIM processes.

A revenue cycle assessment can help to identify organizational revenue cycle challenges that are affecting the bottom line, in addition to identifying areas of risk. During such assessments, it’s important to assess the master patient index, charge master, demographic and guarantor information, systems, and clinical documentation data. This is also a golden opportunity for HIM professionals to conduct a “self-assessment” in order to ensure the tools and information needed to move the organization forward are available to the entire HIM team.

HIM professionals understand it’s more important than ever before to make sure data is accurate. If a patient’s name is entered wrong at registration, for example, that will have a negative effect downstream. So, healthcare organizations need to purposefully analyze processes they use for collecting the right data and producing the best clinical documentation.

Example: Organizations often discover that some clinical documentation templates actually produce denials. This can be attributed to templates that are not current or accurate – they may have been put in place at systems go-live and never revisited. Furthermore, in some organizations over the past several years, IT has moved into the role of template owners and HIM may not play the same role in the development, implementation and maintenance of the templates. With value-based care, HIM must re-engage in the creation and maintenance of templates in order to achieve a constant state of preparedness, consistency, and integrity of the data.

Additionally, HIM professionals must work closely with organization leaders for the evaluation and implementation of appropriate technology and systems. Multiple systems across the organization that do not always share information can contribute to denials and misleading analytics.

Managing Denials through Integration

Denial management and prevention in the value-based world is one area that clearly illustrates the need for a CIRC.

Denials are fiscally painful. In a perfect world, provider organizations provide a service, get paid, and are able to reinvest the money into their operations. But when there are denials, payers ask for the payment back retrospectively. Organizations then find themselves in a situation of having “paid their rents and eaten their dinner” – being asked to pay back money that has already been reinvested. This is why processing denials quickly is so critical for healthcare organizations. However, doing so is a complicated endeavor.

Imagine the following scenario: A hospital has a stack of payment denials that need to be resolved. To accomplish this, the revenue cycle management team needs to access patients’ electronic medical records (EMR). The problem is that in most healthcare organizations, the RCM workflow is disconnected from the HIM workflow.

With a traditional revenue cycle model in place, the RCM denial team would use a low-tech means to notify the HIM department of the need for medical records. For example, they might fill out a form on a SharePoint site or in Word and email or fax it to the HIM department. The HIM department would receive the request and place it into a general records request queue. Typically, there is no way for the requester to indicate that the record is needed in five days in order to ensure timely filing of the denial and proper reimbursement.

Another option might be to allow RCM staff to directly access the electronic medical records (EMR.) This alternative, however, introduces significant risk, including giving staff members who typically don’t work with clinical information full access to electronic records. What’s more, you’re taking these staff members outside of their skill

set, which is to understand payment requirements and payment policies not to interpret clinical documentation.

A CIRC-driven Denials Process

With a CIRC, when RCM staff come across an account that requires information from the medical record, they can request those records from HIM systematically, without gaining entry to the complete electronic health record system. When the request is connected to both the primary RCM workflow tool and HIM's release of information process and system, requests for records tied to a denial can be prioritized above requests that are not as time sensitive – and don't have the financial repercussion a denial does. Furthermore, the system could prioritize requests based on the value of the denial – a \$50,000 denial will be given higher priority than a \$100 denial. This process definitely outlines a step in the proactive direction of addressing denials.

Another benefit of an integrated approach is visibility. Clinical and financial teams can work more efficiently when they both have visibility into how much time remains for the provider to respond to the denial, how much the denial is worth, whether it is the first or second request for clinical information, and how the information needs to be delivered – whether that is electronically or by fax or in person.

Visibility plus the use of analytics to correct avoidable denials through easy-to-interpret information that is driven from source data such as the 835/837 files and remit files, coupled with CMI data, coding data and a quality lens is key to addressing the denials challenge that all organizations struggle with.

A Call to Action for HIM Professionals

To optimize the revenue cycle, the clinical and financial paths must be brought together so that it is easier to move toward the common goals of delivering high quality patient care and being reimbursed appropriately for the level and quality of care delivered.

Who better than HIM professionals to lead the charge towards the CIRC? HIM professionals are uniquely qualified to:

- Understand and utilize data to address a multitude of challenges – and to share that knowledge across the organization
- Assist all contributors in the world of documentation and advocate for complete, concise, and clear documentation
- Drive the shift from denials management to denials prevention
- Guide the integration of clinical and financial processes and data to succeed under a reimbursement system that hinges on quality of care and outcomes achieved

The Clinically Integrated Revenue Cycle is not a single person, process or technology, it is a cumulation of many different people, processes, and technologies that bring varying skill sets to the table to ingest information and make informed decisions based on data.

At the end of the day, everyone wins through quality – patients receive optimal care, healthcare providers benefit financially and operationally and ultimately, everyone realizes the benefits that come with the availability of high-quality health information. Focusing on improving the quality of documentation and medical records will allow you to consistently present the True Clinical Picture that, when part of a Clinically Integrated Revenue Cycle, allows your organization to make meaningful use of health information and achieve positive outcomes – both clinically and financially.

References

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- 2 American Medical Group Association. Taking Risk, 4.0: Clearing a Pathway to Value-Based Care. <http://www.amga.org/wcm/SM/2019/takingRisk4.aspx>

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As Vice President of Provider Solutions, Geoff New leads a team that develops comprehensive Revenue Cycle Management solutions for health systems. An experienced leader with more than 27 years of professional experience in the healthcare industry, Geoff excels at delivering quality services that improve fiscal performance for hospitals and health systems, and he has spent his career working collaboratively with senior leadership, vendors, colleagues, staff, and facilities to exceed operational objectives.

He holds a Master of Science in business administration, a Bachelor of Science in health information administrative services, and he also holds an associate degree in health information management. Geoff is a Registered Health Information Administrator (RHIA) and has also earned a Certified Revenue Cycle Representative (CRCR) designation. He is an active member of numerous professional organizations, including the American College of Healthcare Executives (ACHE), American Health Information Management Association (AHIMA), and Healthcare Financial Management Association (HFMA).



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