**Strategies to Optimize Your Revenue Cycle**
September 3, 2020
Questions and Answers

**What initiatives have been taken to help ensure accurate documentation of infusions? Especially in cases where start/stop times are required for payment**

First, we have a charge reconciliation policy that is conducted by clinical leaders within the clinic on a daily basis. This allows nursing staff or other department leads to validate that all charges were entered from the previous day. This also includes validated that their injections/infusions were entered. We also work directly with our HIM & coding teams to help perform audit of all injections and infusion (with start/stop times) in the cancer/infusion centers. Sites have to reach a 95% accuracy rate or they will need to go on a 100% review of charges until they can maintain consistent accurate charging.

**Do you have any recommendations specific to working with a revenue cycle company that is a vendor relationship rather than employees of your hospital?**

Minimal experience in this area as we do not outsource any of the pharmacy revenue cycle. There are other aspects of the revenue cycle that are outsourced (i.e. lab) that require repetitive work or validation. The work typically does not require any decision to be made. The organization monitors productivity of the vendor as it could be a source of delaying a claim to get out the door; thus, increasing AR days.

**If this is currently outsourced, how would you recommend bringing this back in house?**

Greatly depends on the area of the revenue cycle that is being outsourced. Evaluate the risk associated with the function (i.e. if done incorrectly are you at compliance risk or loss of revenue), outcomes of the vendor, and if you have the internal capacity/know how to bring this function in house.

**Question for Maxie Friemel: Do you have a meeting template for Revenue Integrity meeting? I discovered we do not have access to view final claims which is why it is so important to meet as a multi-disciplinary team.**

Core membership include: IT (pharmacy and revenue systems), compliance, care site pharmacy directors, billing, denials

Standing agenda items each month include:
- Review of government audit results
- Review of IT/new build
- Compliance review
- Denials review
- The remainder goes through various projects or issues to be resolved or rebill efforts.

**JW- Waste - what were your thoughts when this new rule came out and has it been beneficial for our organizations financially?**

Billing for waste can have significant financial impact. All patients should be charged the same; therefore, if applying a waste charge to Medicare patient you would also apply waste charge to the commercial patient. This will increase the gross revenue across the board. You will see added net revenue when billing waste for separately payable drugs.

**Question for Maxie Friemel: What suggestion would you have for pharmacy to get involved as a first step role in the revenue roles at an organization? We can't "own" it but we want to show a role in almost a pilot format. Ideas?**

Start small and create small wins. Meet with various individuals within the revenue cycle and ask the process for drugs as they flow through. Try to access some data of your high cost drug lines and follow them to reimbursement. Or, evaluate your charge master. Any error identified in the charge master or gap in reimbursement is strong potential of a downstream billing error. Additionally you could access the CMS quarterly transmittals and evaluate the changes in billing codes, and then ask who in your organization is responsible for ensuring these are updated.

**Can you describe where in the pharmacy revenue cycle medication assistance program processes best fit?**

Medication assistance programs are as, if not more, important today then yesterday with increasing drug cost and under insured population. It is advantageous to evaluate the need for medication assistance when there is an unsupported prior authorization or lack of medical necessity (Medicare). Many manufactures will support free drug for individuals with insurance when it is off labeled or their plan does not cover the cost of the drug. This is an area pharmacy is keen on owning.

**Question for Grayson Peek: With regards to Site of Care changes, we are seeing our payers indicate that free standing locations *cannot* be hospital owned. Are you also seeing this barrier in your local markets?**

Not hearing of this as an issue in my local market. The key is that the ownership of the location can’t be “hospital-based” even if they are off-site/freestanding. Many entities will have off-site facilities designated as “hospital-based” for other purposes (e.g. 340B).

**Hi! I am an ambulatory care pharmacist and the majority of my billing question our related to professional billing codes, rather than medications... The billing and compliance individuals at my institution have rejected the majority of the information that I have gotten from ASHP so far. Is there any information on this specific topic on the Certificate Program?**

Yes. The Pharmacy Revenue Cycle Management Certificate Program has 1.5 hours of content dedicated to Billing for Clinical Pharmacy Services and Collaborative Practice, and 2 hours of content dedicated to Additional Billing Opportunities and Value-Based Care.

**What types of industry benchmarks are available to determine goals/priorities of focus?**

Discussed during the Q&A session. Unfortunately, industry benchmarks are not very prevalent, and would likely vary greatly by organization and structure. Recommend establishing a peer group that you can discuss key indicators with, while also following internal benchmarks over time.

**Question for Gene Rhea: Regarding Clinical Review Board...Please explain how your P&T Committee is integrated into this process. For example, are these high impact therapies reviewed by P&T before they go to Clinical Review Board? Is the Review Board an "extension" of the P&T Committee?**

These are already P&T approved agents. The Review Board is essentially an *OK to Treat* approval where we are ensuring each individual patient is an appropriate candidate for the medication and has the financial clearance to be treated – usually with preauthorization or predetermination documentation from their payer as a guarantee of payment.

**Do you still find missing administrations on Unreconciled Dispense Report in a charge on administration hospital?**

Yes we do, and we typically have those flow into a work queue and triage by $ charge value when investigating and reconciling the cause.

**What is your opinion on restricting access to newly FDA-approved medications for the first several months after approval to allow rev cycle to evaluate the financials or until CMS assigns a permanent billing code?**

This is not something we have typically done formally, though it often happens in that payers will be slow to respond to preauthorization requests and/or will provide early denials until their systems are updated. We generally don't wait until a permanent billing code is assigned as they can take multiple months.

**We have all the pieces reporting to different managers in pharmacy (IT, compliance, and billing). Is there an org structure you recommend to support high efficient integrity? Centralized to 1 director vs many?**

It depends on the size of your department and the scale these individuals would need to perform on. In a smaller institution one pharmacist may be able to do all this work, with a specialized analyst supporting them. In a larger institution, you likely need to have multiple specialized pharmacists or managers supervising this work with specialists supporting them.

**In regards to pharmacy revenue what processes are in place to help receive re-imbursement from medications that have temperature excursions that are no longer able to be used? Does pharmacy eat the cost of the medications or can you submit insurance claims on the inventory that you have to expire?**

In my experience, we use either our reverse distributor for cost recoupment or we eat the cost. Insurance claims can be used depending on the dollar value involved, but generally deductibles apply which may make that claims processes less valuable.

**Is the ASHP Revenue Cycle Management Certificate Program specific for a hospital system? Or are community/retail pharmacies included?**

The certificate's focus is health system-based medication and clinical service revenue cycle. Detailed information is available at: http://elearning.ashp.org/products/8146/pharmacy-revenue-cycle-management-certificate

**Question for Gene Rhea: Roughly what proportion of cases are denied at the high impact clinical review board? We have difficulty engaging our oncologists in a similar process. How do you get them on board?**

Very few cases are ultimately denied, but probably 30% get returned for further documentation, usually if the payer authorization is too narrow, say from a date of service standpoint, or there are site of care or white bagging type requirements.

**Did the idea to create the High Impact Drug Review board generate from pharmacy leadership or from executive hospital leadership? If the idea did generate from pharmacy, how did you engage CMO and physician champions to join this initiative (ie, how did you secure resources and participation for this review board)?**

The CPO led an interdisciplinary committee that developed the plan to make CART available to the health system's patients. The *Clinical Review Board for High Impact Drugs* was stood up to operationally manage requests for CART and evolved to include other high impact therapies when they became available. The CPO, Chair of the Pharmacy and Therapeutics Committee, the hospital's Chief Medical Officer and the Chief Medical Officer of the health system's Patient Revenue Management Organization designed board's role and function and are the leaders of the board.

**Question for Gene Rhea: What are your next steps once you identify drugs with high denial rate? Do you change therapy protocols?**

Our next steps are generally to try to identify the root cause of the denials to see if there is a common theme. Often time's denials are based on either changes in course of therapy (delays in treatment which cause it to be outside of authorization) or lack of predetermination. We rarely change therapy for a patient.

**Is it necessary for a pharmacist to be familiar with multiple systems (EPIC, CERNER, etc) for charge integrity monitoring?**

Yes, it is necessary to be very familiar with your medical record and the charging methodology used – this can be learned and having specialists who are non-pharmacists (i.e. technicians) involved is very helpful.

**Question for Maxie Friemel and group: Does your team address billing questions/review regarding Medicaid patient accounts and following 340b regulations? How is that process and what are the difficulties the team has faced/currently face?**

Response from Maxie Friemel:

Medicaid – We have transitioned our hospitals to “Medicaid carve-in” which does require a number of billing changes if you plan to insource this function (i.e. UD modifier, AAC vs. UC). We have automated the pricing overrides and applications of the UD modifier when appropriate. Additionally, we have work queues in place to find any accounts in error.

Medicare – We have overrides built directly on the medication record itself to apply the TB or JG modifier. Additionally, we have this updated on a quarterly basis as status indicators change. We have a failsafe check in place as we have created a claim edit review to evaluate all claims going out the door for the appropriate modifier.

Response from Gene Rhea:  Yes, our revenue integrity team monitors hospital billing to ensure proper Medicaid modifiers and Medicare OPPS (JG/TB) modifiers are applied as required. The process was a bit cumbersome to setup but we have charge router rules in place today where we are generally monitoring outliers via work queues.

**What are some of the challenges in capturing charges from OR medication use (due to a lack of pharmacy orders in this area)?  Have you looked at how RFID can capture 99.99% of all OR transactions?  Thank you**

We have implemented anesthesia tools within our EHR to streamline ordering/documentation of medications. We audit transactions and evaluate high level revenue and usage reports. We have not evaluated the use of RFID.