

Year End: Time To Tighten The Revenue Cycle Through Internal Controls

Prevent or Defend

Disclaimer Statement

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William L Malm

VP, Financial Transformation

Agenda & Objectives

Agenda

- Overview
- Importance of Internal Controls
- Where data and tools can be used for enhanced outcome
- Involve necessary personnel to break down silos
- Summary

Objectives

- Participant will be able to identify two potential causes of lost charges
- Be able to state the importance of internal Controls
- Be able to state how to create an internal control
- Understand why Inpatient Only List continues to create operational concerns
- Be able to state how data can assist in identifying opportunities

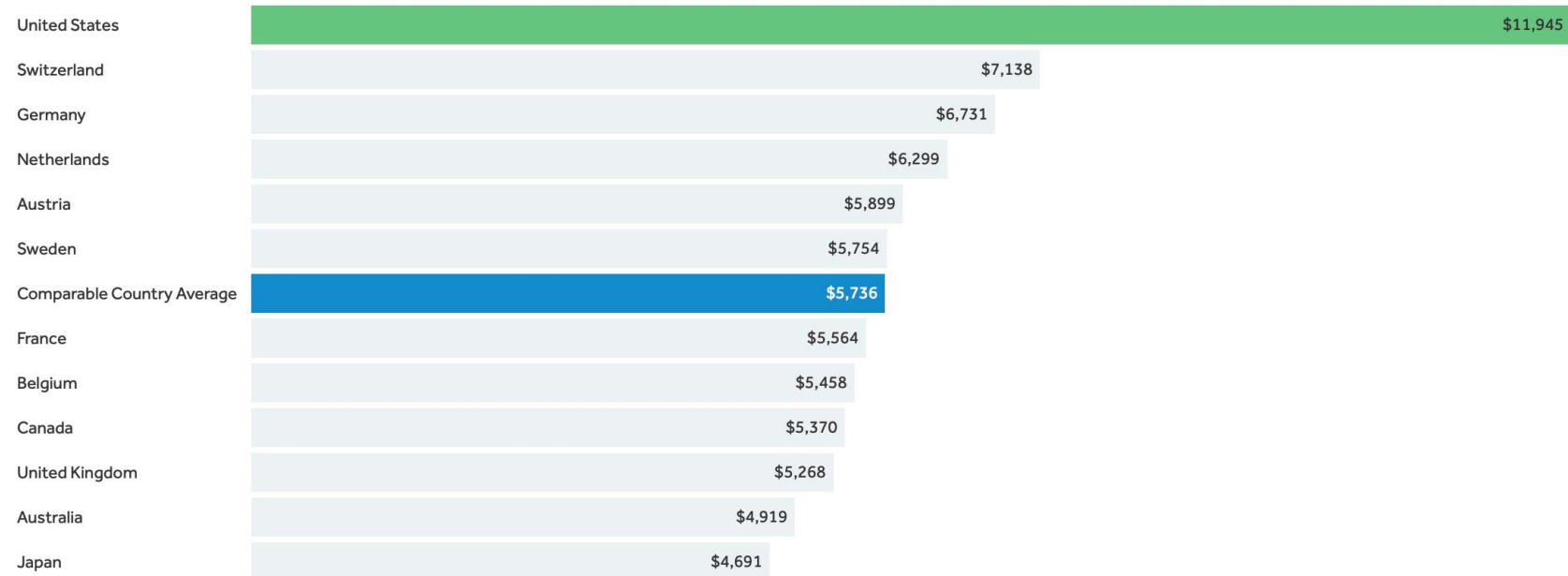
Why Now – What's Changed ?

The Call to Arms

Per Capita Spending on FFS

On average, other wealthy countries spend about half as much per person on health than the U.S.

Health consumption expenditures per capita, U.S. dollars, PPP adjusted, 2020 or nearest year



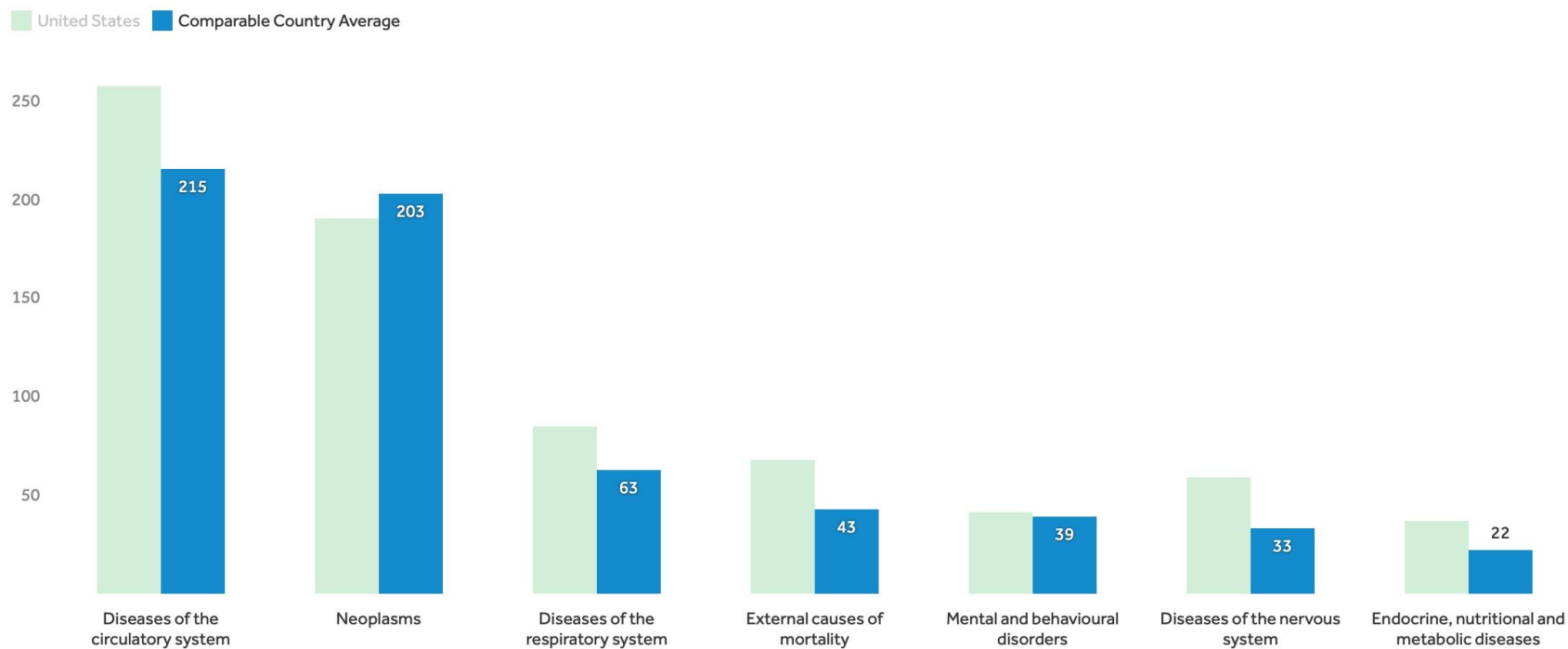
Notes: U.S. value obtained from National Health Expenditure data. Data from Australia, Belgium, Canada, Japan and Switzerland are from 2019. Data for Australia, France, and Japan are estimated. Data for Austria, Canada, Germany, Netherlands, and Sweden are provisional. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of [National Health Expenditure \(NHE\)](#) and [OECD data](#) • [Get the data](#) • [PNG](#)

Peterson-KFF
Health System Tracker

Higher Costs Do Not Equate to Lower Mortality

Age-adjusted major causes of mortality per 100,000 population, 2015



Note: Data for Canada are from 2013 and France are from 2014

Source: [KFF Analysis of OECD Health Statistics \(Database\)](#) • [Get the data](#) • [PNG](#)

Peterson-KFF
Health System Tracker

American Healthcare Executives (ACHE)

- Healthcare delivery is challenged more than ever before post pandemic
- They list the top 3 concerns, as ranked by healthcare executives as:
 - **Personnel shortages**
 - **Financial Challenges**
 - **Quality and Safety challenges**
 - Also included in the top 10 is population health management

Personnel

- Registered Nurses are the highest priority for staffing
- Use of contract or travelling nurses has increased the cost of provision of services
- Personnel not matched to the required task (i.e. RN used when a patient care assistant would suffice)
- Creates a patient safety, quality and provision of care concerns

Financials

- This has always been a focus of facilities however now seeing:
 - Increased medication and supply costs
 - Increased payroll and contract labor
 - Capped / shrinking reimbursement
 - Culture of Fee for Service requiring change to value care and/or fully capitated services changing the focus to Per-Member-Per Month methodology.

What has caused the **MASSIVE** financial pressure our clients are feeling?

- Labor shortages
 - Higher mix of nursing labor contracted vs employed (up from 4.7 to 38.6%)*
 - Increase in contracted hourly billing rates (up 213% compared to pre-pandemic)*
- Fewer high-margin elective procedures
- Inflation
 - Increased supply costs (up 36.9%)*
 - Increased medication costs (up 20.6%)*
- COVID
 - Federal COVID relief mostly gone
 - COVID cases are still present

What's the true **root cause**?

What if **HALF** of everything we are doing in health care is unnecessary or preventable?

Wasteful?

What if **HALF** the hospital admissions were prevented because care providers moved upstream, **would we have a labor shortage?**

Waste and Death Preventable and Must Be Managed

250,000 deaths per year are due to medical error in the U.S.*

Experts estimate **\$1 trillion** of financial **waste** in healthcare**

*Makary, Martin and Daniel, Michael - Johns Hopkins Study – “Medical error—the third leading cause of death in the US” *BMJ* 2016;353:i2139

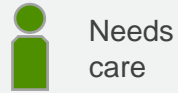
**James Brent C and Poulsen Gregory P. The case for capitation: It’s the only way to cut waste while improving quality. *Harv Bus Rev* 2016; 94(7-8):102-11, 134 (Jul-Aug).

Waste Category Question

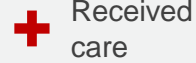
Who should get care and when?

Case-rate utilization
(# cases per population)

Symbol Key

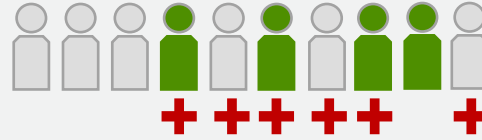


Needs care

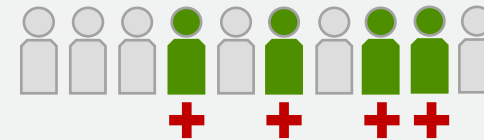


Received care

Current State



Ideal State



Improvement

- Fewer inappropriate cases
- Early intervention to prevent disease or injury

What care should be included?

Within-case variation
(# and type of units per case)



Procedures



Diagnostic test



Labs



Drugs



Behavioral consults



Patient education



- Only the right care is included: avoid duplicate testing and eliminate complications and less effective interventions
- Do what we know works

Is each care component delivered efficiently?

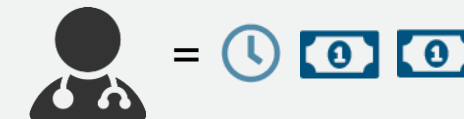
Efficiency
(cost per unit of care)



Time
(both patient and clinician time)



Resources
(both direct and indirect costs)



- Lower-cost drugs and supplies are used
- Technical and administrative processes are streamlined to reduce indirect costs

3 Major Payment Models (Business Models in Healthcare)

- Fee-For-Service
 - Insurance pays Care Delivery System for each and every component of care
 - Example: A surgical back procedure includes 3 lab tests, an MRI, and 4 medication doses and a 5 day stay in the hospital – the health system receives payment for each individual care component
- Bundled per Case
 - Insurance pays a pre-negotiated set amount for a specific type of procedure
 - Example: A health system receives \$50,000 for a spine fusion surgery, regardless of how many lab tests, medications, MRIs are used and how long the patient stays in the hospital
- Condition Capitation / Full Capitation (Provider at Risk)
 - Insurance pays a pre-negotiated monthly rate to care for a population of patients
 - Example condition capitation: Insurance agrees to pay \$225 per member per month to care for a population of patients with back pain issues (whether they get surgery or not)
 - Example full capitation: Insurance agrees to pay \$525 per member per month to care for all health issues for a population

Financial Incentive Alignment

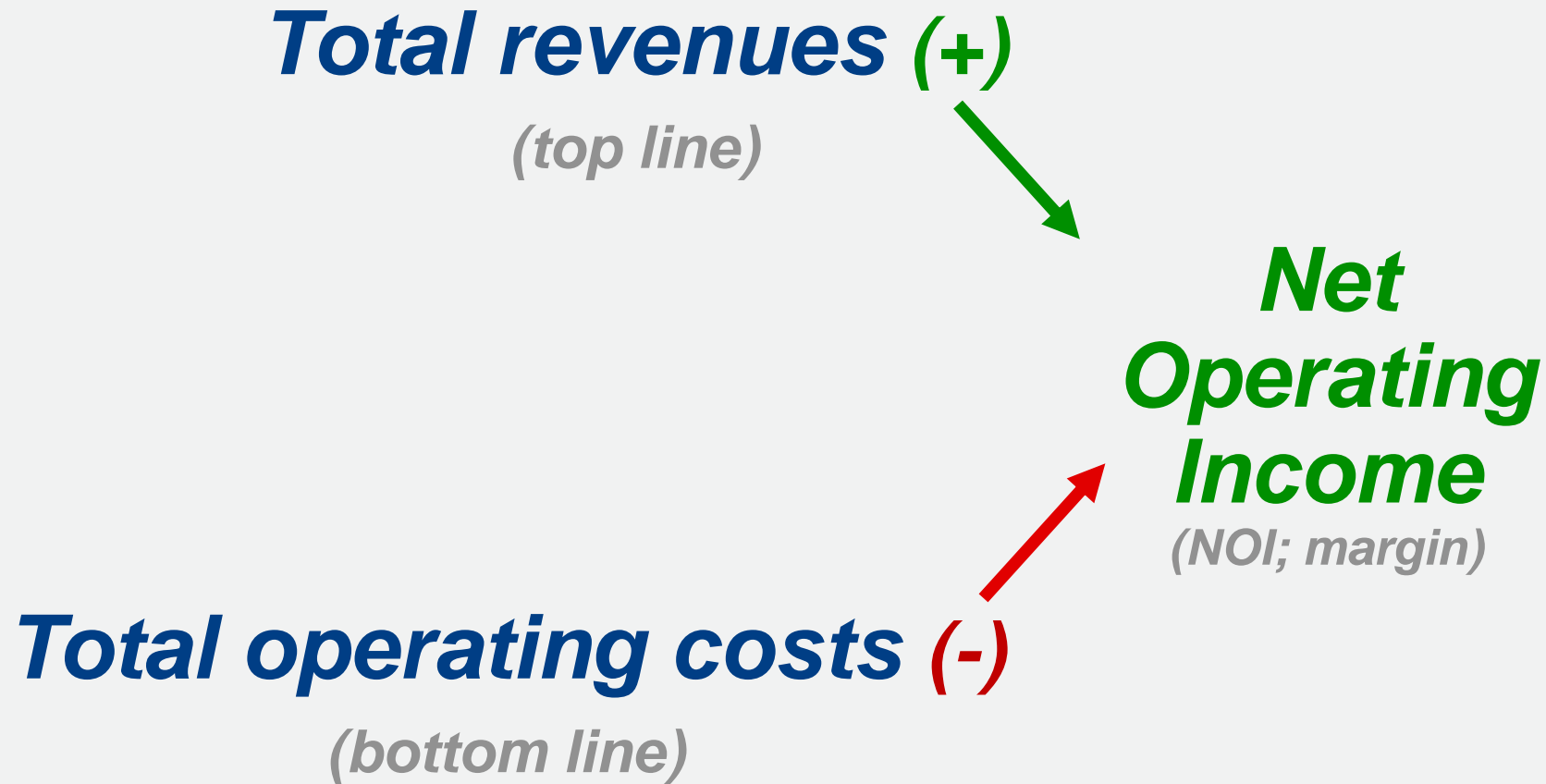
Under Different Payment Mechanisms to Remove Waste

WASTE REMOVAL LEVEL			PAYMENT METHOD		
		<u>% of all waste</u>	<u>FFS</u>	<u>Per case</u>	<u>Provider at risk</u>
3.	Case-rate Utilization <i>(# cases per population)</i>	45%	▼	▼	▲
2.	Within-case Variation <i>(# and type of units per case)</i>	40%	▼	▲	▲
1.	Efficiency <i>(cost per unit of care)</i>	15%	▲	▲	▲

Note:
For green arrows, savings from waste elimination accrue to the care delivery organization.

For red arrows, savings go to payer organizations.

Financial Survival = Operating Margins



MUCH Higher Financial Impact: Quality eliminating waste vs. Revenue Growth

Revenue growth:

5 to 9%

contribution

for each case added

Quality eliminates waste:

50 to >100%

contribution

*for each case **avoided***



**Net
Operating
Margin**

*(and return
on investment)*

Value Creation Framework

Do we know what we should we be doing?

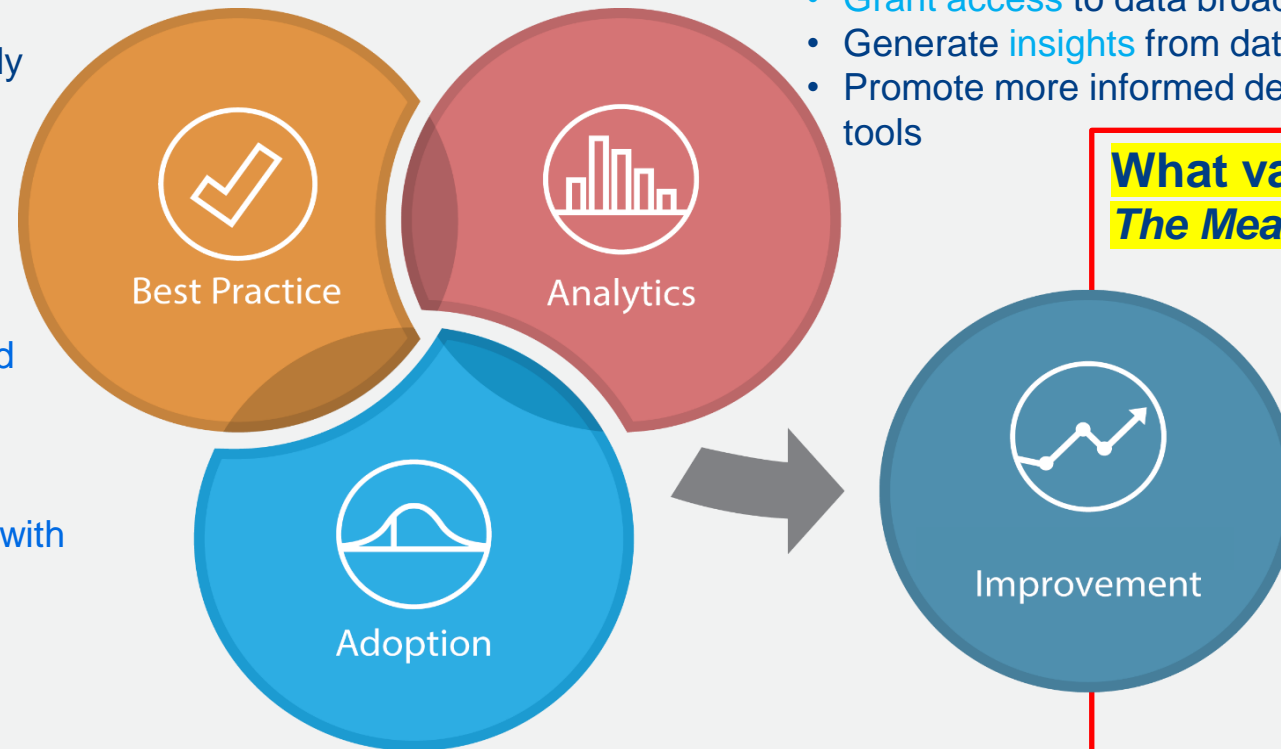
- Quantify **ideal process** potential gains
- Identify **root cause** of process challenges/pains
- Re-design and improve processes
 - Follow Evidence-based **guidelines** & protocols
 - Establish **expert consensus**
 - **Standardize work** operationally

Can we measure how we are doing and predict how we will do?

- **Capture** correct data about the process
- **Integrate** all relevant data
- **Grant access** to data broadly
- Generate **insights** from data
- Promote more informed decisions and **actions** with better tools

Can we transform?

- **Educate People** to learn required
 - Skills
 - Knowledge
 - Attitudes
- In addition, Accelerate Adoption with
 - Strategy
 - Competences
 - Culture
 - Operating Model



What value can we realize? *The Measurable Improvement:*

- **Health impact**
 - Lives saved
 - Lives improved
- **Financial impact**
 - Revenue enhancement
 - Productivity gain
 - Cost avoidance
 - Hard cost reduction
 - Shared savings
- **Experience impact**
 - Patients & their families
 - Clinicians
 - Admin/support staff

Financial Implications Overview

Action Steps to Control Waste and Improve Outcomes

What is an Internal Control

The University of Florida provides a definition for both accounting but also healthcare. They state:

- There are two basic categories of internal controls
 1. preventive and
 2. detective
- An effective internal control system will have both types, as each serves a different purpose.
- The revenue cycle is no exception. Both types will be required to ensure compliant charge capture



- As you perform routine processes, or when you are thinking of implementing a new procedure or process, it is important to ask the following questions to help determine the appropriate control:
 - What could go wrong?
 - What steps have been taken to ensure that something does not go wrong?
 - How can you verify that nothing went wrong?



- **Preventative:** controls aim to ***decrease the chance of errors and fraud before they occur***, and often revolve around the concept of ***separation of duties***. From a quality standpoint, preventive controls are essential because they are proactive and focused on quality.
- **Detective:** controls are ***designed to find errors or problems after the transaction has occurred***. Detective controls are essential because they provide evidence that preventive controls are operating as intended, as well as offer an after-the-fact chance to detect irregularities.
- Both methods require consistent and dependable data and analytics

Preventative

- Criteria:
 - Decrease the chance of errors before they occur,
 - Revolve around the concept of separation of duties
- Examples:
 - Time out procedures
 - Medication reconciliation
 - Inpatient only list
 - Prior authorizations
 - Medical necessity
 - Evidenced based medicine

Detective

- Criteria:
 - Find errors or aberrancies after the fact
 - Data driven in nature
- Examples:
 - Claim checks
 - Charge Capture Reviews / Reconciliation
 - CCI Edits
 - Duplicate charges
 - Procedures not consistent with diagnosis or coding
 - Denials

What has caused the **MASSIVE** financial pressure our clients are feeling?

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Cost of Medical Errors – Avoidable Costs

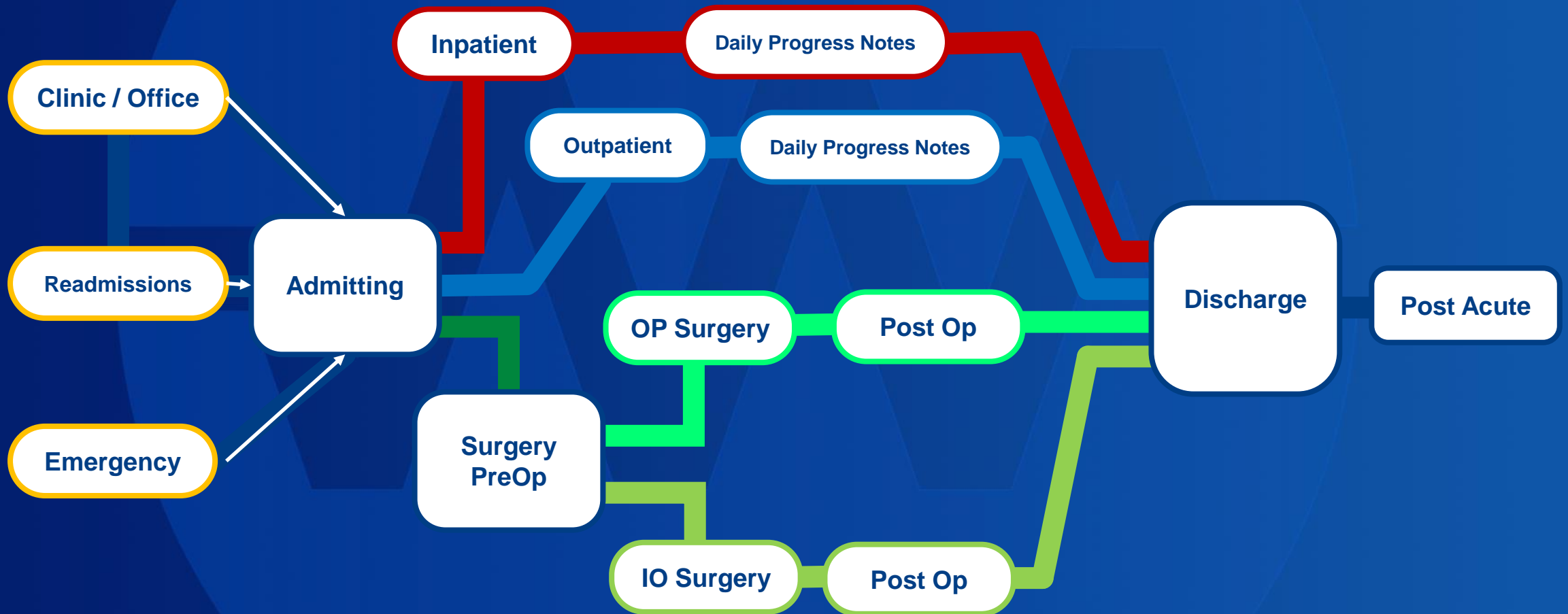
- <https://www.ncbi.nlm.nih.gov/books/NBK499956/>

“There are two major types of errors:

1. Errors of omission occur as a result of actions not taken. Examples are not strapping a patient into a wheelchair or not stabilizing a gurney prior to patient transfer.
2. Errors of the commission occur as a result of the wrong action taken. Examples include administering a medication to which a patient has a known allergy or not labeling a laboratory specimen that is subsequently ascribed to the wrong patient.”

- These are Preventative Control Points
- Nursing burnout is exacerbating this concern in 2022

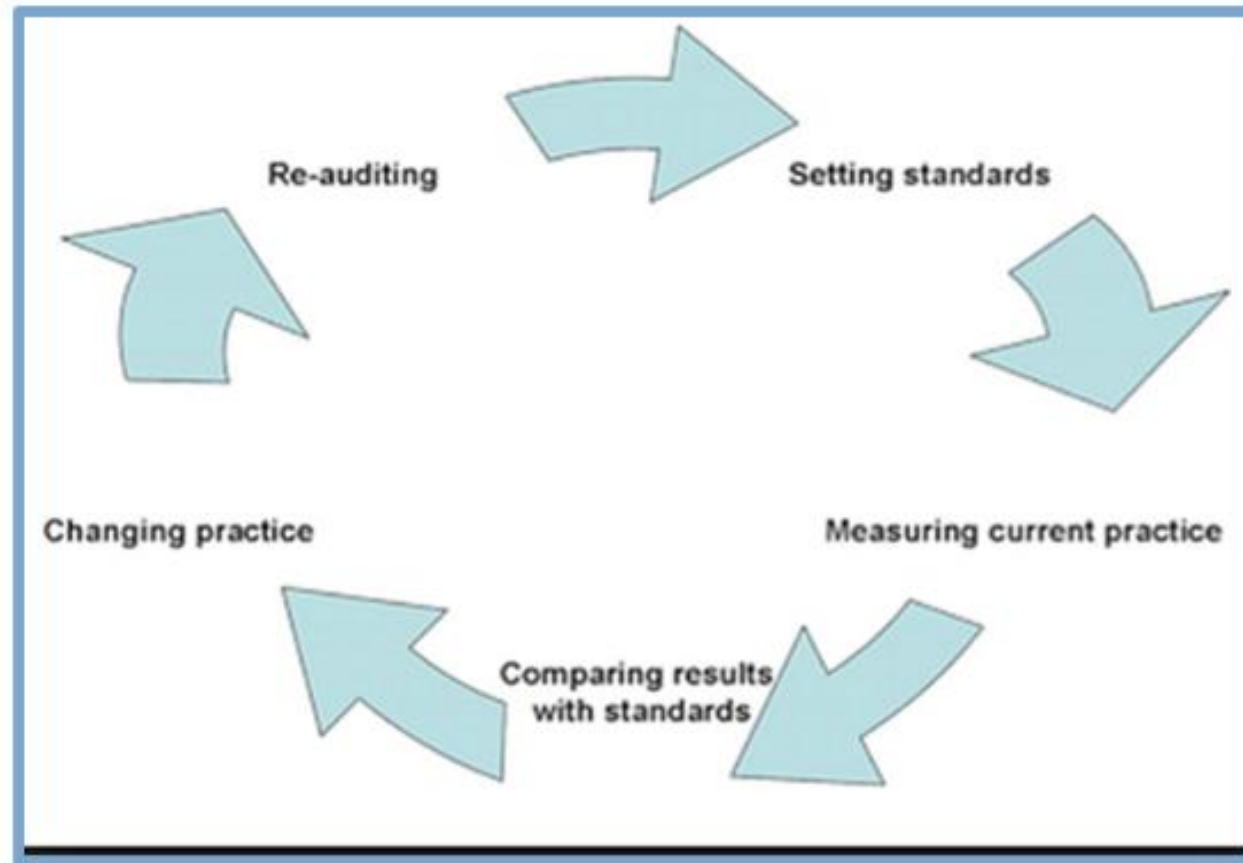
Internal Control Points



Each Point

- Each point demonstrated above must have a preventative and detective
- **Focus should not change** no matter if it is fee-for-service or fully capitated
 - Managing costs
 - Providing safe care in the best location
 - Using data to manage revenue, cost and outcomes – data can be the destroyer of endemic silos in facilities
- Imaging next steps moving forward on outpatient care focus

Each Point of the Charge Cycle



<http://www.dchft.nhs.uk/patients/wards-depts/clinical-audit/clinical-audit.html>

The Importance of Charge Cycle Overcoming Silo Management

The key elements to any predictive and defence capture cycle are:

1. Definitions – what is the objective of the audit
 2. Written set of standards – policies, procedures ✓
 3. Data Elements
 4. Specific review of the data elements against the written set of standards
 5. Published findings illuminating discrepancies against the published standards
 6. Corrective action
 7. Review is it working as designed
- ✓ Important to use the correct standards to ensure correct findings

The Importance of the Charge Cycle

- It is the expectation that every charge follow these steps
- If a step requires amendment or change it must be noted as a “variance” from the prescribed technique and specifics as to the “variance” must be described in the report. What preventative or detective point failed?
- The charge cycle can be implemented for any charge capture by using the 5 steps
- The objective is to apply a preventative and detective approach at each control point that is sustainable

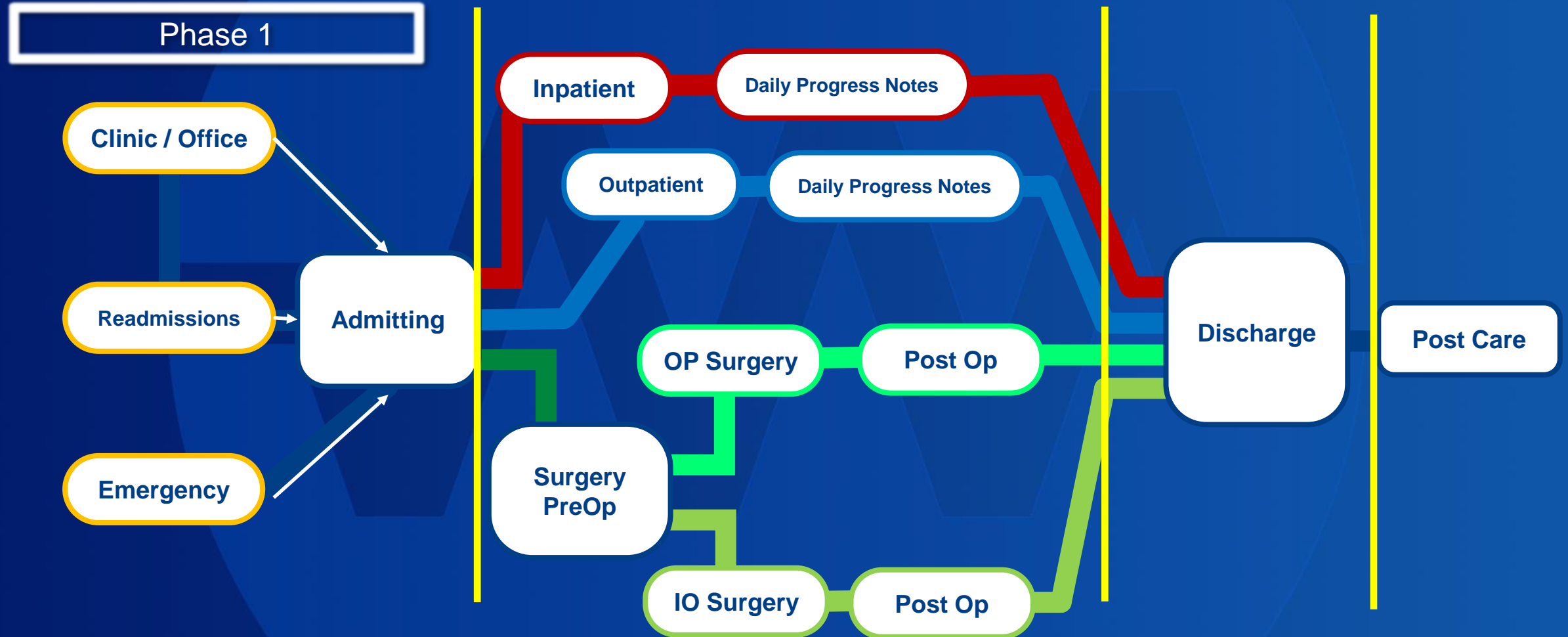
Technology for Detection and Prevention

- VitalCDM and VitalKnowledge – correct coding
- VitalIntegrity – accurate charge capture and root cause remediation
- PowerCosting – activity-based costing
- PowerLabor – focusing on the labor acuity and cost management
- Clinical Quality Improvement – focus on variations and look to the margin
- Population health – management of patients to achieve maximal wellness and move to capitation

Phase 1

Failure in this stage causes the majority of denials

Internal Control Points



According to the survey, **61 percent of initial denials are due to demographic/technical errors, followed by eligibility** (16 percent) and medical necessity (12 percent). Forty-two percent of denial write-offs are due to demographic/technical errors.

<https://www.beckershospitalreview.com/finance/4-ways-healthcare-organizations-can-reduce-claim-denials.html>

Phase 1 – Intake and Admission

- Key Control Points

- Physician Office
- Clinics
- Emergency
- Planned Admissions

- Key Objectives

- Clear concise policies and procedures
- Accurate Demographics to reduce denials
- Consistent use of eligibility technology in a standard fashion

- Preventative:

- Accurate demographics
- Inpatient Only List (Medicare)
- Contract Visibility – authorizations

- Detective:

- Avoidable denial data – look at initial denials for failed demographics
- Failed Authorizations

What Do Phase 1 Controls Look Like

Preventative:

- Create a policy and procedure and technology changes to ensure that any Medicare patient who is planning to have a procedure listed as “inpatient only” (per CMS) follows a specific process
 - Get the CMS Inpatient Only List
 - Work with IT to develop a mechanism of stopping the admit process if patient has a procedure scheduled that is inpatient for which there isn’t an inpatient order
 - Alert care management team that an inpatient order was obtained
 - Ensure the operative report is reviewed and provisional coding complete within 24 hours of any procedure that was changed from the originally intended procedure
 - Review all criteria prior to discharge to prevent discharge without an order

What Do Phase 1 Controls Look Like

Preventative:

- Consider payer specific registration processes
- Implement technology holds that prevent filing demographics unless complete
- Some systems allow “recall” of previously entered information which should be avoided. Entering the information again reduces the likelihood of maintaining old information and overall denials.

What Do Phase 1 Controls Look Like

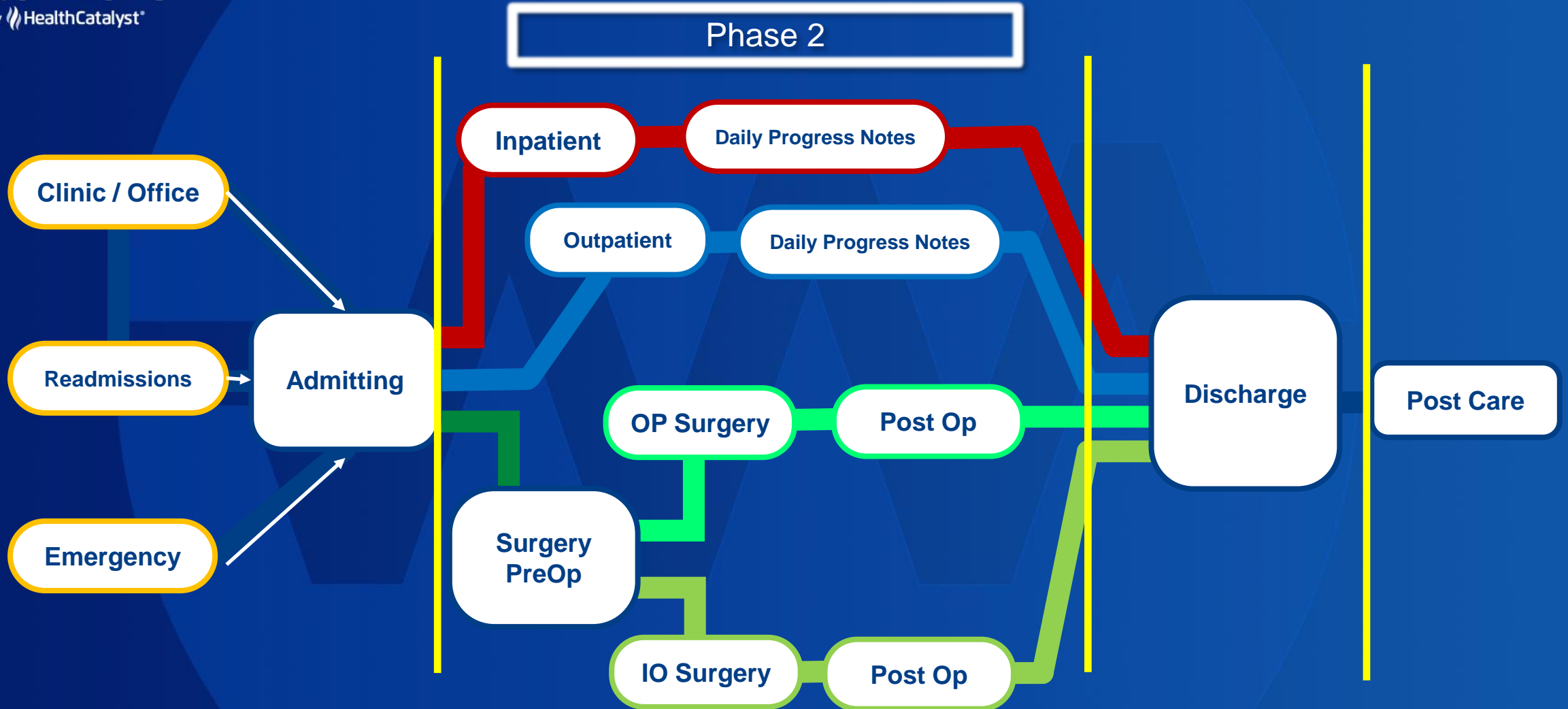
Defensive:

- Data – Data – Data:
 - Denial Management – were there procedures that failed to meet the requirements of inpatient only
 - Surgery anticipated to be an outpatient procedure that changed to inpatient due to the change in surgical approach and/or actual surgery
 - Data demonstrating the following:
 - Provider involved
 - Incomplete HIM coding prior to discharge that would indicate an inpatient order
- Use data to associate the registration staff to the errors and retrain and monitor
- Use internal technology to associate incomplete fields associated with denials and eligibility failure

Phase 2

The most significant internal controls and technology resources

Internal Control Points



Importance of Phase 2

- Phase where most avoidable costs and denials occur
- Focus will be on preventative internal controls
- Right Patient - Right Time – Right Place – Right Service or Procedure – Right Location
- Objective is to have cost managed quality care provided devoid of errors

Phase 2 – Patient Care

- Key Control Points

- Inpatient Services
- Outpatient Services
- Surgical Services (IP and OP)
- Emergency Services
- Infusion Center's and Oncology

- Objectives

- Quality outcomes and control of clinical variation
- Revenue and Cost Management
- Labor Management

- Preventative

- Technology

- CDM/Knowledge/VI – Revenue
 - Clinical Outcomes
 - PowerCosting – Cost Management
 - PowerLabor – Labor Management
 - CC/MCC/CMI/LOS accelerators
 - Population Health Management

- Detective

- Lost charges
 - Suboptimal Clinical Outcomes
 - Increased LOS
 - Rework claims
 - Denials

Phase 2 – Patient Care

•Preventative

- Non-Technology
 - Ensuring that each person reviews the prior internal control point for completeness
 - CDI to focus on outcome measure not just reimbursement
 - Ensuring all required documentation is present prior to surgical events
 - Pop Health – ensuring post ED event patient has necessary care to prevent recurring visits

•Preventative

- Non-Technology
 - Every step should be diagrammed, and appropriate “hand-off” occur
 - Focus on care management to ensure that inpatient authorizations and discharge plan start from the point of admission as outpatient or inpatient

What Do Phase 2 Controls Look Like – Example: Complete & Accurate Charge Capture

Preventative:

- Create a daily reconciliation policy for charges
- Employ technology to look for missing and erroneous charges
 - Software that compares CPT to CPT and CPT to ICD-10 CM and ICD-10PCS to ICD-10 CM
 - Software should cover both compliance and revenue concerns
 - Adaptable to specific cultures and charge capture situations
 - EX: Medications charged without administration, administration without medication, pacemaker insertion without lead, Trauma without critical care, and other rule and AI based findings.
 - Technology requires human interpretation and **ROOT CAUSE** remediation

Example: Drug on Claim without Admin

Missing Administration: Chemotherapy Admin for Alemtuzumab

YES

NO

Start Date

01/01/2021

End Date

dd/mm/yyyy

Type

HOSP

Category

Revenue

Present On

DOS

Workload Types

ALL x Select...

Rev Code

0331 (Chemotherapy)

Status Indicator

S

Average Gross Charge

1130

Estimated Net Reimbursement

235.64

Patient Class

OP

Global Average - Gross Charge

\$1,917.23

Conditions

WITH

ANY

Hospital CPT/HCPCS

J0202 x Add value(s)...

WITHOUT

ANY

Hospital CPT/HCPCS

96409 x 96413 x 96549 x C8957 x Q0084 x Q0085 x Add value(s)...

Preventative – Protect Your Margin

“No Margin, No Mission”

Sister Irene Kraus

Founding Chief Executive of the Daughters of Charity National Health System
American Hospital Association Chair

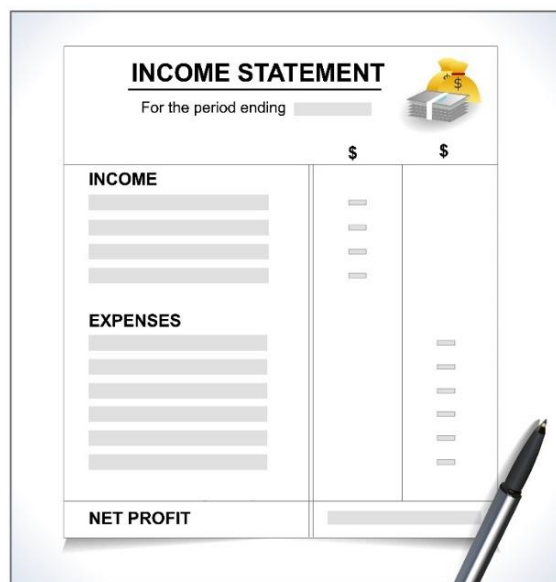
Protecting Your Margin

- Can either increase your volumes and reimbursement **OR**
 - Aggressively manage costs through patient activity costing and evidence-based practices
 - Lost charges continue but the cost to perform those lost charges are still occur expediting the erosion of the margin
 - Utilizing control points to examine the prior steps, use data to predict potential future failures and address current known failures

Cost Management

Linking Cost to Patient Activity

General Ledger (Costs)



The image shows a template for an income statement. At the top, it says 'INCOME STATEMENT' with a small icon of a stack of money. Below that, it says 'For the period ending' followed by a blank line. The form is divided into two main columns, each with a '\$' symbol at the top. The left column is labeled 'INCOME' and has several horizontal lines for entries. The right column is labeled 'EXPENSES' and also has several horizontal lines. At the bottom of the form, there is a section labeled 'NET PROFIT' with a blank line for the result. A pen is shown at the bottom right of the form.

- 1 Organizing departments and accounts into meaningful groups

Services / Products



- 2 Identifying the activities that drive costs for the services and products you provide



Cost Management Controls

•Preventative

- Reviewing preference cards in OR to avoid wastage
- Utilization review committees to limit incidental testing
- Appropriate Use Criteria (AUC) CMS
- Evidence based medicine guidelines
- Patient in the best level of care criteria – moving care to outpatient and home

•Detective

- Managing waste of opened items in OR that are not consistently used through data
- Use data to identify potential readmissions
- Data to look at downgrades – should the patient have been in a different level of care that would reduce costs
- Use data – what patient activities are ripe for lowered cost

MUCH Higher Financial

Impact Example:
Quality eliminating waste vs. Revenue Growth

Revenue growth Strategy:

Do nothing and 1 additional preventable heart failure admission occurs:

FFS Revenue:	\$25,000
Cost to Deliver Care:	<u>-\$23,000</u>
Margin:	\$2,000*

Quality eliminates waste:

Move upstream and prevent 1 heart failure admission

Revenue:	Fixed \$PMPM
Prevention Investment:	-\$1,000
Cost Avoidance:	<u>+\$23,000</u>
NET Margin Impact:	\$22,000*

**Net
Operating
Margin**
(and return on
investment)

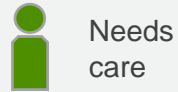


Waste Category Question

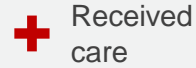
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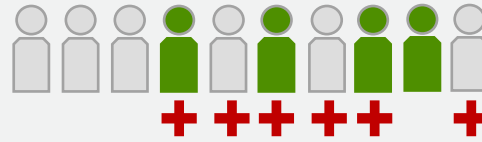


Needs care



Received care

Current State



Ideal State



Improvement

- Fewer inappropriate cases
- Early intervention to prevent disease or injury

What care should be included?

Within-case variation
(# and type of units per case)



Procedures



Diagnostic test



Labs



Drugs



Behavioral consults



Patient education



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- Do what we know works

Is each care component delivered efficiently?

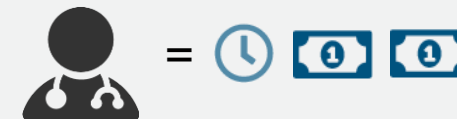
Efficiency
(cost per unit of care)



Time
(both patient and clinician time)



Resources
(both direct and indirect costs)



- Lower-cost drugs and supplies are used
- Technical and administrative processes are streamlined to reduce indirect costs

Removing Waste Moving to Risk

WASTE REMOVAL LEVEL

PAYMENT METHOD

	<u>% of all waste</u>	<u>FFS</u>	<u>Per case</u>	<u>Provider at risk</u>
Who should get care and when?	45%	▼	▼	▲
What care should be included?	40%	▼	▲	▲
Is each care delivered efficiently?	15%	▲	▲	▲

*Adapted from James Brent C and Poulsen Gregory P. The case for capitation: It's the only way to cut waste while improving quality. *Harv Bus Rev* 2016; 94(7-8):102-11, 134 (Jul-Aug).

Phase 3

Adding Full Review is Preventative at Last Stage

Phase 3 – Discharge

- Key Control Points

- Inpatient
- Outpatient
- ASU

- Objectives

- Healthy population seeking optimal level of health without medical error and high-quality outcomes

- Preventative

- Technology

- Patient Engagement to optimize post discharge care through Twistle
- Substance abuse pathways

- Detective

- Readmissions data
- Return Emergency Visits data

Move to Value – Focus On Patient Experience as an Outcome

both preventative and detective control points for patient compliance

Overview

Twistle™ by Health Catalyst

93%

Improved Patient Satisfaction

30%

Reduced Length of Stay

38%

Reduced Readmissions

30%

Reduced No Show Rate

The Human Component



Labor Shortage

- Nursing shortage post Covid is acute
- Have been paying a premium to hire or use traveler's
- **Not sustainable** – culture will need to change to attract and retain high quality nurses
- Some reasons are:
 - Burnout
 - Fear of retribution or criminal charges for medical errors
 - Inability to care for patients adequately
 - <https://nurse.org/articles/nurse-calls-911-washington/>
 - Charge nurse called 911 to get assistance to take care of emergency patient

Fully Integrated Team

- Silos can develop due to:
 - Budgets where gross charges can become border disputes
 - IT documentation (EMR) that is too tailored to the provider and not for the patient outcome result in disruptive documentation
 - Culture of the facility – does it encourage interaction from board level or rewarded when a department or person excels
 - When staff don't feel valued
 - When there is not cross team interactions and problem solving
 - ***Fail to focus on quality patient care and outcomes provided in the most cost-efficient method possible as the endpoint***

Action Items for the Team

- Every control point requires that the team members understand what happens at that control point and be able to execute on it
- Every control point mandates that the team review all aspects of the prior step to ensure that accuracy and completeness was achieved
- Every control point serves as an opportunity to ensure reimbursement, manage costs and contribute to the ultimate quality outcome for the patient
 - Ex: Serves to decrease medical errors that result
 - Ex: Serves to ensure patient service charges are not lost or charged erroneously

Review the Prior Control Point

Phase 2: (Review activities in phase 1)

- Medical: confirm procedure to be performed, allergies, medications etc.
- Will review demographics with the patient
- Will review reason for presentation
- Will review eligibility (especially at beginning of the month and new year)
- Ensure medical necessity achieved
- Medicare inpatient only list
- Review authorization (correct date and procedure)
- Ensure correct account (multiple accounts may exist for patient)

Review Prior Actions within Current Phase (Ex: Phase 2)

- Preventative – create and complete daily charge reconciliation
 - Review documentation remembering that CDM charges also code the procedure – is the documentation present and does it support the charge
 - Review OR flowsheet – are all supplies and devices charged ?
 - Look especially at implant logs – are devices present and match charges
 - HCPCS code for devices correct ?
 - Charges that are only partially represented – ex: Infusion / Injection of Chemotherapy without the chemotherapeutic
- Team members are responsible for creating procedures to prevent lost charges.

Charge Capture

- An example where technology is required to assist, due to the sheer volume, is charge capture
- Every control point may have been reviewed by the team accurately but someone else changes or adds something after the fact
- Therefore, assistive technology will be required to process the thousands of daily charge transactions to create a preventative barrier to errors moving to phase 3

Assistive Tools for Team

Drag and drop a column header here to group by that column

Workflow Status	Assignee	Root Cause	Rule ID	Rule Name	Rule Scope	Service Area
In Process	Adele The Admin	Billing Issue	2330	Missing Primary Procedure - CPT Code 96367	Encounter	IV Therapy
Queued	Infusion Center		2334	Missing Primary Procedure Code - CPT 96375 or 96376	Encounter	IV Therapy
Queued	Laboratory Services		20011	Missing Lab/Pathology	2019-12-09	Laboratory
Queued	Emergency Services		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Infusion Center		913	Missing Radiological Supervision & Interpretation	2019-12-09	Diagnostic Ra
Queued	Surgical Services		20162	Missing Device - Intraspinal or Intradiscal Catheter	2019-12-09	Medical/Surgi
Queued	Emergency Services		3345968	Missing Administration IV Push Routes Only	Encounter	IV Therapy
Queued	Emergency Services		3345916	Missing Administration - IM or SC Drugs	Encounter	IV Therapy
Queued	Infusion Center		2330	Missing Primary Procedure - CPT Code 96367	Encounter	IV Therapy
In Process	Observation Unit		24	Missing Procedure Charge - Blood Transfusion	2019-12-08	Blood Bank
Queued	Emergency Services		3345916	Missing Administration - IM or SC Drugs	Encounter	IV Therapy
Queued	Emergency Services		3345916	Missing Administration - IM or SC Drugs	Encounter	IV Therapy
Queued	Adele The Admin	Rule Adjustment	3380888	Unlisted CPT Code Review - Pulmonary Service	Encounter	Pulmonary Fu
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Surgical Services		20160	Missing Supply - Hemodialysis or PICC/Midline Catheter...	2019-12-04	Medical/Surgi
In Process	Observation Unit		24	Missing Procedure Charge - Blood Transfusion	2019-12-07	Blood Bank
Queued	Emergency Services		3345916	Missing Administration - IM or SC Drugs	Encounter	IV Therapy
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Infusion Center		3345904	Missing Procedure - IM, IV, or Subcu Drug Administration	Encounter	IV Therapy
Queued	Emergency Services		3345968	Missing Administration IV Push Routes Only	Encounter	IV Therapy

See More

Account Cases

Cases selected: 0

				Case ID	Rule ID	Rule Name	Gross
				14732	3345904	Missing Procedure - ...	\$500.00

Additional Accounts

Charges

Drag and drop a column header here to group by that column

	↓ 1	CDM Code	↓ 3	Department ID	Department Name	Rev Code	CPT/HCPCS	Modifiers
		250000563		25000	Pharmacy	0636	J2405	U8
		250000509		25000	Pharmacy	0636	J1170	U8
		450000051		45000	Emergency Departm...	0999		
		402000039		40200	Ultrasound	0402	76856	
		402000029		40200	Ultrasound	0402	76830	
		350000049		35000	CT Scan	0255	Q9967	
		350000007		35000	CT Scan	0352	74177	
		300000342		30000	Laboratory	0300	81003	

Scope

Encounter

Rule Source

Global

Case Trigger Details ?

HOSPITAL CPT/HCPCS

J2405J1170

Rule Targets ?

✓

Your team has resolved similar cases 0 times in the last 6 months.

HOSPITAL CPT/HCPCS

963659636696367

963689637296374

9637596376

REV CODE

036003610362

DISCHARGE LAST CHANCE

- In most cases once the patient has been discharged most of the opportunity has expired
- Correct phase 1 and phase 2 preventive and detective controls must be completed
- Documentation must support the medical necessity and charges

Summary

External Forces

- Rising costs without subsequent improvement in mortality and morbidity (except cancer)
- Decreased labor pool requiring outsourcing
- Need to move from Fee for Service to more fully capitated per member per month
- American culture demands access to healthcare but disparity in delivery creates on-going concerns requiring a significant shift to population health metrics
- Facilities need to focus on preventative services to do cost avoidance

Control Points are Key

- Break down silos and change culture to incorporating other team roles
- Change thought practices from performing more volume to services that increase the overall margin
- Review of prior steps to ensure all steps are completed
- Use discharge as a final review step
- Incorporate technology along with human control points for synergistic outcomes

Overall Objectives

- Focus on patient care for the right place, right patient, right procedure / service in the right time
- Goal is to provide cost effective care that is of the highest quality without any medical errors
- **Control Wastage**
 - **Unnecessary** Death and Suffering (Clinical & Experience Outcomes)
 - **Unnecessary** Time, Energy and Resources (Financial Outcomes)
- Healthcatalyst / Vitalware Mission might be yours too:
 - To be the catalyst for massive, measurable, data-informed healthcare improvement



Questions?

A large, faint, light blue watermark of the Vitalware logo is centered in the background. The logo consists of a stylized 'V' and 'W' combined into a single graphic.

Thank you!