The Future of Revenue Cycle: Preparing for Near-Term Change

A White Paper Prepared by HIMSS Revenue Cycle Improvement Task Force

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OVERVIEW

This document introduces near-term issues revenue cycle leaders face as newly-enacted legislation and procedures require changes in process and technology. While there are a variety of revenue cycle-related changes occurring in healthcare, the HIMSS Revenue Cycle Improvement Task Force selected five changes that merit immediate attention, discussion, and planning. And while some, like ICD-10, are not exactly imminent (with a deadline of October 1, 2013), the preparation and potential impact can be so significant that they should be on everyone's radar screen right now.

Each of the sections in this document covers different areas of the revenue cycle. Collectively, the document addresses patient access functions, including scheduling, registration and preauthorization, service delivery and charge capture, and business office functions. While there may be some overlap from one area to the next, each functional section of this piece stands on its own, enabling revenue cycle professionals to focus on their specific area of expertise.

Who Should Read This Document?

This document is for any revenue cycle professional, or any healthcare executive whose job function is impacted directly by the revenue cycle (CEO, CFO, etc.) As stated above, not every section will apply to every job function, and it will be up to the reader to decide on priorities. The goal is to raise awareness for all revenue cycle professionals about issues that will confront them in the near and medium-term. These are not hypotheticals or possibilities. These are real-world changes. They are substantial, and they can be very impactful.

In addition to the five topics, there is an additional section at the end of this document which considers some broader IT implications and considerations for revenue cycle and healthcare financial executives.

The five topics which will be evaluated for each revenue cycle area are the following:

1. ARRA (The American Recovery and Reimbursement Act)

The American Recovery and Reimbursement Act includes billions of dollars in Medicare and Medicaid incentive payments to providers and hospitals for the "Meaningful Use" of certified health IT products. The legislation requires the Department of Health and Human Services (HHS) to take regulatory action in several areas, including electronic health record (EHR) incentives for eligible professionals and hospitals, standards and certification criteria, an HHS Certification Program, and privacy and security. CMS released its Stage 1 Medicare and Medicaid EHR Incentive Payment Programs Final Rule on Meaningful Use that identifies the initial criteria for becoming a meaningful user of health IT. The Incentive program started in federal fiscal year 2010 for hospitals and calendar year 2011 for eligible professional (EP) categories.

The primary impact of this legislation for revenue cycle professionals will be the incentive payments made available for utilization of certified EHRs. Many organizations that have contemplated a move toward such a system will accelerate that process and will want to "pull the

trigger" quite soon to take advantage of the funds available. The problem with rushing into such a decision is the difficulty in taking the concerns of all stakeholders into account. And, since many organizations will take the opportunity to accept these funds as part of a wholesale transition to a new combined EHR/Patient Accounting System, the impact on all revenue cycle players could be substantial. Therefore, we strongly recommend that revenue cycle leaders make sure they are involved in any such planning process, regardless of who is spearheading the investigation and selection, and make their needs and requirements known early in the process.

The HITECH provisions of the Act will also have a significant impact on disclosures for treatment, payment and operations of protected health information (PHI). This will require healthcare professionals to increase their understanding of what is protected and what is not, and includes the requirement to produce documentation when requested by patients.

2. The Affordable Care Act

This law includes numerous health-related provisions to take effect over a four-year period, including: prohibiting denial of coverage/claims based on pre-existing conditions; expanding Medicaid eligibility; subsidizing insurance premiums; providing incentives for businesses to provide healthcare benefits; establishing health insurance exchanges; and support for medical research.

The Act has two primary impacts on revenue cycle professionals. The first is simply an increased need for understanding a range of issues, from coverage on pre-existing conditions, to the $250 drug rebate for Medicare, to what is covered under flexible spending accounts. While none of these are questions necessarily requiring answers from patient access or business office staff, patients will inevitably begin their questions with whomever they have on the phone, so education in this area will be important. At a minimum, your staff should know where to direct patients for answers. The second issue is Medicaid eligibility. Changes brought about by this Act mean that states will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This began April 1, 2010, which may mean some current patients who were not pursued because they were deemed ineligible may now be eligible for coverage.

3. 5010

The ASC X12 version 5010 transactions (a.k.a. version 5010) focus on the electronic exchange of administrative and financial information between healthcare providers and health plans. These transactions cover patient care services, including eligibility inquiries, service (treatment) authorization and referrals, claims status requests, and claims and remittance advice (claims payment). The updated HIPAA transactions (ASC X12 and NCPDP) also play a critical role with the future of ICD-10. Clearly, HIPAA's transaction updates impact all healthcare stakeholders, including hospitals, pharmacies, clinician offices, payers, billing software vendors and clearinghouses. They also impact consumers, with this sector taking on more significant responsibility for service payment.

In HIPAA version 5010, the authorization and referral transactions are significantly improved,

removing many of the implementation obstacles that were initially encountered. Also, necessary medical information has been added to allow health plans to make more timely and efficient decisions for authorizations. The remittance transactions have not changed much, but the implementation instructions are much improved, providing clear guidance to health plans on how to populate the transaction.

These changes will significantly reduce many of the problems that have prevented providers from automating their reimbursements. Collectively, version 5010 will bring many improvements and new features to all stakeholders. Revenue cycle impacts will be significant. Eligibility transactions will improve. Health plans will be required to provide fuller, more complete benefit and coverage information about a patient, thus eliminating many phone calls needed today. The new claim transactions and instructions should to help to reduce AR (accounts receivable) days by bringing faster payments. Currently, claims are often denied because they are not properly coded or completed due to ambiguous instructions, confusing data requirements, or payer specific workarounds. More automated processing will be possible for secondary claims, and health plans will be able to populate remittance transactions more accurately and completely, allowing providers to automate the claims payment functions that now are still manual for many provider organizations.

4. ICD-10

ICD-10 is the most significant change to charge capture that we have seen in a long time. CMS's deadline for the transition is October 2013. Many of us ignore such dates in the belief they will be extended, but since CMS has now made the new codes and procedures publically available, it appears that this date will stick. So now is the time to begin preparation.

So how is ICD-10 different? ICD-9-CM contains approximately 13,000 three-to-five character alphanumeric diagnosis codes, while ICD-10-CM contains approximately 68,000 three-to-seven character alphanumeric diagnosis codes. Procedural codes will grow from 4,000 to over 70,000 and the increase in character alphanumeric is from three-to-five to three-to-seven. Obviously, there are a lot more codes. But, and this is important, you are already doing a lot of this work through modifiers and supplemental documentation. There really is not a lot new here that you are coding for, just new ways of marking it down.

The impact of ICD-10 can be easily divided into two main areas. The first is obviously technology, both your internal systems and those of your vendors. In the coming months, you will begin to see more and more discussion from systems vendors about their readiness issues regarding ICD-10. It will be extremely important to be proactive with your vendors on this, or you might find out they are not ready when it is too late to make a change.

The other key area is training. And while it is far too early to start training your coding team about the specifics of each claim to be coded, it is not too early to begin introducing the concepts. We recommend a phased program that includes:

- Understanding the thinking behind ICD-10,
- Explaining how the increased specificity is the key,

- Discussing what new specifics everyone needs to be thinking about, and then
- Determining how to do the actual coding as the last step.

Include care providers in this process, as they will likely need to modify their documentation procedures if they want to avoid constant questions from the charge capture area.

QUALITY MEASURES

The increasing focus on quality, which is largely driven by public outcry and a political focus on Medicare, is actually an opportunity for proactive healthcare organizations to gain ground and increase revenue. This can happen through direct means, such as the PQRI, where a two percent override on billed charges is available to qualified physicians. Or it can occur through less direct means, where quality measures are published publicly, and patients choose to use one facility over another based on those measures. While much of this is out of control of the revenue cycle team, there are many reporting initiatives and other tracking issues which they can affect.

New quality legislation includes provisions regarding quality reporting by healthcare providers. Health IT is a key tool among these provisions to efficiently improve the accuracy and expand the scope and type of data collected. Specific sections are highlighted here:

Section 2717: Directs the establishment of quality reporting requirements for group or individual health insurance issuers offering insurance.

Section 3004-3005: Requires long-term care hospitals, inpatient rehabilitation hospitals, hospice programs and cancer hospitals to submit data on quality measures to the Secretary.

Section 3013: Directs the establishment of new quality measures where no quality measures exist and to improve, update, and expand existing quality measures. The law defines a quality measure as a standard for measuring the improvement of population health or of health plans, service providers, and other clinicians in the delivery of healthcare services. The law requires grants to be awarded to entities for the purpose of developing quality measures that allow for the assessment of, among others, meaningful use of health IT, health disparities, and equity of health services.

Section 4302: Requires federally conducted or supported healthcare programs or surveys to collect and report demographic data, including ethnicity, sex, primary language, and disability status, as well as data at the smallest geographic level possible, such as state or local, etc. Requires HHS, with the Office of the National Coordinator for Health Information Technology (ONC), to develop national standards for data collection, and interoperability and security for data management systems.

Section 6301: Calls upon the Office of Communication and Knowledge Transfer to disseminate findings of government-sponsored research to groups such as, among others, vendors of health IT focused on clinical decision support. The Office must assist users of health IT so that the research is incorporated into clinical practices in a timely and efficient manner.

Section 10332: Requires claims data for items and services under Medicare parts A, B, and D to be made available for performance evaluations of providers and suppliers of healthcare services.

Section 10333: Establishes grants to support the development of community-based collaborative care networks. Grants can be used for, among many things, telehealth services.

Section 10109: Directs the Secretary to seek input on a variety of topics from such organizations as the National Committee on Vital and Health Statistics (NCVHS), the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee, and standard setting organizations and stakeholders as determined appropriate.

Section 10305: requires the public reporting of performance information, which must be aligned with the expansion, interoperability efforts, and standard setting of health IT.

Reference - www.himss.org/content/files/PPACA_Summary.pdf

PART 1: PATIENT ACCESS

Many of the challenges facing patient access professionals in the near term will come in the form of additional knowledge required by staff. For example, while they are not coders, they will need to have a thorough understanding of ICD-10 to be able to properly determine what is required for a preauthorization. And while they will not be much involved in EHR selection, they will need to understand the HITECH provisions of ARRA because they involve patient questions and disclosures.

There will also be a need to make patient access staff more aware of your facility's success, or lack thereof, on quality measures, as increasing patient awareness of such measures and their availability will almost certainly increase patient inquiries and discussion.

Patient Access: Scheduling

Your scheduling team is on the front line of your organization when it comes to patient contact. Many of the changes currently underway and those anticipated do not cause a change in scheduling procedure. They will, however, raise many questions from patients when they contact your organization. Training is the best way to ensure your team is ready to deal with these issues.

ARRA – What will impact you?

Push toward EHR

Overall push toward EHR system from funds provided by ARRA may mean wholesale changes in patient accounting systems and processes -- scheduling could be included.

HITECH rules on patient rights

Patients may need to be better informed of their rights regarding PHI accounting under the HITECH rules.

ARRA – What you need to do:

About the push toward EHR

Ensure that EHR planning includes your team's concerns and requirements so you do not implement a system or process that will add complexity to your work.

About the HITECH rules on patient rights

Plan for training to make sure your team is compliant with the new HITECH rules.

Affordable Care Act – What will impact you?

Changes in Patient Payments will generate questions

While strictly not the purview of your scheduling team, you will almost certainly have to field questions regarding changes to outpatient non-prescription costs, as flexible spending account rules are changing and patients will ask questions regarding what they may be liable for before receiving service.

Affordable Care Act – What you need to do:

About the changes in Patient Payments

Make sure that your staff is informed in the basics of the rules changes under the Affordable Care Act, but as importantly, determine which resources you can supply so that your staff can quickly direct patients to those resources, saving your staff valuable time.

5010 – What will impact you?

Transaction 270 – Eligibility Request

With introduction of 38 new Patient Service Type codes, information for the same should be available during scheduling or registration to identify coverage details.

Transaction 834 – Enrollment

Privacy Functionality - Ability for designation of confidentiality, where access to information can be restricted.

Transaction 834 – Enrollment

Provision to capture drop off locations other than home residence.

Transaction 837 – Submission

Dependent patients with unique member ID's under a health plan will now have that information included in the subscriber loop and not the patient loop.

Transaction 820 – Premium Payment

Remittance delivery method will allow health plan sponsors to indicate remittance method to be used, i.e., online, by mail, etc.

5010 – What you need to do:

Make sure your staff is informed about basic service type details and the procedures to retrieve that information.

Application used for scheduling and registration should be able to store information pertaining to 'Patient Service Type' received from health insurance companies.

ICD-10 – What will impact you?

Schedulers will need to supply enough information for preauthorization

Scheduling team will need to understand new procedure codes enough so that any initial diagnosis and scheduled treatment can be used for pre-authorization purposes – this is not recommended until coders are trained, but should be on your radar screen. An example would be an obstetric procedure – since the new codes will identify which trimester the patient is in; it is likely the preauthorization will require the same detail.

ICD-10 – What you need to do:

Schedulers needing to supply enough information for preauthorization

As the deadline draws near, create training materials which pinpoint the critical new pieces of information schedulers will need to gather to generate enough specificity for obtaining preauthorization. As importantly, you need to talk with your payers to see what changes, if any, they anticipate for preauthorization as part of the ICD-10 implementation. While the primary burden will be on the preauthorization team, collecting the right information at the point of scheduling will aid the process significantly.

Quality Measures – What will impact you?

Patients are asking more questions about quality

With a steady increase in the volume of quality measures being published and made available online, patients are beginning to ask about such measures at the time of scheduling and registration.

Quality Measures – What you need to do:

About the fact that patients are asking more questions about quality

Gather the quality metrics that your organization is currently making available publicly, and any planned measures. Regularly engage your scheduling and registration teams in a review so that they are equipped to field questions, or redirect such questions if necessary. In particular, be prepared to respond to any negative or lower quality scores with an explanation of the score and any corrective actions that your organization has taken.

Patient Access: Registration

Changes in the registration area will likely focus more on process than technology, with the exception of the possible implementation of an EHR with registration capability. Patients are becoming increasingly informed of their rights, and new healthcare legislation expands those rights and the information available to them. Registration teams need to be aware of this and must be given the tools to respond.

ARRA – What will impact you?

Push toward EHR

Overall push toward EHR system from funds provided by ARRA may mean wholesale changes in patient accounting systems and processes – registration procedures, and possibly the technology used, will be affected by these changes.

HITECH rules on patient rights

Patients may need to be better informed of their rights regarding PHI accounting under the HITECH rules.

ARRA – What you need to do:

About the push toward EHR

Ensure that EHR planning includes input from your team. This is an opportunity to ensure registration becomes part of a revenue cycle feedback loop, so EHR information pertaining to patient access is reported directly, resulting in the opportunity to improve information gathering at the time of registration.

About the HITECH rules on patient rights

Plan for training to make sure your team is compliant with the new HITECH rules.

Affordable Care Act – What will impact you?

More patients under coverage

Providers will benefit with insurance through coverage expansions and expansion of existing government programs.

Medicaid Eligibility Changes

The expansion of Medicaid eligibility will mean that registrars may have a greater opportunity to qualify patients under Medicaid at time of registration.

Rate increase for Primary Care Physicians

With increasing the insured population, access can be an issue, and the Act increases rates paid to primary care physicians.

Affordable Care Act – What you need to do:

About the Medicaid Eligibility Changes

Work with your registration and financial counseling staff to inform them of the Medicaid eligibility changes and consider reviewing current charity and self-pay accounts to see if they may be eligible under the new guidelines.

5010 – What will impact you?

Medicaid Eligibility criteria

Transaction HIPAA 5010 – 270/271

Provision to support 38 Service Type code

Transaction HIPAA 5010 – 270/271

Alternate search options – Support to search based on Member ID, Last name only, and Date of Birth to be supported

Transaction HIPAA 5010 – 270/271

Health Plans to mention explicitly either monetary amount (EB07) or percentage amount (EB08) when reporting co-insurance, co-payment, deductible or stop-loss

Transaction HIPAA 5010 – 837

Subscriber/Dependent Relationship: If the dependent patient has a unique Member ID with their plan, then the patient information is reported in the subscriber loop and the patient loop is not used

5010 – What you need to do:

From a staff perspective, make sure your team is aware about basic changes in eligibility criteria

From a technology perspective, eligibility criteria need to be updated to accommodate changes

ICD-10 – What will impact you?

Registrars will need to supply enough information for preauthorization

If not already captured by the scheduling team, your registrars need to understand new procedure codes so that any initial diagnosis and scheduled treatment can be used for pre-authorization purposes – this is not recommended until coders are trained, but should be on your radar screen. An example would be an asthmatic patient who is just being released from the hospital since the new codes will identify require additional specificity on the type and severity of asthma, so it is likely the preauthorization will require the same detail.

Maintaining Problem list that identifies patient diagnosis

The problem list is usually part of the patient chart, which is updated prior to a patient visit or after consultation. This problem list, which is part of the EHR, helps track disease management specific to a population.

ICD-10 – What you need to do:

About the fact that Registrars will need to supply enough information for preauthorization

As the deadline draws near, create training materials which pinpoint the critical new pieces of information registrars. Your whole access team will need to gather to generate enough specificity for obtaining preauthorization. As importantly, you need to talk with your payers to see what changes, if any, they anticipate for preauthorization as part of the ICD-10 implementation.

Quality Measures – What will impact you?

Patients are asking more questions about Quality

With a steady increase in the volume of quality measures being published and made available online, patients are beginning to ask about such measures at the time of scheduling and registration.

Quality Measures – What you need to do:

About the fact that patients are asking more questions about Quality

Gather the quality metrics that your organization is currently making available publicly, and any planned measures. On a regular basis, engage your scheduling and registration teams in a review to equip them to field questions, or redirect such questions if necessary. In particular, be prepared to respond to any negative or lower quality scores with an explanation of the score and any corrective actions that your organization has taken.

Patient Access: Verification and Preauthorization

Shifting eligibility requirements and more stringent coding procedures will begin to affect your verification and preauthorization processes, if they have not already. Much has yet to be defined around preauthorization, but it is likely that payers will take advantage of the opportunities afforded by more specific coding as defined in ICD-10 to require more targeted preauthorizations. The immediate needs, though, are more process-oriented because of the preauthorization changes required by the new 5010, due at the beginning of 2012.

ARRA – What will impact you?

Push toward EHR

An overall push toward EHR systems from incentives provided by the HITECH Act may mean wholesale changes in patient accounting systems and processes – i.e., registration and scheduling; such changes may affect verification and preauthorization procedures and technology.

ARRA – What you need to do:

About the push toward EHR

Ensure your preauthorization team has input into the EHR selection process. The most critical factor may be to give input on the need for increased specificity of planned procedures to obtain an authorization. If any planned EHR/patient accounting system for your organization includes capturing this information, become involved in how that is set up.

Affordable Care Act – What will impact you?

Medicaid Eligibility Changes

Medicaid Eligibility has been expanded, so process change may be required for Medicaid to include patients previously considered ineligible -- may even apply to current charity cases where Medicaid eligibility was denied

Enrollment and Referral Authorization attachments

Under section 1104 of Affordable Care Act, transactions to support enrollment and referral authorization attachments

Affordable Care Act – What you need to do:

About the Medicaid Eligibility Changes

Working with registration and financial counseling, you may have the opportunity to qualify and verify Medicaid benefits on accounts currently considered self-pay or charity.

5010 – What will impact you?

270/271 changes

More information is required to be captured and shared with healthcare providers as well as customers

278 changes

Will help health plan to determine whether authorization was received for the treatment by service provider

5010 – What you need to do:

About the 270/271, 278 changes

Train your eligibility and preauthorization teams on the electronic submission and response changes caused by 5010. Work with your IT team on any changes to the tools your group is currently using to submit both eligibility and preauthorization requests. With the deadline at the beginning of 2012, begin testing in the first or second quarter of 2011 to allow time to fix any technical or process issues that may arise.

ICD-10 – What will impact you?

ICD-10 procedural specificity may be required sooner than later

Payers are currently gearing up for ICD-10 and several have signaled that they may require more detailed procedure codes for preauthorization ahead of the deadline, possibly to coincide with new 5010 requirements.

Health Plan underwriting process to become more stringent with specific diagnosis and procedure information available on claims

ICD-10 – What you need to do:

Before a patient arrival, administrative activities such as eligibility verification, prior authorization and referral check need to be confirmed

About the fact that ICD-10 procedural specificity may be required sooner than later

While it is not reasonable to train your preauthorization staff ahead of your coders for ICD-10 (with a deadline of Oct 1, 2013), begin getting them in the habit of using more detailed procedural submissions when obtaining preauthorization. While no one knows yet exactly what will happen; it may transpire that modifiers, currently required only at bill time, will soon be required as part of the preauthorization. Such modifiers will disappear under ICD-10 and will just be included in more specific codes.

Quality Measures – What will impact you?

Patients will be inquiring about published quality measures

Your access team will play an increasing role in the PR function of your facility, as you will see an increase in patient queries regarding quality measures, outcomes, etc.

Quality Measures – What you need to do:

About the fact that patients will be inquiring about published quality measures

This is all about training. Review any published quality measures and outcomes with your staff and teach them what they can discuss, what they cannot discuss, and how to respond to questions regarding specific metrics. This can get tricky if any of your quality measures fall below established benchmarks. You may want to consider bringing in outside resources if the inquiries increase and your staff are not able to properly field the questions.

PART 2: SERVICE DELIVERY AND CHARGE CAPTURE

Obviously, the overwhelming consideration for those involved in the service delivery and charge capture areas of the revenue cycle will be the impacts of ICD-10. This will not only involve personnel readiness in terms of training, process change, etc., but it will involve a great deal of system and process auditing to ensure readiness. The HIMSS Revenue Cycle Improvement Task Force strongly encourages revenue cycle professionals to take advantage of the work HIMSS has done to prepare members for this substantial change by assimilating a large body of literature and the views of many experts in how to prepare for this transition.

In addition to ICD-10 considerations, charge capture will be affected by certified EHR systems.

Service Delivery and Charge Capture: Care Providers & Case Managers

Since all impacts related to charge capture, coordination of benefits, etc., will affect care providers and case managers, many of these changes need to be watched closely by those professionals. Revenue cycle leaders can employ a strategy of "early intervention" on these issues to demonstrate to these healthcare professionals how many of these changes will actually have a positive impact on their work and, at least for physicians, on their financial picture. Such a strategy may help to get early adopters on board and limit the amount of pushback you receive from staff that is often inevitable with change of process and technology.

ARRA – What will impact you?

Push toward EHR

Beginning in 2011, physicians can receive Medicare incentive payments ($18,000 first year, declines each year, max of $44,000) and Medicaid (up to $21,250, max of $63,750) for "meaningful use" of a certified EHR. Penalties will be incurred if such criteria are not met by 2015. Obviously, this involves their own practice work, but education, training, and encouragement in this direction will support their efforts to embrace EHR technology and standards, which will help from an organizational standpoint.

Accounting of disclosures for treatment, payment, and operations

HITECH requirements that allow for patients to receive an accounting of disclosures for treatment, payment and operations of their PHI, means that there will be more pressure placed on formalizing disclosures and communicating about them with the patient, so discussion and possibly training will be needed for care professionals and case managers.

ARRA – What you need to do:

About the accounting push toward EHR

Obviously, this involves their own practice work, but education, training, and encouragement in this direction will support their efforts to embrace EHR technology and standards, which will help from an organizational standpoint.

About the accounting of disclosures for treatment, payment, and operations

Training and process change around formally documenting disclosures will be necessary. Care staff and case managers will need to clearly understand how to communicate disclosures to the patient, such that they can be cleanly documented, how to document same, and how to respond to requests for disclosure accounting.

Affordable Care Act – What will impact you?

Written documentation requirements

Care professionals will need to adopt procedures for providing written documentation on DME, home health, and other items or services

Medicare hospital readmission payment reduction

Medicare will no longer pay for certain hospital admission starting October 2012 and will publish hospital readmission rates

Acquired conditions payment reduction

Medicare will reduce payment by 1% for certain hospitals and health systems for select

hospital-acquired conditions

Affordable Care Act – What you need to do:

About the written documentation requirements

Care providers must be trained to understand when written documentation for specific services is necessary and what form it needs to take. This may also incur systems changes to ensure such orders are accompanied by proper documentation.

5010 – What will impact you?

The 278 transaction will allow a provider to inquire a health plan to determine whether an authorization was received to permit plan treatment

5010 – What you need to do:

Majority of entities send some kind of acknowledgement, but they are not always an X12 transaction, consistently implemented. Payers and providers need to implement this.

ICD-10 – What will impact you?

ICD-10 will increase coding requirements

For those care providers that do their own coding, the substantial changes ushered in under ICD-10 will require significant training. For the majority that do not do their own coding, there will be an increased burden on documentation to reduce the need for coders to interact with care professionals to clarify the notes from which they determine the proper codes

- Ordering Lab test or other ancillary services
- ICD-10 codes captured under referral need to be captured
- All Medical Necessity for durable medical equipment will require ICD-10 codes

Increasing specificity will provide an opportunity to care providers to identify patient requiring special attention sooner

Improved Utilization Management

Better Wellness Management thus risk reduction

Improved Stratification

New codes will facilitate better identification and stratification of members for enrollment to preventive programs and automated outreach programs.

ICD-10 – What you need to do:

About the fact that ICD-10 will increase coding requirements

ICD-10 will be the most significant procedural change to revenue cycle that healthcare has seen since HIPAA. Your care team needs to prepare for the changes it will bring, through training and testing. Coordinate efforts between care professionals and coders to ensure that the coders are getting the information they need to select the much more precise codes that will be required under ICD-10. Since some of these are already required to properly apply modifiers to codes, now is a good time to begin enforcing this increased level of documentation from care providers.

Quality Measures – What will impact you?

PQRI initiative is permanent, meaning possible additional revenue

MIPPA legislation made the PQRI (Physician Quality Reporting Initiative) permanent. Two percent of allowed charges is available.

Quality Measures – What you need to do:

About the fact that PQRI initiative is permanent, meaning possible additional revenue

Right now, the PQRI is providing incentives for properly reporting outcomes. Eventually, failure to do so will result in financial disincentives. Inform your care staff of their responsibilities under the initiative and ensure the proper training is made available.

Service Delivery and Charge Capture: Charge Capture/Clinical Documentation

Several of the topics discussed here will have notable impacts on charge capture and clinical documentation. The most obvious will be the ICD-10 and related 5010 impacts to coding processes and supporting documents, but revenue cycle leaders will also need to consider the potentially large impact of EHR and related systems changes on your coding team. These changes, due to ARRA and quality initiatives, need to be anticipated and may require significant training to avoid losing revenue during any transition phase.

ARRA – What will impact you?

Push toward EHR

Overall push toward EHR system from funds provided by ARRA may mean wholesale changes in patient accounting systems and processes. The affect on charge capture will be significant as EHR will likely include new charge capture procedures. Therefore, consider charge capture training burden and budget when exploring an EHR system.

ARRA – What you need to do:

About the push toward EHR

Ensure that EHR planning includes your team's concerns and requirements so you are not forced into a system or process that will add complexity to your work. Depending on the scope and breadth of the EHR shift, charge capture and documentation processes could change substantially. Make sure the EHR selection team understands how your people currently work and how changes to those processes can affect charge capture and, ultimately, revenue. While an EHR system should eventually assist in automating and refining charge capture, training and process change steps must be taken to minimize short-term burden.

5010 – What will impact you?

Transaction 278 to support service level for institutional, professional and dental detail segment

- Support for procedure modifiers
- Ability to report revenue codes and rates
- Provision to capture tooth information

For greater specificity, claim transactions will have more procedure codes, thus making the charge capture difficult to start with

5010 – What you need to do:

Develop or enhance transaction 278 which will help get patient's procedure and revenue codes related information very specifically
Provide training to charge capture team for ICD-10 transition

ICD-10 – What will impact you?

ICD-10 is not currently supported by most charge capture systems
Virtually no current charge capture systems, whether they are embedded in your patient accounting system, EHR, or standalone, are prepared to handle the new ICD-10 codes.

ICD-10 will require additional training for your charge capture teams
Your charge capture team will be primarily responsible for understanding the new codes required under ICD-10.

ICD-10 equivalency mapping is not well defined
While initial guidelines for GEM (General Equivalency Mapping) are already available, these crosswalks between current coding and ICD-10 will not be comprehensive and reliance on them may result in rejections and denials due to lack of key information.

Payers have not determined how/when they will handle ICD-10
While many large payers have stated that they plan to be ready to process ICD-10 when CMS is, the form of such processing is not yet defined, and different payers are indicating they may use different methods. Section 1 on Patient Access describes the payer position on this in more detail.

Providers need to start preparing for new contracts with payers
With new procedure codes coming, steps need to be taken proactively to minimize revenue loss. Be prepared with details focused on resource utilization, such as physicians' time, equipment usage, room usage, etc.

Changes in Superbills
To expedite coding, physicians usually order large number of superbills with common diagnosis codes printed on them; with ICD-10 codes coming and the number of codes going up by multiples of 4 or 5, superbills will require revision. Work with your vendors to create a superbill that is reflective of all typically-used diagnosis, procedures and differential diagnoses.

Maintaining both codes
Both payers and providers need to main both codes for services before October 1, 2013.

Provider Contracts
With payers updating their payment polices for ICD-10, all provider contracts will be revisited.

ICD-10 – What you need to do:

About the fact that ICD-10 is not currently supported by most charge capture systems
Spend time with each of your vendors preparing for the ICD-10 transition. It is not too early to ask them for their current state of readiness and their timeline with very specific milestones spelled out – so if they miss deadlines, you can alter your strategy as necessary. HIMSS provides a detailed ICD-10 readiness checklist which includes questions you can ask your vendors regarding the upgrades required.

About the fact that ICD-10 will require additional training for your charge capture team
Your coding team will require extensive training in the new codes and methodologies represented in ICD-10. While there is little value in training them so far ahead that they are

unable to use the codes, a staged process in which your entire charge capture team is first made aware of the changes and progresses through deepening levels of granularity should prove effective.

About the fact that ICD-10 equivalency mapping is not well defined

The only current action here is to keep an eye on the GEM process and watch for updates from CMS. The most important thing to realize, however, is that you should not assume that GEM will reduce the need for your charge capture team to learn the new codes. No matter how sophisticated these crosswalks become, if you rely solely on GEM, you will give up revenue.

About the fact that payers have not determined how/when they will handle ICD-10

You will need to query your payers about their plans to reimburse under ICD-10 and the timelines associated with those plans. More will be coming out in 2011 and 2012 from the payers, and you need to take advantage of any testing capabilities offered to determine your readiness to submit claims under their new guidelines.

Work on existing contract and identify codes having less resource utilization with reference to ICD-9 codes

Quality Measures – What will impact you?

Quality metrics may reflect decisions in care

As more quality metrics become available, they may impact certain decisions about care, which in turn will impact what is documented and how.

Quality Measures – What you need to do:

About quality metrics reflecting decisions in care

It will be important for documentation staff and care providers to understand any changes in process related to capturing information that can reflect on quality metrics.

Service Delivery and Charge Capture: Health Information Management (HIM)

Few revenue cycle areas will be more impacted than HIM by the issues discussed in this document. In addition to EHR implementation affecting HIM workflow, new disclosure requirements under the HITECH provisions of ARRA will require HIM to compile information in new ways by creating limited data sets. HIM leaders should attempt to determine the likely content of these new data sets before any EHR is implemented, as it might be possible to automate at least some of the processes required to generate such data at the time of implementation.

ARRA – What will impact you?

Push toward EHR

Overall push toward EHR system from funds provided by ARRA may mean wholesale changes in patient accounting systems and processes – HIM workflow will be impacted by a change in request flow and possibly submission to the requestor.

Need for limited data sets

Expect increased labor to put together limited data sets, as the new HITECH provisions allow an individual to request that a covered entity withhold release of PHI to a health plan for payment of healthcare operations if the service has been paid out of pocket.

Patients have new disclosure rights

Under HITECH, patients have a right to an accounting of disclosures for treatment, payment and operations of their PHI; this will get complex quickly as many of these are not formally documented by care staff, and the information will be centralized in, and requested from, HIM.

Payer and patient care info need to be segregated

Health information available to payers may have to be segregated from information used for patient care.

ARRA – What you need to do:

About the push toward EHR

Ensure that EHR planning includes your team's concerns and requirements so you are not forced into a system or process that will add complexity to your work. For HIM, this means a thorough understanding of how requests for records will be sent and how you will fulfill such requests under the new system. The process should simplify your work in this regard, but the transition will require change and training.

About the need for limited data sets

Create rules around the limited data sets and see if any technology (such as an EHR or your current HIM technology) will allow you to flag records by whether or not they can be disclosed. Otherwise, you will have to manually assemble collections of records based on which are related to out-of-pocket payments.

About the fact that patients have new disclosure rights

Make sure you and your team has a thorough understanding of the new patient disclosure rights. Create a formalized process for responding to requests for compiled information under these new requirements. Investigate technological solutions for flagging records as to whether they are available for inclusion in such disclosures.

About the fact that payer and patient care info need to be segregated

Consider how records can be segregated in your HIM or EHR system so that they share common account or MRN numbers, yet can still be tagged by which entities are they are available to. HIM leaders may also wish to consider converting patient care info to non-editable formats before release for limiting exposure on data security.

A Note about Disclosure Rights

To assist providers in secure data transmission and to meet the new patient disclosure rights, ONC has established "CONNECT."

CONNECT is an open source software solution that supports health information exchange (HIE) – both locally and at the national level. CONNECT uses Nationwide Health Information Network standards and governance to make sure that HIEs are compatible with other exchanges being set up throughout the country. This software solution was initially developed by federal agencies to support their health-related missions, but it is now available to all organizations and can be used to help set up HIEs and share data using nationally-recognized interoperability standards.

Reference: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_connect

Affordable Care Act – What will impact you?

Standards for Health Data Exchange

The Affordable Care Act expands health insurance coverage. By expanding health insurance, the Act also requires the development of standards for health data exchange. The exchange of data should generate opportunities and motivate HIM departments to develop consumer-centric and performance measured delivery systems. HIM departments must create, implement or deploy unique software applications to better serve patients and public health.

Affordable Care Act – What you need to do:

About Standards for Health Data Exchange

HIM departments must be willing to evolve to adopt "Software As A Service" applications, use HIEs, and expand the use of Cloud computing to allow the health systems to become as integrated, reliable and secure as possible.

5010 – What will impact you?

Changes to the HIM domain

Prepare for changes to your domain, including a decrease in traditional functions such as filing, analysis, and chart location; a change in functions such as scanning; and consideration of new applications such as computer-assisted coding and data analytics.

D.0. Pharmacy Standards

The "5010" transactions and "D.0" pharmacy standards address electronic claims, electronic eligibility verification, electronic claim status, electronic referral certification and authorization, electronic remittance and more.

5010 – What you need to do:

Changes to the HIM domain

Secure the talent you need to help implement agnostic data analytic software application to positively affect provider's revenue cycle.

About the D.0. Pharmacy Standards

Train your team in these standards. These transaction sets could ultimately improve the revenue management cycle and allow for expanded contracting models allowing providers to benefit with potentially more reimbursement or at least improved efficiency. Version D.0 of the pharmacy standards facilitate both coordination-of-benefits claims processing and Medicare Part D claims processing.

Other Key Considerations

Hospital Charge Master Codes

Must be able to link charge master to revenue codes

HIM systems must allow for a tracking system that alerts missing charge master to revenue codes. Example: A service with no charge and consequently not linked to revenue code.

Link Revenue Code to a Claim

Assures that all the revenue codes are link to a claim
Information system must alert on low volume or time limitation for claim

Explanation of Payment (EOP)
Links 837 claim to reimbursement form 835
No volume or time limitation for alert system

Providers need an electronic method of analyzing a specific service performed
(e.g., CPT, HCPC, J Code, MS-DRGs, etc.)
A data analytic software application needs to link patient and physician and location of service to the ICD-9 codes, charge master and revenue codes associated with hospital's intervention.
A data analytic software application needs to evaluate: Performed service, captured the service, billed for service, reimbursed for service, link to physician that performed service, link to patient that received the service and the diagnostic codes.
A data analytic software application needs to display all of the key components of care which are reflected in both the physician and patient databases.

ICD-10 – What will impact you?
Mapping engines for ICD-10 coding will not be efficient
Example: In reimbursement maps from ICD-10 to ICD-9, there are 3,334 instances in the mappings for diseases where a single ICD-10 code can map to more than one ICD-9. In addition there are more than 2,300 instances in the mappings for procedures where a single ICD-10 code can map to more than one ICD-9. (reference; ICD-10: A Master Data Problem, John Wollman, HighPoint Solutions, 2011)
ICD 9 to ICD 10 will greatly affect cash flow
Providers burdened with meaningful use, healthcare reform and HIPAA lack the time, resources and budget to change or alter all of their systems to meet the ICD-10, October 1, 2013 mandate. We will almost certainly see delayed payments and higher rejection/denial rates from claims not submitted accurately. Payers will tend to err on the side of caution and precision in this regard. The result will be lowered reimbursements when claims do not meet the new guidelines, meaning your AR will rise and your denial workload will increase.

ICD-10 – What you need to do:
About the mapping engine issues and cash flow considerations
Negotiate a strategy with third party payers to receive reimbursement on both ICD-9 and ICD-10 codes for a contracted period until the organization makes a full transition to ICD-10 in the HIM system…And meanwhile, get there as fast as you can.
Other risk mitigation activities include:
securing a pre-approved working capital NOW before revenues reflect decreased cash flows due to ICD-10 conversions
identifying cost saving measures
renegotiating other business contracts
reducing overhead if possible

assessing appropriateness of staffing
establish good working relationship with your financial institutions
obtaining financial counseling to be sure there is enough cash reserved for post implementation glitches/payment delays
avoiding overstocking supplies, etc.

For more prescriber/provider safety net guidance, go to www.himss.org/ICD10Playbook

Quality Measures – What will impact you?

Quality measures will require significant HIM extracts and processing

Quality measures and performance targets are being used to develop a national strategy to improve delivery and outcomes of care. Impending regulation is focused on developing a national quality improvement strategy that includes priorities to improve the delivery of healthcare services, patient health outcomes and population health. Regulators' goals are to create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. The intent is to motivate providers to extract data from HIM systems, convert the data to information and benchmark key attributes of care across all locations of service, providers of service and population receiving services.

Quality Measures – What you need to do:

About the additional extracts and processing

Providers need to incorporate data analytics into their health information plans just to maintain financial viability. Data analytics or business intelligence (BI) applications that are agnostic to the EHR are critical for providers to maintain reimbursement at their current level. Healthcare payments, in the near future, will be linked to performance measures associated with both incentives and disincentives to reach national quality measures. Examples of BI /data analytic outputs:

A system to automatically monitors electronic claims submission and alerts when variation occurs
Tracks claim outliers and alerts when variation from a benchmark occurs
Alerts when services are not billed
Allows for specific contract analysis and is able to benchmark performance standards
Provides high level and drill down to patient, physician and employer group to track providers A/R

PART 3: BUSINESS OFFICE FUNCTIONS

Often, the business office is the catalyst for change throughout the revenue cycle. It is here where patterns of denials and payment delays are uncovered. All of the subjects discussed throughout this paper will ultimately affect the success of business office functions. The key here is that information discovered in the business office is quickly dispersed to other revenue cycle areas to allow for changes in process and systems so delays and denials can be avoided entirely, rather than having a large number of claims caught up in a lengthy process of recovery. Once again, it is ICD-10, together with 5010 implementation, which will cause the largest number of issues.

There will be a huge surge of denials as both payers and providers grapple with proper coding and submission under the new format. Business offices need to be prepared for not just the increased workload, but the critical function of communicating their discoveries so other departments can adjust accordingly.

Business Office Functions: Bill Submission and Edits

The volume of bill edits you receive should increase substantially with the changes required for 5010 and ICD-10. However, this will only be the case if your bill scrubber is compliant with the new coding and has the appropriate edits prepared. It is not too early to begin discussing with your vendor, as this is your first line of defense against denials and payment delays due to miscoding or improper submissions.

ARRA – What will impact you?

Addition of EHR system could mean shift in charge capture and bill submission

If your facility implements a new EHR, which many will because of the reimbursements available through ARRA, you are likely to see significant changes in the way charges are captured, and therefore in the structure of your claims.

ARRA – What you need to do:

About the addition of EHR system

Your business office and charge capture teams need to get up to speed about the information being captured in the new EHR. Create a capture and reporting mechanism to ensure the bill edit information and trends are presented to those managing the EHR, as well as patient access and other departments. Regular revenue cycle meetings which include EHR implementation team members can help reduce the impact of the new implementation on revenue.

Affordable Care Act – What will impact you?

New administration simplification requirements

Insurers will adopt single set of operating rule for claims status, eligibility verification, electronic fund transfer for healthcare payment and remittance, enrollment and disenrollment referral certification and authorization.

Affordable Care Act – What you need to do:

About the administrative simplification requirements

While it is not yet clear how much the new rules will impact each area of the revenue cycle, it is safe to assume that your team will require additional training to understand the impact of these rules, and to be able to operate successfully within them.

5010 – What will impact you?

When reporting on co-insurance, co-payment, deductible, out of pocket stop loss, cost containment, and spend down, it is now explicitly required that the patient's portion of payment responsibility be reflected in either monetary amount (EB07) or percentage amount (EB08).

Coordination of Benefits (COB)

Anesthesia Reporting
Pharmacy Drug Reporting
Payer Subrogation
Transaction 837 – Claims
Present on admission indicator, ambulance pick-up and drop-off locations, remaining patient liability are added.

5010 – What you need to do:
Enhance transaction response 271
Create a provision for remaining amount to be paid after adjudication by other payer
Provision for anesthesia services in minutes
Tie single HCPCS tied to single NDC
Add pay-to-plan name and address to support Medicaid and other allowing payers to electronically perform pay-and-chase functions between plans

ICD-10 – What will impact you?
New codes leading to more errors thus impacting A/R
Impact on productivity due to more codes thus impacting A/R

ICD-10 – What you need to do:
Provide training to coding staff
Check for vendor readiness in case product is used

Quality Measures – What will impact you?
Bills are not just about getting paid
While it is critical to capture information for optimal reimbursement, ensure the billing team pays close attention to submissions and edits as they relate to quality tracking functions. For instance, simple edits which reflect missing demographic or related information, which may not result in non-payment, can affect quality measures and result in lower scores and reduced payments.

Quality Measures – What you need to do:
About capturing quality information for bills
Emphasize to your billing team the importance of correcting edits for reasons other than reimbursements. Review the specific quality measures that can be reviewed and consider incentives across your billing and all revenue cycle teams for meeting quality reporting metrics and other criteria.

Business Office Functions: Follow-Up and Denial Management
Your business office team will see the greatest impacts from the success, or failure, of your other teams to comply with the shifting regulations and new requirements. Many of the changes, such as 5010 and ICD-10, could ultimately result in cleaner processes and, therefore, fewer payment lags and denials. It is likely, however, that in the early period of these changes, we will see an increase in the number of claims denied as other teams adjust to the new processes. It will be

critical, therefore, for your follow-up and denial management teams to push their findings forward to spur optimization elsewhere in the organization. Just fixing things after the fact will not result in process improvement.

ARRA – What will impact you?

Push toward EHR

As stated elsewhere in this document, the push toward taking advantage of EHR incentive payments will result in systems additions or replacements. This will inevitably mean impacts, if not wholesale changes, to patient accounting.

ARRA – What you need to do:

About the push toward EHR

Get involved in patient accounting impacts now. Involve your team in any move toward an EHR system so the effects it will have on the information you receive through your patient accounting and related systems are well understood. The last thing you want to do is find that information you have always counted on to process a denial or follow-up on a claim is now in a different place, or worse no longer available.

Assure the EHR evaluation and adoption integrates seamlessly with the billing and revenue cycle management system. Critical investigation before adopting new technology is to assure the EHR and billing and collection applications run on the same data platform. The two applications, which can be purchased separately, should not run off different data depositories supporting patient demographics. This will increase the complexity of integrating data, decrease data reliability and diminish user friendliness of the selected EHR.

Affordable Care Act – What will impact you?

New rules that ensure coverage for certain pre-existing conditions

The Affordable Care Act includes a series of new rules that will phase in over time and will change how pre-existing conditions are treated. It is unlikely that all payers will have implemented all of these rules across the board so may see unwarranted denials.

Medicaid Eligibility

Medicaid eligibility is expanded under the Act, so certain claims that have been denied or remain unpaid may tie to accounts where eligibility was actually available, or may now be available.

Affordable Care Act – What you need to do:

About the new rules that ensure coverage for certain pre-existing conditions

The key here is to make sure your business office team, and any denial and follow-up systems where you can add rules to look for issues, are aware of the new regulations when denials come across or payments are not made. It is entirely possible that payers will continue to deny certain claims on old pre-existing clauses.

About Medicaid eligibility

Not only will your business office staff need to understand that certain accounts that are currently charity, bad debt, etc., may actually now qualify for Medicaid, but they will need additional communication channels to push possible eligibility situations forward to financial

counseling. If one does not already exist, establish a clear and formal communications conduit and process.

5010 – What will impact you?

Pharmacy Information

Use of 276 transaction to identify prescription numbers and 277 response transaction.

Status Segment

Provision for payers to report more status codes and greater detail about claims status.

Standardization in Code usage

Medicare to standardize usage of PLB reason codes at provider level, Claim Adjustment Reason Codes and Remittance Advice Remark Codes at claim / line level.

Improved Information on LCD and NCD

Explanation of Medicare Benefits will indicate what Local Coverage Determination (LCD) or National Coverage Determination (NCD) is applied when a claim is denied due to conflict between LCD and NCD.

Transaction 835 – Claims Payment / Remittance

Remittance Delivery method is added to facilitate communication between payers and providers by indicating provider delivery preference.

5010 – What you need to do:

Provide for detailed claim status storage

Ensure that your systems have a place and mechanism for capturing the more detailed claim information available through 5010 – you may want to talk with your vendors about this if you have not already.

Pharmacy transaction upgrade

Upgrade transaction to capture prescription numbers and status of paid/unpaid claims.

Replace trading partner codes

All trading partner level codes to be replaced with standard codes.

ICD-10 – What will impact you?

ICD-10-CM codes have greater specificity

ICD-10-CM codes offer greater coding specificity and will help increase the accuracy of diagnosis reporting. This will have a significant impact on denial management. Expect an increase in denials secondary to coding errors or poor mappings related to creative payment schemes (medical home models, Accountable Care Organizations) and standard contractual agreements between insurance organizations and providers.

ICD-10 – What you need to do:

Implement a Master Data Management (MDM) approach

Applied to ICD-10, a master data management (MDM) approach could provide central, managed storage and access point processes for various revenue cycle management systems to link ICD-9 and ICD-10 codes consistently. Reimbursement tables, override codes and other mappings or hierarchies could be accommodated in an organization's MDM. A MDM has the objective of providing processes for collecting, aggregating, matching, consolidating, quality-

assuring, persisting and distributing such data throughout an organization to ensure consistency and control in the ongoing maintenance and application use of this information.

Quality Measures – What will impact you?

Link quality measures to new ICD-10 codes

Quality and performance measures will be linked to ICD-10 codes. This may prove difficult for provider organizations to compare populations equally using ICD-9 data to show effective outcomes longitudinally.

Quality Measures – What you need to do:

Develop third party agreements to allow for reporting variation

Develop third party agreements for reporting variation in coding and data aggregation so outcome measures which may drive contract provisions that are quality, performance or financially based, are clearly definable and can be generated without the need for manual data collection.

PART 4: ADDITIONAL CONSIDERATIONS FOR SENIOR MANAGEMENT

It should be clear from the sheer size of this document and the issues discussed herein that your organization is facing enormous changes and challenges over the near-term. But it might also be clear that these changes provide opportunities to streamline processes, replace archaic technology and methods, and optimize performance in a variety of areas – and some with financial support. Get in front of these issues now, and you may find that you can make significantly positive impacts to your organization without the pain and financial instability of playing "catch-up" with processes and with revenue.

ARRA – What will impact you?

Benefits for meaningful use of EHR

Hospitals can receive benefits, from both Medicare and Medicaid, for "meaningful use" benefits of a certified EHR. While total revenue impact is not currently known, and must be weighed against implementation costs of a new system (if one has not been recently implemented). Full information on the CMS EHR Incentive Program is available through HIMSS's online Meaningful Use OneSource.

Patients have new disclosure rights

Under HITECH, patients have a right to an accounting of disclosures for treatment, payment and operations of their PHI -- this will get complex quickly as many of these are not formally documented by care staff and HIM may not currently have the workflow or procedures to handle aggregating such information.

ARRA – What you need to do:

About benefits for meaningful use of EHR

Every section of this document makes the assumption that most executives will want to consider the implementation of an EHR system, or a patient accounting system with an integrated, certified EHR system to take advantage of the CMS EHR Incentive Program. If that

is the case for your organization, and you have not started down that path, you have a lot of investigative work to do to select such a system. HIMSS has done a lot of work in this area and you can find many good references and articles on our Meaningful Use OneSource to help point you in the right direction. It would also help you to read the other sections of this document pertaining to this issue for other revenue cycle areas, as they should have input in the selection process to ensure a smooth transition and optimal outcome.

About the fact that patients have new disclosure rights

Make sure your care staff, HIM teams, and customer service reps have a thorough understanding of the new patient disclosure rights. Have them create a formalized process for responding to requests for compiled information under these new requirements. Consider putting together a cross-functional team for addressing how such requests will be processed.

Affordable Care Act – What will impact you?

Increased RAC activity

RAC activity is likely to pick up under the new rules with expansion in Medicare, Medicaid and Part D. Overpayments must be self-reported within 60 days.

Affordable Care Act – What you need to do:

About the increased RAC activity

If you do not already have RAC procedures and technology in place, it is probably already on your planning horizon. And since overpayments must be self-reported within 60 days, internal auditing and data transparency will be critical to avoiding penalties. Talk with your HIM and other affected teams about procedures and technology approaches to keep an eye on this, because missing something here could get extremely expensive.

5010 – What will impact you?

Impacted Business Operations / Processes

Customer service departments will be required to provide more information from eligibility perspective. With enhancement in claim status transaction set, the pressure on customer service department should reduce.

Improved A/R

With enhancements in the 837 and 835 transaction set, provider A/R should improve both from claims submission and adjudication perspective.

5010 – What you need to do:

About the Impacted Business Operations / Processes

Train your customer support team to disseminate more information on eligibility issues. This may require increased knowledge of eligibility vendor systems and output.

About the Improved A/R

Co-ordination with trading partners for 5010 transaction implementation with emphasis on 837 I/P, 835 and 270/271.

ICD-10 – What will impact you?

ICD-10 is coming, and your team is worried

The market talks about ICD-10 the way they talked about HIPAA – it is a big, bad scary monster that will cause you no end of grief with systems, people, and ultimately revenue.

ICD-10 is coming, and systems are not ready

Virtually no current charge capture systems, whether they are embedded in your patient accounting system, EHR, or standalone, are prepared to handle the new ICD-10 codes.

ICD-10 is coming, and your people need to be ready

Your charge capture team will be primarily responsible for understanding the new codes required under ICD-10, but other areas, such as denials and follow-up, will need to understand the new codes in order to handle payer requests and responses.

Payers have not determined how/when they will handle ICD-10

While many large payers have stated that they plan to be ready to process ICD-10 when CMS is, the form of such processing is not yet defined, and different payers are indicating they may use different methods. While some payers have stated they may accept ICD-9 codes and map everything automatically and then pay on ICD-10, we would strongly advise you do not count on this. The goal should be to submit clean, accurate claims that will not be rejected. The payers will respond within 30 days of a claims submission, BUT they do not have to pay a claim if there are errors in coding, diagnosis, or it lacks sufficient information for remittance.

ICD-10 – What you need to do:

About the fact that ICD-10 is coming, and your team is worried

Sell it to your team. You can make this a positive. It is an opportunity to implement much more efficient coding that actually results in payment. Get people on board with the process now and get them involved in planning…and some may actually start looking forward to the change. This is also an excellent time to plan for optimizing business processes, including medical banking processes. For example, start the process of getting all of your paper claims and remittances as digitized transactions to save financial resources and increase efficiency.

About the fact that ICD-10 is coming, and systems are not ready

Spend time with each of your vendors preparing for the ICD-10 transition. It is not too early to ask them for their current state of readiness and their timeline with very specific milestones spelled out – so if they miss deadlines, you can alter your strategy as necessary. HIMSS provides a detailed ICD-10 readiness checklist which includes questions you can ask your vendors regarding the upgrades required.

About the fact that ICD-10 is coming, and the changes are big

Your coding team will require extensive training in the new codes and methodologies represented in ICD-10. They will also need additional training in anatomy to learn the more extensive terminology required. While there is little value in training them too far ahead that they are unable to use the codes, a staged process in which your entire charge capture team is first made aware of the changes and progresses through deepening levels of granularity should prove effective. This could start as soon as you are ready. Your billing, follow-up, and denials teams will also have to have an understanding of these codes and need to be trained alongside the coders, though probably not to the same extent. It will be critical to have enough well-trained staff to handle the AR and denials load in advance of this change to avoid large gaps in cashflow.

About the fact that payers have not determined how/when they will handle ICD-10

Query your payers about their plans to reimburse under ICD-10 and the timelines associated with those plans. More will be coming out in 2011 and 2012 from the payers, and you need to take advantage of any testing capabilities offered by the provider to determine your readiness to submit claims under their new guidelines. Even though it will not be mandated for all health plans, it would be prudent to conduct Level 1 testing before proceeding to Level 2. Once testing is complete, any remediation should be done ASAP to make sure you are prepared for the October 1, 2013 deadline.

Quality Measures – What will impact you?

Revenue impacts for meeting or failing to meet standards

CMS has already begun rewarding or failing to reward facilities with reimbursement dollars according to their quality scores. Much of this is linked to the reporting of these scores as well as what they reflect.

Measures can enhance or hinder your ability to market services

With more demand for public disclosure of quality and outcome metrics, there will be increasing patient focus and questions on the quality of your organization's service delivery.

Quality Measures – What you need to do:

About revenue impacts for meeting or failing to meet standards

Make sure you have the necessary systems in place to report your quality metrics and be prepared to take corrective actions when you see anomalies in these numbers.

About the fact that measures can enhance or hinder your ability to market services

Get pro-active on managing the disclosure of information about the quality of your services, especially in those areas where the revenue impact can be meaningful and you have better than standard scores or ranking.

CONCLUSION

The revenue cycle changes discussed here are substantial, and many are imminent. If they are not right around the corner, they are certainly just down the block. And that means you and your teams have a lot to do. Prepare for change every day, as the sheer volume of what is changing will overwhelm you if you do not start right away. HIMSS is here to help you with that. Take a look at the ICD-10 PlayBbook and refer to our site for continuing coverage and advice on revenue cycle issues. And get involved. Let us know what else you need to see as you face these challenges. The more we pull together, the more chance we all have of getting through the next few critical years in tact…and maybe even better than where we started.

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