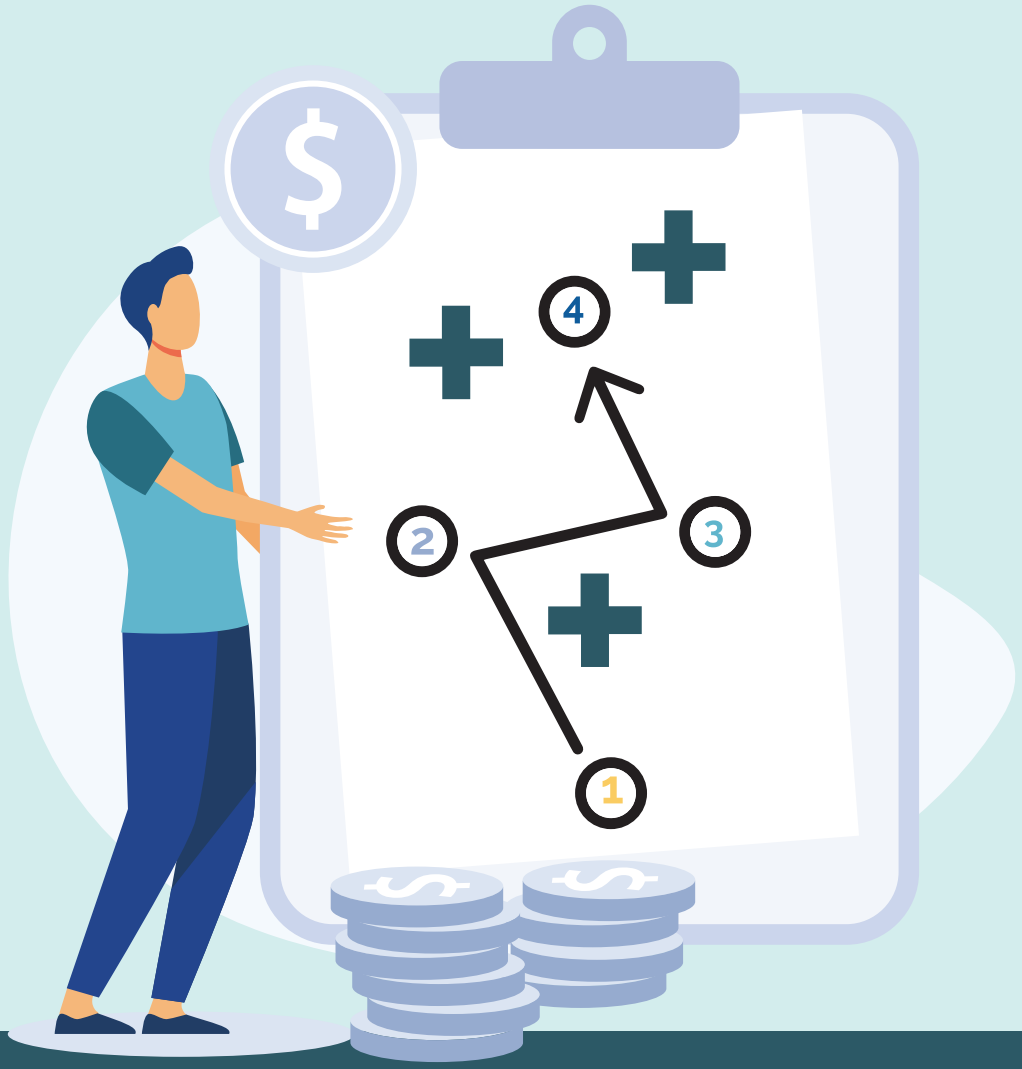

Playbook for High-Value and High-Impact Pre-bill Reviews

4 techniques that produce **BIG** results

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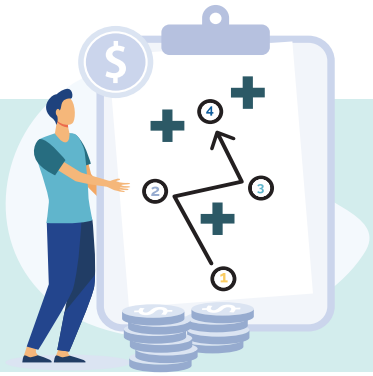
Executive Summary



Hospital financial performance, although improving, remains constrained due to shifting patient volumes, lower reimbursement proportional to cost of patient care, and ongoing expense due to staffing challenges. With decreased revenue, increased costs, shifts in payer mix, and lower operating margins, savvy revenue cycle, CDI and HIM leaders need to look for innovative ways to ensure revenue integrity and financial sustainability while driving a competitive patient experience measured in care quality outcomes.

To remain competitive, healthcare providers can double down on pre-bill review programs. An important step to revenue capture, pre-bill reviews are a post-code review of documentation and coding within 24-48 hours of discharge and prior to the final bill to avoid impact on discharged, not final billed. Organizations that invest in this proactive approach ensure physician documentation supports coding compliance, MS-DRG and APR-DRG accuracy, and quality performance data prior to claims submission. Ultimately, a pre-bill review should promote coding accuracy to drive improved revenue integrity, risk mitigation and denial rates prior to claims submission. With the growth of value-based care, coding accuracy to support pay for performance is just as important.

All pre-bill reviews are not created equal. To be successful, revenue cycle, CDI and HIM leaders must consider integral elements at every step in their pre-bill review strategy.

This playbook shares four techniques that produce big results for pre-bill reviews and ultimately, a physician-led approach to ensure clinical and coding accuracy for revenue stability.

1

Case Mix Index (CMI)

Case Mix Index (CMI) is a historical metric estimating reimbursement tied to inpatient severity and patient volume. COVID-19 temporarily reset CMI expectations; however, it no longer holds true which has created a vulnerability for hospital financial performance.

CMI is driven by the clinical and financial classification of patients based on the reason for admission, comorbidities, complications and associated procedures. So capturing patient complexity through accurate coding and documentation is paramount. In addition, the exactness of the medical record ensures truth in quality measure reporting.

For these reasons, healthcare organizations should seek out expertise in active patient care and clinical coding to ensure financial stability.

For one Enjoin client, CMI rose from 1.5 to 1.8 — adding $18.1 million annually after implementation of a daily pre-bill review process and development of a physician advisor program.

Here's how CDI efforts impact CMI

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2

DRG Optimization

Designed to enhance financial and clinical accuracy, DRG assurance as part of a pre-bill review program helps revenue cycle, CDI and HIM leaders thrive amidst today's market challenges. We know this to be true because we take clients on a deep dive into their current level of DRG accuracy to discover new revenue and education opportunities. Clinical validity within documentation and coding practices fortifies financial accuracy and mitigates denial risk.

Capturing accurate and appropriate CCs and MCCs (CC = Complication or Comorbidity MCC = Major Complication or Comorbidity) to drive reimbursement plays an especially important role with surgical DRGs. For example, applying clinical and coding expertise for additions of MCCs or CCs for small and large bowel procedures can result in a higher weighted DRG.

Example: For one academic health system, leveraging clinical and coding expertise shifted DRG 331 to 329/330, resulting in an accepted ROI of approximately $1M in one year.

Here's how to achieve revenue recovery with DRG optimization:

Review coded discharged records for documentation and coding opportunities with 24-hour TAT prior to claim submission.

Discuss cases with clinical coding analysts and board-certified physicians with coding credentials (added benefit: supports a proactive approach for denial prevention).

Filter daily feedback and provide physician-led recommendations that integrate evidence-based clinical medicine and coding rules and guidelines.

Optimize principal diagnosis sequencing (often missed with technology tools).

Create a customized focus list to narrow and shift focus for high value/high impact.

- Ensure your vendor provides free denial defense on any chart reviewed.
- For optimal results, clinical coding analysts should work directly with board-certified physicians who are also credentialed documentation and coding specialists. The result? A powerful combination of clinical insight with coding know-how.

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2

DRG Optimization

Interested in turning process into strategy? Enhance your current physician advisor program with a focus on DRG assurance.

Include these KPIs:

Case Mix Index (CMI) (medical and surgical)

Denial rate by payer/denial write-off as a percentage of net patient revenue

Discharge not final billed (as a function of program efficiency and provider participation)

Revenue at risk (amount of decreased payment due to errors or clinical validation)

Revenue recovery (amount of added payment)

Identify your greatest opportunities for revenue recovery with Enjoin's DRG Assurance Program.

Learn more here

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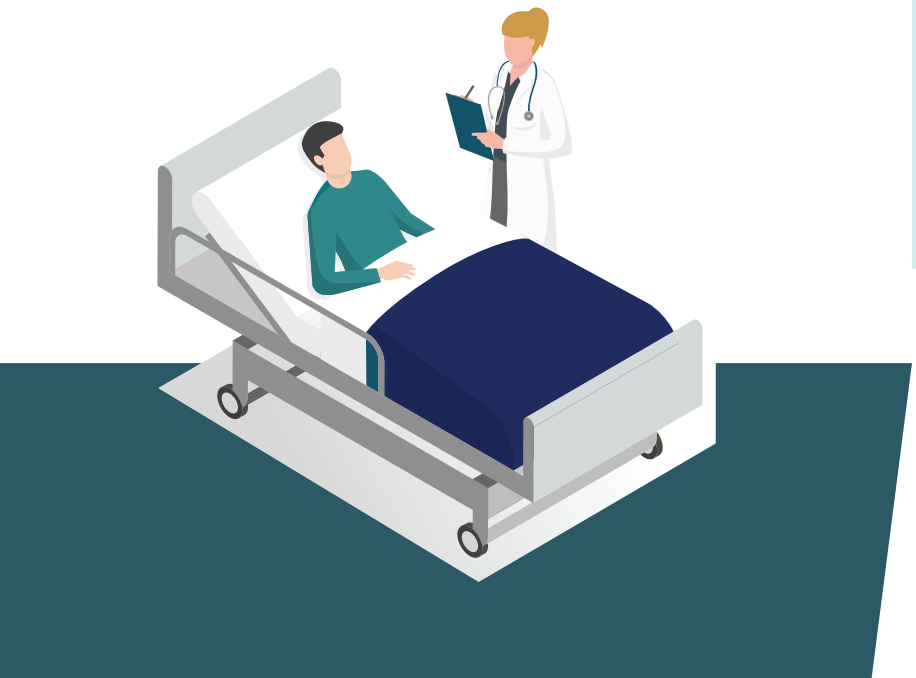
3

Clinical Validation and Documentation

By validating the entire clinical picture in a pre-bill review, you mitigate the risk for future denials.

Documentation must represent the patient story. This requires a delicate balance of clinical validation and coding. By ensuring clinical documentation accurately reflects the high-quality clinical care patients receive, a thorough pre-bill review program can help an organization stop significant revenue loss associated with avoidable payer denials.

Case in point – For the past 3 years, 69% of Enjoin's pre-bill review recommendations were related to principal diagnosis selection. Technology alone can't accomplish this and physicians who don't have clinical acumen can't detect this.



How to Ensure Payment with Principal Diagnosis

To consistently and reliably arrive at the optimal and valid principal diagnosis requires expert clinical interpretation of the documentation in a patient's record. Records can be very complex, including conflicting documentation, indicators present but the condition is not documented or a diagnosis is documented but not supported by the information in the chart. Navigating this complexity requires clinical expertise, an understanding of the current ICD-10 CM/PCS coding guidelines and the regular updates issued by the Coding Clinic. When it comes to reimbursement and denials, don't underestimate the power of a physician-led team to generate compliant queries and diagnoses.

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3

Clinical Validation and Documentation

How do you maximize clinical validation and documentation? Develop a physician advisor.

A physician advisor program should focus on the mid-revenue cycle, which is when providers translate bedside care for accurate payment, justify services rendered and measure quality. [1]

TIP
Physician advisors also must be able to speak both clinical and financial languages to bridge operational and knowledge gaps.

A strong PA can bring advanced clinical coding insights not only to reinforce CDI and coding but also to enhance physician engagement, increase query response and acceptance rates, and foster long-term program success. Additionally, PAs contribute to revenue growth and denial reduction.

79%

Of pre-bill review recommendations were related to Principal Diagnosis selection consistently over the last 3 years.

To break down silos between clinical care and finance, leaders from these two areas should work together to identify a champion to oversee the physician advisor program. This person should:

- Be an exceptional, respected clinician and communicator who is intellectually curious and dedicated to lifelong learning.
- Exhibit a genuine interest in how clinical documentation affects revenue, quality and utilization.
- Be able to understand a variety of clinical and administrative workflows.
- Be humble and willing to relinquish control and learn from others.

4

Elevate Quality Outcomes with Pre-bill Reviews

As healthcare continues to shift from volume to value, new payment models and evolving measures of performance are changing the way health care systems operate.

Value-based payment models have introduced numerous claims-based, risk-adjusted quality outcome measures which impact both financial performance and quality profiles.

Risk-adjusted mortality rates, readmission rates, complication rates, patient safety events, and episode payment models are significantly impacted by the integrity of documentation and code assignment across the continuum.

Methods to Consider

Hospital Specific Report Analysis to identify opportunities.

Incorporate quality cohort reviews in the pre-bill process.

Quality measure reviews for cohort accuracy and top risk adjustors.

Customized physician-led Quality Measure Training.

Outcomes from Quality Cohort Reviews

Accurate representation of expected rates associated with hospital centric, claims-based performance programs.

Strengthen reimbursement and quality profiles for performance measures derived from claims data.

Bridge comprehensive coding beyond the DRG.

“The Pre-bill review process plays an integral part in the education of our coders and CDS and has enhanced physician communication through improved queries. We have no doubt that you have helped us achieve a higher level of quality documentation within our medical records; and this in turn has proved to have a positive impact on our CMI, Severity of Illness Index, and Risk of Mortality.”

Director of Coding & Documentation, TX

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(844) ENJOIN1 | www.enjoincdi.com | info@enjoincdi.com

Sources:
1 Enterprisewide physician advisor programs are key to improving costs and revenue cycle performance | HFMA