As hospitals and health systems face tightening margins, increased regulatory review, and a shift toward value-based payment, many find clinicians playing a greater role in revenue integrity initiatives. With this in mind, this HFMA Executive Roundtable, sponsored by Adreima, focuses on ways healthcare finance executives can work with clinicians to improve revenue integrity and how to best position these initiatives for success.

### How important is the clinician role to revenue cycle performance, and how would you say this influence has changed in recent years?

**Craig Morley:** The clinician role is very important and is becoming increasingly so from two perspectives: increased scrutiny of claims by payers and higher patient deductibles. As a result of greater scrutiny of clinical documentation, the assumptions behind what was billed have to be able to stand. And as patients shoulder increased financial responsibility within their coverage, they increasingly are concerned about the impact of payment denials.

**Charles Reitano:** Changes to the payment system and shifts in care delivery are also an influence. Today, as we focus on quality- and value-based reimbursement, physicians’ ability to accurately capture patient health status is increasingly important. Complete and accurate documentation also helps ensure smooth transitions of care between the professional- and provider-based settings.

In addition, physician practice revenue cycle management is becoming increasingly important for those who employ physicians. It has a greater influence on the bottom line, as care delivery continues to shift to less acute settings.

One thing that is really helpful at Cooper, where we employ more than 600 physicians, is the integration of the physician leaders with the institutional leadership team. That alignment helps us with our strategic plan, supporting a unified vision for driving clinical and financial performance.

**Mary Anne Taukiuvea:** I’ve seen a pretty drastic change in prioritization of the physician’s role, in particular with regard to revenue integrity. Some of this emphasis is due to us pushing for greater accountability. But the impact on the organization’s financial performance is also worth noting.

I recently completed a study for our organization’s CFOs that examined revenue loss associated with denials performance. Interestingly, even though our denials associated with medical necessity and non-covered services have gone down in quantity for the past couple of years, they have gone up in dollar impact by 320 percent. In 2013 we had $8.2 million in medical necessity denials, and in 2014 we have $34 million. In non-covered services, we went from $218 million to $382 million. Are we winning many of these challenges through appeals? Absolutely. But payers are still denying them at the outset.

### PARTICIPANTS IN THE HFMA EXECUTIVE ROUNDTABLE

- **Craig Morley, MBA**, is senior director of revenue integrity, Banner Health, Phoenix
- **Charles Reitano** is vice president of revenue cycle, Cooper University Health Care, Camden, N.J.
- **Mary Anne Taukiuvea** is director, denials/appeals/payer coordination, Intermountain Healthcare, Salt Lake City
- **Glen Reiner, RN, MBA**, is senior vice president of clinical services, Adreima, Phoenix
To me, what this trend is saying is that payers are looking closely at how well we are meeting medical necessity and authorization components, and that we need to continue to be particularly vigilant in these areas as a result of this growing financial risk.

Glen Reiner: Over the past 10 years there has been an increased focus from all payers, initiated by Medicare, on clinical decision making and documentation. In the past, we typically would see registration as the leading cause of denials. However, over the past three years, we have seen an increasing shift in the percentage of clinically related denials. Regulatory requirements around short-stay patients, readmission requirements, and a continued increase in the correlation of clinical quality to payment have created an environment that requires the active engagement of clinical resources in the revenue cycle.

In addition to the payer focus, the pressure of consumerism in health care will require clinical engagement. As changes in payment and coverage methodologies increase the number of price-sensitive, savvy consumers, there will be an increased need to demonstrate the effectiveness of clinical outcomes compared with consumer cost.

What types of revenue integrity initiatives are clinicians engaged in at your organization?

Taukiuva: Our efforts at Intermountain Healthcare have grown significantly through the years. About 10 years ago, we were writing off many claims. We recognized the need to effectively manage appeals, so we created a denials management team that was initially quite small, comprised of five individuals. Since then, our efforts have expanded to maintaining an appeals unit of about 90 individuals that covers all of our 22 hospitals. All denied claims that require a hard appeal [not a soft denial] are automatically routed to the appeals unit, which tracks and trends performance by insurance company, DRG, and physician. In this way, the unit helps us understand and educate clinicians about performance in relation to medical necessity, non-covered services, preauthorization status, pre-existing condition documentation, and so forth.

As part of this denials management effort, we hired registered nurses and approached the case managers at our facilities to identify the data needed to accurately demonstrate to the insurance company the reason for the appeal. At the same time, we have been educating the case managers about changes needed to ensure information is accurately and completely captured and reflected in processes going forward.

In many instances, the registered nurses are acting almost in a consulting role. As physicians become more focused on revenue integrity and the appeals process, they have started to seek information from the nurses.

Morley: We currently are involved in a large initiative at Banner focusing on revenue integrity processes in relation to five key focus areas: defining patient medical necessity status before admission; managing length of stay in the observation unit; improving case management/utilization management to avoid denials and managing inpatient length of stay; refining clinical data documentation services to ensure the DRG accurately reflects the clinical situation; and improving denials processes and reporting overall to make it most useful for stakeholders, from improving department feedback loops to communicating the most meaningful trends.

From a collaboration perspective, we’re trying to improve cross-communication about efforts in all five areas. We want to share what we are learning about challenges in appropriately identifying status, assigning working DRGs, and understanding how to effectively capture the information needed so that when we are trying to appeal the case we have a consistent, solid background regarding clinical judgment.

What are some of the biggest challenges you face in these efforts?

Morley: One of the challenges relates to our technology. When a clinician asks why he or she is getting so many denials, it can be challenging to dive into the data since the system’s denial database is not linked with our electronic medical records system, which in turn doesn’t directly link to our billing system. With such disparate systems, it’s challenging to provide drill-down capability or share a global dashboard.

Another key issue is identifying and communicating metrics that will be the most meaningful for various stakeholders. For example, physician executives may be most interested in outcomes data while the financial team will want to examine driver metrics that show whether the front-line processes and staff are working appropriately. Many of those sets of metrics are multi-dimensional and derived from multiple systems. So you may struggle with how to compile the information into a single database and best tailor reports for the various users. To do this successfully, you need the right resources. Although we have strong analysts in the financial and clinical care areas, we sometimes see talent gaps where these areas overlap. As a result, as in many other organizations, it’s easy to be data-rich and dashboard-poor.
Reitano: We have recently moved to a matrix management model that includes institutes and service lines, and this structure can make looking at revenue integrity data more challenging. We no longer have a division reporting to a clinical department with a leadership structure that operates as a silo. Instead, we have opened up the reporting structure such that the service lines are co-managed by physicians and operations/business leaders. For each service line, we have an executive director and a clinical director who work hand in hand to drive growth, service, and quality improvement. Although this structure aids accountability and decision making, it can be challenging to follow up with meaningful data and information, since we’re now organized on a different level. You’re not looking at data by department anymore, which is how your revenue, charge, and claims information is set up. In this way, reporting and trending to support revenue integrity become more challenging.

That said, we’re doing pretty well. We bring our cost-accounting data from our two legacy systems into a data warehouse. Then a talented analyst team in our finance department is able to take that data and map everything down to the service line level.

What role do clinicians play in denials management?

Morley: It has to be a clinical and financial partnership if you’re really going to address improving your denials. The biggest strength I have on our initiative is Banner’s vice president of clinical stewardship. He leads the projects and works with the clinical teams in our hospitals. The vision for improvement and continued reinforcement of that vision from a physician leader is critical to the success of any project. We have also engaged a number of clinicians to help with the project work, including physician advisers, case management leaders, and physician leaders.

Reitano: We have a utilization management committee, and part of its standing agenda is dedicated to examining case management denials and downgrades. Fifty percent of that committee is physician-based. We regularly talk about level of care, authorized stays, carve-out days, and so forth.

To support our service line leaders, we put together narratives and summaries of our denials trends. We then review the narratives with the clinical director and executive director of each service line and discuss areas for performance improvement.

Taukiuva: We have also garnered physician support for leading process change by sharing data. We share information with the clinicians about accounts that we have had to appeal and how many dollars we are retaining by winning those appeals. We also share data to help clinicians understand areas of revenue loss, recognizing that insurance companies have a fiduciary responsibility to withhold payment for services that aren’t medically necessary. The other component is sharing administrative write-offs associated with missing or improper authorizations or incomplete documentation supporting extended length of stay and so forth. We help clinicians better understand the role they are playing in relation to financial performance.

Can you describe any challenges associated with gaining cooperation from those in a clinical role, and some of your tactics for garnering their support?

Morley: We are currently in the middle of the previously mentioned project. One of the first areas where it was challenging to unify the clinical and financial teams was in the development of common goals and objectives. That’s because even when goals and objectives are appropriate, they often naturally conflict. Consider operations within the emergency department (ED), as an example. Clinicians are highly focused on improving patient flow, which is frequently measured in “door-to-doc” and “doc-to-door” time to support productivity and minimize wait times. But if you’re trying to best manage whether a patient should be admitted with observation or inpatient status, then it may be more desirable to build in time to receive an additional lab test or complete an X-ray—that step naturally works against the ED goal of “doc to door.” Also, when you have independent ED physicians, they may have contract metrics related to “doc to door,” and so you may have already given them a message to work on those metrics, and now you will be approaching them to engage in a different way to manage the patient. To further complicate the issue, ED physicians and hospitals often have different objectives that they’re working to achieve.

Therefore, as you optimize the functional silos of whichever specialty you engage with, you need to be aware of potential consequences that can sub-optimize the collective goal or objective across the care continuum. You need a physician leader who can navigate these complexities and share a global vision for how we can collectively work together.

Reitano: Although you want to obtain a high level of integration and collaboration with clinicians, you need to be respectful of the productive time that a clinician has in the office, and recognize that your access to
discuss issues is sometimes limited. You have to understand and respect the operational pressures that physicians are under.

Proper preparation also is key. You have to be ready to navigate complex conversations and provide meaningful data to help physicians better understand the many ways that their work related to the revenue cycle has importance.

Many providers are focused on ensuring compliance with the two-midnight rule. What are some strategies you use to effectively educate clinicians on such issues, where processes not only need to support the right clinical decision, but also meet criteria that have financial impact?

**Morley:** Education up-front is important. We provide formal education when an issue arises, whether it’s the two-midnight rule or any other issue where clinical actions need to comply with regulatory guidance. For addressing day-to-day issues, we have seen the greatest benefit from enlisting the help of a physician-adviser organization. These individuals interact peer to peer and are able to explain the impact around a process change from both a clinical and financial perspective.

**Reitano:** We have very tight service line leadership, but when we talk about these areas where regulatory language meets clinical practice, we rely on the medical director to develop the plan for how the physicians need to digest this information. Our medical director determines the best way to monitor current processes or the data needed from the financial team to help drive the change.

**Taukiuvea:** We, too, rely on clinical leadership to steer education. For example, we send weekly reports to all the case managers showing any inpatient who stayed less than two midnights and any outpatient who stayed more than two midnights. We sort them by admitting diagnosis, region, facility, and by attending physician. For every one of those that are under two midnights, we pass it through to our internal physician-adviser group and they assess whether accounts did not meet inpatient criteria. With those that didn’t meet the criteria and we had to bill Medicare Part B, the group will highlight them for the medical directors. The medical directors will then use these as examples when further educating the physicians about the criteria.

Any parting advice to others about supporting long-term revenue integrity success?

**Reiner:** The true goal of any effective revenue integrity program goes beyond denial resolution to denial prevention. As the volume of clinical denials increases, we are seeing that it is no longer realistic to expect the care management area to both focus on current in-house patients and work retro denials. From a best-practice perspective, creating a dedicated denials management team with clinical resources in the business office proves to be an effective way to increase cash flow by quickly resolving denials. In addition, future performance is improved because the denials management team is focused on collecting actionable root-cause data and the care management team is focused on preventing denials for patients currently in-house. The more emphasis placed by the denials team on understanding why the denial occurred and on providing meaningful information to the care providers, the more effective subsequent interactions will be.

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Adreima provides clinically-integrated revenue cycle services to over 700 hospitals to capture the full value of their services through innovative revenue cycle solutions. Our specialized clinical, technical, and financial experts are engaged in the conversation of healthcare reimbursement with proven solutions in areas ranging from ED Registration Staffing, Eligibility Advocacy, Revenue Integrity, Denial Management, Coding Services, Clinical Audit Services, A/R Management, Conversion Support, RA/ADR Defense, Patient Responsibility Account Resolution and Bad Debt Collections. The results are clear—regulatory readiness, optimized cash flow and reimbursement, appropriate revenue recognized, better patient experiences, and operational efficiency.