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HEALTHCARE

CHARGE CAPTURE AND CDM

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Today we are speaking with Erick McKesson, a director with Navigant. Erick is a seasoned project manager with considerable experience in EHR optimization and revenue cycle operational process improvement. Erick has served as a project lead for revenue cycle EHR implementations, net revenue in process improvement projects, reporting enhancement initiatives and organization-redesign projects. Throughout his career, he has focused on operational engagement, process improvement and technology enhancement as a means of streamlining hospital and medical group revenue cycle operations.

Hi, Erick. Thanks for joining us today on Navigant On Healthcare podcast series.

Erick McKesson: Thank you very much, Bob. It's a pleasure to be here with you.

Host: Excellent. Let's just get started. Healthcare providers strive to ensure that all patients are cared for, that the procedures provided are charged, and that those charges are billed in a timely manner. So, to accomplish this, a reconciliation in a timely-charged capture process is critical. Can you describe for our listeners what is involved in charge capturing?

Erick: Yes, absolutely. I think it's a pretty complex answer if you were to ask anyone out there in the industry that's working in this realm. There's a lot of different answers, you could probably get ... If we were to think back even 10 years ago, five years ago for some organizations, a lot of people would probably say: "For the most part, we have clinicians performing care, they're checking off what they're doing, and we've got a clerk that is going through a stack of papers and manually answering charges on a normal basis." Pretty straightforward. "We might have a couple specialty systems for lab or radiology, or something along those lines, that is sending us interface charges, but we're fairly contained in our clerks entering charges." That's all changed.

SPEAKER

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About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

I think for the majority of organizations out there in the last 10 years, especially as we've been rolling out new EHRs across the nation, and really internationally as well, we've put a lot of shift into: "How do we take that manual process and start to automate it as much as we can?" Where we used to see clinicians writing on chart sheets, maybe that charge sheet is within a system today, they're on the chart and it presents them with a screen and says: "You're in ophthalmology so here's some things to consider. Did you perform any of these?" They may be taking those off on a chart sheet that's now in the system.

Alternatively, I think going even further, there maybe things that are taken off of a chart sheet idea at all, and really are now being linked into an order, directly linked to something that's being documented on the chart, linked to your surgical events, your drug administrations, your lab results, your imaging exam being performed, various clinical activities now drive what the charge capture approach should be and, ultimately, what's going to end up on a claim.

I think an important piece here is we think about automation, we think about finding the right owner for the charge capture cycle, and I think pushing that upstream is excellent, but we also inherently bring in new risk. A couple things to consider, and I think that are embedded in the charge capture process today: first of all, completing documentation. If I'm requiring ...I'm going to charge for an infusion when a provider starts and stops that infusion clock, are they consistently doing that? Are they signing off on their encounters in a timely manner? Are they being held to some sort of standard that says: "I need to complete my chart in X days, and it needs include each of these drivers that are for patient care, but also for the revenue cycle and revenue capture process?" Are they doing the right thing?

I may have five different orders that all sound very similar. Am I choosing the right one that also is going to generate the charge on the backend? If I'm using the right order so I'm completing it on time, is there any duplication? Do I have someone that's reconciling?

I think a big concept for me is making sure every single clinical department is performing a daily reconciliation. They're looking at what did we actually do and what actually made it to the account. For a lot of people, that's a whole new concept. They may not have this idea of an integrated reconciliation group or an integrated charge capture group that's out there, being able to define upfront: "What's that clinical department level of ownership and what are the processes that they need to run through?" I think it's a critical factor in this cycle.

A few other things I would point out that are part of charge capture as a whole: first off, charge level of claimable erroring. You may enter what you think you've done upfront, now we need to look at it on the backend and say: "Is it appropriate? Are there certain critical issues that need to be resolved before we actually generate the claim?" That's another area that we are starting to see much more clinical departmental engagement in, where it used to be much of a backend rev-cycle process. It's being pushed back upstream.

Then, the last piece I'll mention here is that IT is actually really a critical component of charge capture now. Again, when we were back with charge sheets and a change needed to be made, the CDM team could update the charge sheet for that specific department, make sure it's sent out, the right people have a stack of them available. Now, if I'm making a CDM change, depending on where that is being charged from, I need to go to the right IT person to fix upstream the entry points, do that linking to an order, do that linking to a flow sheet, do the update to the digital charge capture sheet that may be out there. So, there's a whole new concept of ... I may have 15 or 20 people now managing really the CDM and charge capture process, so critical that we have appropriate IT engagement--critical that they are also held to standards and processes as updates occur.

Host: Right. You have, obviously, a lot of experience working with organizations, implementing EHRs, particularly around revenue cycle and how to manage the charge capture process as well as maintenance of the CDM. In spite of all the automation and all the tools available, you still have people working with these tools, they're managing these tools and dictionaries, or CDMs, and I'm just wondering: how do you keep it all organized? What are you seeing out there that are effective strategies of organizations in doing that?

Erick: Number one for me is going beyond that and not making it a dual accountability, but actually just making it a team. I think organizations that are really managing revenue effectively, they have a revenue integrity type of department, that revenue integrity department owns CDM, pricing, they do some sort of reimbursement level auditing, they're looking for ways that contracts might be better suited to charge in certain ways, and they are actually taking over the technical maintenance related to CDM and charge capture. So, rather than I have someone assigned from each clinical application out there, and that individual is also working on normal optimization or maintenance or rollouts of the EHR itself, and then part-time doing charge capture, I'm actually creating charge capture specialists within my revenue integrity department that does roll up through revenue cycle. We're reclaiming ownership of the entire CDM and charge capture process.

It's pretty typical that when you are moving to a new EHR, you're developing those skill sets, but you're keeping it within IT, and that's usually where that breakdown occurs, they don't really have the same level of accountability and same priorities that the revenue cycle team may have in making sure that things are maintained sufficiently. I think that's the biggest item, how do you get a revenue integrity department that really owns this and does it from start to finish?

Host: That was what I was trying to understand is, are you seeing that the business unit or the business department or revenue cycle departments are getting more sophisticated in their use of technology adoption and use of technology? Or, is it that the IT departments are elevating their better understanding of operations to support the technology that's often purchased or used by the business department?

Erick: That's a really interesting question. I think it actually...I would say it's happening on both sides. There's not nearly the same type of expertise wall that there used to be. In order to be an effective IT team member, you really do have to understand clinical or revenue cycle process and exactly how they function, to be able to turn that into a technical spec. I think people are getting much better at that on the IT side, but to that degree, I think that components like this still makes sense to have operational ownership of. We are seeing that operational teams are also becoming much more technical experts in certain areas. This is an area that, for the most part, you should be to send a few team members to go to get trained on the platform, go through that cycle of being proficient, or certified, or whatever it may be for your EHR, and actually keep them on your team but follow technical change control processes, follow, build guidelines. Folks can learn this.

I think people, from an IT perspective, people often shied away from that. They were worried that you wouldn't have a strong enough technical expertise to understand how to build and maintain and work within your EHR, but at the same time, and I think this is contradictory to that assumption, when you go to a new EHR implementation, almost every IT team is stealing team members from operations to join IT and then going through certification. If you can do that, why can't you keep those team members in the operational department and still work in the same facet? I think a lot of people that are successful, probably start with the former where they've taken operational team members, put them into IT during the implementation, but them after implementation, they return them back to their department, but continue their build in technical maintenance role within that department.

Host: Can you talk about some of the more common challenges or mistakes that people make when rolling out a new...or transforming their rev-cycle program? What they've done, or what you've done, to help them resolve those problems or mistakes?

Erick: Yeah, absolutely. I was doing a speaking event recently that was fairly-related to this, and actually working with internal audit and--believe it or not--that's what internal audit is often there for is, how do I look for risk? So, we've been talking with those folks about how to identify some of these risk areas.

A few things that stood out, first, very closely related to what we've been talking about already, is just accountability. Do I have the right structures in place, the right policies or charts? Do I have the right team members, the right turnaround expectations? Do I have a very detailed process that tracks my CDM and charge review approach?

Some things that people don't often think as much about is, for example: "How do I simplify my approach? Am I overbuilding? Am I creating a workflow for the sake of creating workflow, when I could've potentially simplified the approach? Are there themes within my EHR that I can automatically apply a charge for?" A very, very simple example is a vaccine administration. If the drug comes through, why not automate the administration fee? Another simplified piece is most people move into this more robust charge capture process, they're dynamically assigning where it took place and what department did this happen in? They have a full degree of tables that maps out where the charge is coming, what type of charge it is and, ultimately, what's the revenue center, the cost center, the GL going to look like? And, do I really need to go through all that rigor for every area or other areas where I could hard code it directly to the charge code itself?

Similarly, interfaces, we see hundreds and thousands of interface-related errors, especially during the conversion time frame. A big part of it is often you decide to build a charge master in your platform, the interface system, what's called your lab system has their charge master, there really should be one-to-one, but you decided to do it differently in the EHR, now you've got a third level of a mapping table; you've got to maintain that. Is that always up to date? Is there something new being built in the interface system that you didn't realize you missed it in the mapping table? Simplify. Make them one-to-one.

I think another big component that goes into…so I've built out how we're going to charge, I've built out my course CDM, we have a great structure for how we manage that, but ultimately there's going to process breakdown, there's going to be clinicians that don't document discreetly, maybe they use a lot of free-text notation instead and we're missing charges. They're not completing orders timely or they're documenting on the wrong order--various different things that could happen upstream that leads to mischarge opportunity. I think a very critical component is building out an approach to audit for that missed opportunity. In many EHRs, you can do that within the platform itself, you can build a rules-based approach. You've got a great understanding of: "If I document for X, Y and Z, I should charge for one, two and three." Building out those rules in place. Then, also looking at fail safes and making sure that we have an approach to scrub the account and the claim for common charging-related concerns.

Now, with that, I think something that people often go overboard on is over-editing on a claim hold, so you end up seeing the risk being shifted here from: "I missed revenue," to now, "I can't get claims out the door and my AR is increasing and my cash is going down," and finance is going to be on your back. You have to be really smart about it. If I'm going to edit and hold claims for a charge capture-related item, I need to make sure I've got enough staff available to actually work it on daily basis, I need to make sure that the edits that I'm writing for are extremely accurate and there's not a high degree of false positives that I'm having to weed through as a user that's causing an increase in my backlog. You have to be smart. You have to make sure that you're…you're kind of in a test mode while you're in production still so that you're not, again, over-editing, and so that you can staff up your team appropriately, and potentially get that clinical department engagement in the process as a whole.

Host: Great. All right, well, Erick, that's all the time that we have for today. I appreciate you spending your time today to discuss your experiences with charge capture and CDMs. Clearly, a lot that happens behind the scenes to create a claim, within a provider organization…I think from a patient and provider perspective, as well as any of us--our listeners from various backgrounds--I think they got a lot to think about, a lot to consider. Again, thanks for sharing your expertise with us today.

That's it for today's episode. I'm your host Bob Kim.

Announcer: That concludes today's episode. Be sure to check in with us for future installments on the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share it with friends and colleagues on social media. Learn more at navigant.com.