Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Friday, February 21, 2020 at the hour of 9:00 A.M. at 1950 W. Polk Street, in Conference Room 5301, Chicago, Illinois.

I. Attendance/Call to Order

Chair Koetting called the meeting to order.

Present: Chair Mike Koetting and Directors Ada Mary Gugenheim; Robert G. Reiter, Jr.; and Layla P. Suleiman Gonzalez, PhD, JD (4)

Telephonically Present: Director Hon. Dr. Dennis Deer, LCPC, CCFC (1) and Gerald Bauman (Non-Director Member)

Absent: None (0)

Additional attendees and/or presenters were:

Ekerete Akpan – Chief Financial Officer
Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Debra D. Carey – Interim Chief Executive Officer
Jeff McCutchan – General Counsel
Barbara Pryor – Chief Human Resources Officer
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit

Mark Shipman – Information Security Officer
Robert Sumter, PhD – Interim Deputy Chief Executive Officer, Operations and Chief Information Officer
Dianne Willard – CCH Compliance Officer
Shirley Williams – Assistant Coding Manager

Director Reiter, seconded by Director Gugenheim, moved to allow Director Deer to telephonically participate in the meeting as a voting member. THE MOTION CARRIED UNANIMOUSLY.

II. Public Speakers

Chair Koetting asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from Chief Corporate Compliance and Privacy Officer (Attachment #1)

A. Report on External Coding Audit

Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, and Dianne Willard, CCH Compliance Officer, provided an overview of the information contained in the Report. The Committee reviewed and discussed the information.

The Report included information on the following subjects:

- External Coding Audit Results
- Actions in Response to Results
III. **Report from Chief Corporate Compliance and Privacy Officer**

A. **Report on External Coding Audit (continued)**

During the review of the information regarding internal workforce coders, Director Reiter inquired regarding staffing levels; he asked whether Cook County Health (CCH) is appropriately staffed, based on industry standards for coders. Ms. Bodnar responded that she will provide that information.

The Committee discussed the subject of the recruitment of coders. Shirley Williams, Assistant Coding Manager, noted that CCH has been trying to fill the two (2) vacant coder positions for the past two (2) years. Barbara Pryor, Chief Human Resources Officer, provided additional information. Coders are highly sought after and typically work remotely. Although CCH has a telework policy, in order for internal CCH coders to work remotely, metrics need to be established to measure the productivity for these positions, which are highly unionized. They will continue to discuss this subject; she hopes that a decision will be reached soon.

IV. **Recommendations, Discussion/Information Items**

A. **Report on Revenue Cycle Optimization** (Attachment #2)

Ekerete Akpan, Chief Financial Officer, and Robert Sumter, PhD, Interim Deputy Chief Executive Officer of Operations and Chief Information Officer, provided an overview of the Report on Revenue Cycle Optimization. The Committee reviewed and discussed the information.

The Report included information on the following subjects:

- Overview of the Revenue Cycle
- Healthcare Financial Management Association (HFMA) – The Revenue Cycle
- CCH Revenue Cycle Journey, Successes and Challenges
- Revenue Cycle Lookback
- The Journey – Successes and Challenges
- Cerner Patient Accounting Project Status
- Program Governance
- Committee Details and Objectives
- CCH Financial Metrics (as of January 2020)
- Patient Access Status – People, Process, Technology
- Pre-Service in Perspective
- The Revenue Cycle Program: Scheduling, Pre-Registration, Pre-Certification (Authorization)
- Time of Service Status – People, Process, Technology
- Time-of-Service in Perspective
- The Revenue Cycle Program: Patient Arrival, Validation and Activation, and Documentation and Revenue Recognition
- Post-Service Status – People, Process, Technology
- Post-Service in Perspective
- The Revenue Cycle Program: Claim and Remit Processing, Denials Management, and Payer Payment Analysis
- Next Steps and Discussion
- Optum Charge Description Master (CDM) Services and Software
- What to Expect by March 20th
V. **Action Items**

A. **Minutes of the Audit and Compliance Committee Meeting, December 12, 2019**

   Director Gugenheim, seconded by Director Suleiman Gonzalez, moved to accept the minutes of the Audit and Compliance Committee Meeting of December 12, 2019. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Sections V and VI

VI. **Closed Meeting Items**

A. **Report from Director of Internal Audit**

B. **Discussion of Personnel Matters**

   Director Reiter, seconded by Director Gugenheim, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(1), regarding “the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity,” and 5 ILCS 120/2(c)(2), regarding “meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America.”

   On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

   Yeas: Chair Koetting and Directors Deer, Gugenheim, Reiter and Suleiman Gonzalez (5)

   Nays: None (0)

   Absent: None (0)

   THE MOTION CARRIED UNANIMOUSLY and the Committee convened into a closed meeting.

   Chair Koetting declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.
VII. Adjourn

As the agenda was exhausted, Chair Koetting declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXX
Mike Koetting, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

Request: Information was requested regarding whether CCH is appropriately staffed for coders, based on industry standards. Page 2
Meeting Objectives

Review

- External Coding Audit Results
- Actions in Response to Results
External Coding Audit Project - Results

Overall Findings

2019 External Coding Audit revealed opportunities within the following areas:

- Coding quality – for both diagnosis and procedure assignment
- Physician documentation
  - Missing inpatient admission orders
  - Lacking specificity and details to justify coding/billing service(s)
- Laboratory Issues
  - Inaccuracy with billing units relate to technical issues
    e.g. Same lab test done multiple times billed as a quantity of one
  - Customized CCH lab order sets consist of multiple lab tests that lack specificity for medical necessity
    e.g. Orders for laboratory tests must be patient-specific and include the rationale/need for the test
Inpatient Coding – Performed by External/Contract Coders

Probe Audit Results

Examined 25 Records/Claims for facility and professional-fee coding in two (2) Diagnosis Related Groups (DRG) Categories:

- DRG 313 - Chest Pain – 88% Accuracy Rate
- DRG 690 – Kidney and UTI’s W/O Major Complication Comorbidity (MCC) - 92% Accuracy Rate

Reviewed both DRGs due to high frequency of this DRG (Diagnosis-Related Group), this may indicate lost opportunity by not capturing more specific diagnoses

- Identified code assignment errors and missing orders for an inpatient level of service
Outpatient Coding – Performed by Internal Workforce

Probe Audit Results

Probe sample of 25 Records/Claims for facility and professional-fee coding in 2-Outpatient Areas:

- Cardiac Catheterizations
  - Results – 68% CPT Accuracy Rate
  - Reviewed this area due to complex coding where add-on procedures can be under or over coded
  - Identified treating physician orders were missing rationale for procedures

- Dermatology
  - Results – 76% Accuracy Rate
  - Reviewed this area due to high volume of visits and may indicate lost opportunity for capturing all services/procedures based on documentation and coding
  - Identified potential finding of absent procedure documentation; industry standard suggests Dermatology clinics should be performing more procedures than clinic visits
Inpatient Coder Assessment Process

Approach by External Coding Contractor to Assess their Coder Accuracy

- External Coding Contractor,
  - Audits 10-records per month/per coder
  - If a contracted coder does not meet 95% accuracy, a remediation process is initiated
  - During remediation, if the contracted coder does not meet 95% accuracy for 3-consecutive months, then the coder is removed from coding CCH records
  - External coding contractor holds weekly/monthly meetings to discuss any audit or denial findings

- To address inpatient order inaccuracies,
  - If an inpatient order is missing or questionable, the external vendor transitions the records to CCH Coding Leadership
  - CCH Coding Leadership performs a secondary review of the medical records
  - If the secondary review fails to find an inpatient order, the account is transitioned to Finance/Revenue Cycle to modify the admission type based on the existing order.
Internal Processes to Improve Documentation and Coding

The following activities have been implemented at CCH

- Engaged an external Clinical Documentation Improvement (CDI) Specialist team to:
  - Provide physician documentation education through rounding and monthly educational meetings
  - Target diagnosis specificity, complications, co-morbidities, severity of illness and risk of mortality
  - Initiate CDI software to improve CDI activity (3M CDI Artificial Intelligence)
  - Identify specific DRGs for secondary CDI review in the following categories,
    - Hospital Acquired Conditions (HACs)
    - Mortality
    - Signs and Symptoms DRGs
- Implemented software (3M Artificial Intelligence) to guide coders in the following areas,
  - Facility Coding Software (3M 360)
  - Clinic Coding (3M Code Assist)
  - Physician Coding (3M Professional Fee)
Strategy to Optimize Internal Coding Accuracy

Initiatives to Improve Current Processes

- Outpatient and Outpatient Same Day Surgery Coding – Internal Workforce
  - Initiate review and feedback for each internal coder in 2Q2020
  - Continue monthly coding roundtables - discussing difficult coding cases with errors
  - Participate in monthly online webinars from several companies on various industry coding topics where coders can earn their required continuing education units
  - Develop an auditing monitoring program once leadership is staffed
  - Engage external experts to perform independent Quarterly Audits of both Internal and External Coders – contingent upon executive leadership approval and fund allocation (this initiative is not currently budgeted)
Secondary Findings in Laboratory – Probe Review

Findings are an adjunct to the external coding audit

- Follow up on laboratory findings
  - Identifying component of the billing system causing multiple tests to roll-up to one (1).
    - Correction completed, validated the change resolved the inaccurate billing
  - Planning to engage with Physician Leadership to improve Attending/Resident documentation justifying test/re-tests
  - Eliminating/reducing customized CCH lab order sets that are not within nationally defined standards
    - Once complete, will educate all Attending/Residents on tests within any customized CCH lab order set to ensure accurate lab orders are based upon medical necessity
Questions?
Agenda

• Overview of The Revenue Cycle
• CCH Revenue Cycle Journey, Successes & Challenges
• Cerner Patient Accounting Project Status
  • Project Governance & Structure
  • Project Critical Path
  • Metrics Review
• Patient Access Status - People, Process, Technology
• Time of Service Status - People, Process, Technology
• Post-Service Status - People, Process, Technology
• Next Steps & Discussion
Overview of The Revenue Cycle
Overview of the Revenue Cycle

• The Healthcare Financial Management Association (HFMA) defines a revenue cycle as “All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.”

• The Revenue Cycle begins with Medical Record / Encounter creation, and ends with Collection / Write-off.

• 3 Critical Divisions of the Revenue Cycle:
  • Pre-service - patient is scheduled and pre-registered for service. The encounter record is generated, and the patient, guarantor, and insurance information is obtained and/or updated as required.
  • Time-of-service - for scheduled patients, a final account review is completed prior to the patient’s arrival.
  • Post-service - coding claims are prepared and submission payment processing and balance billing is done.
HFMA - The Revenue Cycle

Pre-Service
- Insurance Verification
- Price Estimation
- Pre-certification
- Pre-registration
- Scheduling

Time-of-Service
- Cashiering
- Patient arrival
- Financial counseling
- Patient care delivery
- Validation & activation
- Financial clearance
- Claim processing
- Remittance processing
- Denial processing
- Claim processing
- Case/referral management

Post-Service
- Payer payment analysis
- Third-party follow-up
- Customer service
- Self-pay collection
- Collection agency

Engaged Patient
- Coordination of care
- Coordinated financial & clinical care
- Compliant clinical documentation

Engaged Consumer
- Ease of access
- Improved consumer service
- Improved quality

Satisfied Customer
- Appropriate payment
- Effective & efficient account resolution
- Decreased cost to collect
CCH Revenue Cycle Journey, Successes & Challenges
Revenue Cycle Lookback
• Consistent year-over-year growth in gross charges capture a 3% growth to $1.74B in FY2019 from $1.69B in FY2018

• Consistent year-over-year growth in cash collections a 7% growth to $409M in FY2019 from $383M in FY2018

• Sustained growth in Case Mix Index by an average of 6% in FY2019 vs FY2018

• Ongoing Improvements in Initial Claims Denials

• Sustained Improvements in “Allowances for Bad Debt” and bad debt write-offs in FY2018 vs. FY2017 a trend likely to sustain in FY2019 audited reports
Cerner Patient Accounting Project Status
Committee Details & Objectives

Information Technology Steering Committee
• Committee Chair – CIO
• Objective - Interdisciplinary Executive representation across all IT projects.

Executive Steering Committee
• Committee Chair - CIO & CFO
• Objective - Executive oversight of Revenue Cycle Program.

HIS Clinical Advisory Counsel
• Committee Chair - CMIO
• Objective - Clinician only, bidirectional collaboration of IT based initiatives.

Revenue Cycle Action Team
• Committee Chair - Finance Project Manager & Financial Alignment Executive
• Objective - Execute system-wide revenue cycle initiatives and drive optimization by identifying where opportunities exist, determining best practice, and driving to implement standard process for hospital, outpatient clinics and physician groups.
# CCH Financial Metrics (as of January 2020)

<table>
<thead>
<tr>
<th>Metric</th>
<th>*HFMA Benchmark</th>
<th>Actual</th>
<th>CCH Target</th>
<th>Description</th>
<th>Current Status</th>
<th>Future Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Collection</td>
<td>N/A</td>
<td>$34.5M</td>
<td>$37M</td>
<td>Gross amount of cash Collected Monthly from CCH Services transmitted to payers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Receivable &gt; 90 Days as a % of Billed AR</td>
<td>&lt;20%</td>
<td>47%</td>
<td>40%</td>
<td>Accounts Receivable (AR) is the gross dollar amount of patient accounts that have been billed (transmitted) to the payer but not yet paid. (Unpaid Patient bills Transmitted to the payer 90 or more days/Total number of Unpaid patient bills transmitted to the payer=Accounts Receivable% &gt;90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNFB Days</td>
<td>7 Days</td>
<td>8 Days or $26.4M</td>
<td>5 Days</td>
<td>Discharged not Final Billed (DNFB) is a term used to define unbilled accounts where the patient has been discharged and the account is either not coded, or pending charges, service documentation or claim holds to be released into the final billed receivable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late Charges</td>
<td>&lt;2%</td>
<td>12%</td>
<td>7%</td>
<td>CCH has a target to transmit bills to the payer within 5-7 days after the patient’s last service date. Bills transmitted after 5 days are late. (Charges with postdate&gt; than 5 days from the last service date/ Total Gross Charges)= Late Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total AR to date</td>
<td>Not Applicable</td>
<td>$421.9M</td>
<td>Not Applicable</td>
<td>Accounts Receivable (AR) is the gross amount of patient accounts that have been billed (transmitted) to the payer but not yet paid are classified as receivable.</td>
<td>Not Applicable</td>
<td>TBD</td>
</tr>
<tr>
<td>Accounts Receivable Days (AR Days)</td>
<td>&lt;40 Days</td>
<td>88 Days</td>
<td>60 – 65</td>
<td>The average length of time, in days, that patient accounts are outstanding: billed to the Payer but not yet paid. (Net A/R/ Average Daily Net Patient Service Revenue)=Net A/R Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>60 Days(non HFMA)</td>
<td>-</td>
<td>60 Days</td>
<td>The number of days that an organization can continue to pay its operating expenses, given the amount of cash available.</td>
<td></td>
<td></td>
</tr>
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</table>

* Source Healthcare Financial Management Association (HFMA) Key Hospital Statistics and Ratio Margins
Patient Access Status - People, Process, Technology
Pre-Service In Perspective
**The Revenue Cycle Program: Scheduling**

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient scheduling ensures appropriate reimbursement and/or significant resource coordination, such as reserving rooms and/or equipment, ordering devices or supplies, and ensuring that professional staff, such as physicians, nurses, and/or technicians are available. Patient Access are ‘First line billers’.</td>
<td>• Lack of Standardization&lt;br&gt;• Lack of Accountability&lt;br&gt;• Limited Patient Contact!&lt;br&gt;• Limited Patient data collection due to established roles and responsibilities&lt;br&gt;• Improper system usage - duplicate patients, overbooking.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>People</th>
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<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Org. structure alignment with Industry Best Practice - scheduling functions across the Health System.</td>
<td>Mary Sajdak / Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td>n/a&lt;br&gt;This has not yet been addressed. Determination made to focus on standardization but will not align under Finance (Finance will monitor and advise on process).</td>
</tr>
<tr>
<td>Job role expansion to mirror Industry best practice including collection of patient demographic and financial data at point of scheduling.</td>
<td>Mary Sajdak / Ekerete Akpan</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>n/a&lt;br&gt;Process and people not yet addressed, waiting on org. structure alignment and associated contractual discussions.</td>
</tr>
<tr>
<td>System-wide process standardization, with checkpoints and accountability structure.</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>Cerner Scheduling Appointment Type Cleanup (primary &amp; specialty care)</td>
<td>In progress, Primary Care clinic appointments complete and ready for direct booking. Specialty care in process.</td>
</tr>
<tr>
<td>Process improvement during patient scheduling (i.e. CCH does not adequately contact patient during scheduling process to confirm appointment).</td>
<td>Scheduling Clerks (Ward Clerks) in Central Scheduling.</td>
<td>Luma Health Patient Reminder System</td>
<td>Solution will be evaluated to support patient contact efforts. CCH HIS will work with Luma Health to establish a Proof of Concept.</td>
</tr>
</tbody>
</table>
# The Revenue Cycle Program: Scheduling

## Function

Patient scheduling ensures appropriate reimbursement and/or significant resource coordination, such as reserving rooms and/or equipment, ordering devices or supplies, and ensuring that professional staff, such as physicians, nurses, and/or technicians are available. Patient Access are ‘First line billers’.

## Problem

- Lack of Standardization
- Lack of Accountability
- Limited Patient Contact!
- Limited Patient data collection due to established roles and responsibilities
- Improper system usage - duplicate patients, overbooking.

## Process

<table>
<thead>
<tr>
<th>Process Improvement to Reschedule Patients with Insufficient Financial Verification/Certification</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Improvement to Reschedule Patients with Insufficient Financial Verification/Certification prior to visit.</td>
<td><strong>Scheduling Clerks</strong> (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td>Cerner Discern Analytics Reports (identifying patients prior to arrival), Revenue Integrity</td>
<td>CCH must create a policy and procedure to incorporate into pre-service activity. CCH has drafted a policy.</td>
</tr>
</tbody>
</table>

## Process Improvement to Provide Advance Beneficiary Notice during pre-service activity, ensuring Medicare patient aware of non-covered service.

<table>
<thead>
<tr>
<th>Process Improvement to Provide Advance Beneficiary Notice during pre-service activity, ensuring Medicare patient aware of non-covered service.</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheduling Clerks</strong> (Ward Clerks) in Central Scheduling, at all hospital-based clinics, at ambulatory/remote clinics.</td>
<td></td>
<td>Cerner Medical Necessity</td>
<td>CCH must create a policy and procedure to incorporate into pre-service activity.</td>
</tr>
</tbody>
</table>

## Proper Patient Identification at point of scheduling to avoid duplicate record creation (i.e. search existing person record through model system usage).

<table>
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<tr>
<th>Proper Patient Identification at point of scheduling to avoid duplicate record creation (i.e. search existing person record through model system usage).</th>
<th>People</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheduling Clerks</strong></td>
<td>Cerner Enterprise Master Patient Index Cleanup, Scheduling Flex Forms</td>
<td></td>
<td>6M people records removed, in agreement with HIM, Compliance, &amp; Legal.</td>
</tr>
</tbody>
</table>

## Patient Self Scheduling via online portal.

<table>
<thead>
<tr>
<th>Patient Self Scheduling via online portal.</th>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheduling Clerks</strong></td>
<td>Patient Portal, Luma Health Patient Reminders, Direct Booking</td>
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</tbody>
</table>
The Revenue Cycle Program: **Pre-Registration**

<table>
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<tr>
<th>Function</th>
<th>Problem</th>
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</thead>
</table>
| Pre-Registration is a pre-service activity meant to collect, validate, or complete information such as Insurance Verification, MSP screening, Medical Necessity check, managed care requirement resolution, and financial education & assistance resolution. Target of 98% pre-registration rate. Patient Access are ‘First line billers’. | • Limited staff  
• Due to poor data collection upstream, inability to always complete full pre-registration. |

<table>
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<th>Process</th>
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<tbody>
<tr>
<td>Ekerete Akpan / Mary Sajdak</td>
<td>Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
</tbody>
</table>
| **Insurance Verification** through Batch Eligibility workflow, ensuring member status active with payor. | Pre-Registration Clerks  
Registration Clerks (Clerk V) | Cerner Premium Eligibility | Project in design & build phase, targeted go-live of 3/31. |
| **Determination & communication of patient out-of-pocket liability** including deductibles, co-pays, and co-insurance. | Pre-Registration Clerks | Cerner Premium Eligibility | Project in design & build phase, targeted go-live of 3/31. Process will need to be determined to review how patient liability will be calculated and payment will be collected - integrated discussion with time-of-service collection. |
| **Staffing analysis** and expansion of Pre-Registration team scope. | Pre-Registration Clerks | n/a | Slotting activity, not yet in progress. |
| **Process Improvement to handle Out-of-Network** patients, determining financial liability and routing to Financial Counseling for non-essential care. | Pre-Registration Clerks  
Financial Counseling  
Registration Clerks (Clerk V)  
Integrated Care - Managed Care | n/a | Identified Out-of-Network volumes, drafted Out-of-Network policy. Will review process, communicate and educate for addressing patients with Out-of-Network coverage. Will work with Managed Care group to evaluate contracting with payors. |
The Revenue Cycle Program: **Pre-Certification (Authorization)**

<table>
<thead>
<tr>
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<th>Problem</th>
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</table>
| Pre-certification is a pre-service activity in which a dedicated team (normally clinical in function) works with Managed care plans to ensure there are agreements and those agreements (payor specific criteria for treatment) have are satisfied. | • Limited staff  
• Lengthy & complex requirements to complete Prior Authorization  
• Deficits in upstream data collection often require |

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</table>
| Orders-to-scheduling & proper Pre-Registration (Phase 1 & Phase 2) will ensure all required patient financial data is captured for prior auth req's. | Dr. Claudia Fegan / Mary Sajdak  
Ordering Physicians  
Scheduling Clerks (Ward Clerks)  
Per-Registration Team  
Managed Care Prior Auth | Dr. Robert Sumter | Streamlining work effort for Prior Authorization team, ensuring proper upstream processes necessary. Phase 1 & 2 includes Sleep Lab, Rehab, Cardiology, Radiology. |
| Ophth. & OMFS Image viewing access for Prior Auth submission. | Dr. Fegan / Ekerete Akpan / Mary Sajdak  
Managed Care Prior Auth | Cerner Registration (specific conversation) / Prior Authorization Worklist | Providing CAMM to Prior Auth team, will evaluate workflow for Payors requiring image as part of submitted data. |
| Orders-to-scheduling & proper Pre-Registration (Phase 3) will ensure all required patient financial data is captured for prior auth req’s. | Ordering Physicians  
Scheduling Clerks (Ward Clerks)  
Per-Registration Team  
Managed Care Prior Auth | Cerner Registration (specific conversation) / Prior Authorization Worklist / Cerner Oncology PowerPlans | Engaging Cerner for an Oncology based gap analysis of existing PowerPlans and integration with Orders-to-scheduling. |
| Orders-to-scheduling & proper Pre-Registration (Phase 4) will ensure all required patient financial data is captured for prior auth req's. | Ordering Physicians  
Scheduling Clerks (Ward Clerks)  
Per-Registration Team  
Managed Care Prior Auth | Cerner Registration (specific conversation) / Prior Authorization Worklist | Project slotted. Phase 4 includes Pain. |
Time of Service Status - People, Process, Technology
Time-of-Service In Perspective

Engaged Patient
Coordination of Care
Coordinated Financial & Clinical Care
Compliant Clinical Documentation

Engaged Consumer
Ease of Access
Improved Consumer Service
Improved Quality

Satisfied Customer
Appropriate Payment
Effective & Efficient Account Resolution
Decreased Cost to Collect

hfma healthcare financial management association
The Revenue Cycle Program: **Patient Arrival, Validation & Activation**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Registration is a time-of-service activity and the final checkpoint in which all patient information is captured and confirmed prior to providing service for scheduled patients, and the process to complete full-registration for unscheduled patients.</td>
<td>• Inaccurate data selection, collection &amp; verification of patient information. • Limited adherence to required financial collection.</td>
</tr>
</tbody>
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<td>Ekerete Akpan</td>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td>Org. structure alignment</td>
<td>Registration Clerks (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.</td>
<td>n/a</td>
<td>Process and people not yet addressed, waiting on org. structure alignment and associated contractual discussions.</td>
</tr>
<tr>
<td>System-wide process standardization, with checkpoints and accountability structure.</td>
<td>Registration Clerks (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.</td>
<td>n/a</td>
<td>Standard registration workflow defined but not implemented across org.</td>
</tr>
<tr>
<td>Registration Process standardization across entire health system with checkpoints and accountability structure.</td>
<td>Registration Clerks (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.</td>
<td>Cerner Patient ID in Banner Bar</td>
<td>Awaiting commitment on policy of patient identification capture and inclusion in patient’s chart. CCH will move forward with capturing Patient Image and posting to Patient Chart. Implementation will need to include education, communication, and process review at check-in.</td>
</tr>
<tr>
<td>Patient check-in &amp; verification at time of arrival via self check-in, biometric tools.</td>
<td>Registration Clerks (Clerk V) in acute setting, all hospital-based clinics, and ambulatory/remote clinics.</td>
<td>Patient Kiosk Expansion &amp; Imprivata Palm Vein Scanner</td>
<td>Live at Core, scheduled rollout across system wide clinics.</td>
</tr>
</tbody>
</table>
## The Revenue Cycle Program: Patient Arrival, Validation & Activation

### Function
Registration is a time-of-service activity and the final checkpoint in which all patient information is captured and confirmed prior to providing service for scheduled patients, and the process to complete full-registration for unscheduled patients.

### Problem
- Inaccurate data selection, collection & verification of patient information.
- Limited adherence to required financial collection.

### Process
<table>
<thead>
<tr>
<th>People</th>
<th>Technology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td>Evaluating tools for implementation, and will slot project once vendors selected.</td>
</tr>
</tbody>
</table>

### People
- **Ekerete Akpan**
- **Registration Clerks (Clerk V)** in acute setting, all hospital-based clinics, and ambulatory/remote clinics.

### Technology
- **Imprivata Kiosk / Credit Card Processing Vendor**

### Status
- Point-of-service collection via credit card payment, determined through eligibility check either at check-in or prior.
## The Revenue Cycle Program: Documentation & Revenue Recognition

Clinical documentation is a time-of-service activity which includes the processes required to accurately capture the services rendered through use of the Electronic Medical Record. Revenue Recognition is triggered through key selection points within the Electronic Medical Record.

### Problem
- **Timely documentation completion.**
- **Complete documentation.**
- **Charge reconciliation processes not in place to support monitoring activity.**

### Function

<table>
<thead>
<tr>
<th>Function</th>
<th>Problem</th>
</tr>
</thead>
</table>
| Clinical documentation | • Timely documentation completion.  
| | • Complete documentation  
| | • Charge reconciliation processes not in place to support monitoring activity. |

### Process | People | Technology | Status |
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Dr. Claudia Fegan / Mary Sajdak</td>
<td>Dr. Fegan / Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td><strong>Order-based Medical Necessity</strong> checking and ABN discussion at time of order between Physician and Patient.</td>
<td><strong>Ordering Physicians</strong></td>
<td>Cerner Medical Necessity</td>
<td>Multiphase project beginning at the point of physician order entry - live in Lab, 2/24 in Cardio &amp; Rad, 3/24 in Rehab.</td>
</tr>
<tr>
<td><strong>Clinic Manager roles and responsibilities expansion</strong> to include Charge Reconciliation and revenue/cost monitoring.</td>
<td><strong>Clinic Managers Providers (all physicians)</strong></td>
<td>Revenue Integrity Initiative</td>
<td>Clinic Manager needing to be hired/staffed in order to initiate Pilot project. Executive leadership team authorized kick-off.</td>
</tr>
<tr>
<td>Infusion specific data including start &amp; stop time, dose, etc.</td>
<td><strong>Nursing HIM</strong></td>
<td>Infusion Management w/ Infusion Billing Form &amp; HIM PowerForm</td>
<td>End User Training in progress with targeted go-live on 3/24.</td>
</tr>
<tr>
<td><strong>Provider clinical E&amp;M documentation</strong> specific to Evaluation and Management for Outpatient Visits.</td>
<td><strong>Physicians</strong></td>
<td>nCode expansion</td>
<td>Project is currently on hold</td>
</tr>
</tbody>
</table>

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Go Back
The Revenue Cycle Program: **Documentation & Revenue Recognition**

### Function
Clinical documentation is a time-of-service activity which includes the processes required to accurately capture the services rendered through use of the Electronic Medical Record. Revenue Recognition is triggered through key selection points within the Electronic Medical Record.

### Problem
- Timely documentation completion.
- Complete documentation
- Charge reconciliation processes not in place to support monitoring activity.

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<td>Dr. Fegan / Ekerete Akpan / Mary Sajdak</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td><strong>Provider clinical surgical documentation</strong> specific to Surgical procedures.</td>
<td>Perioperative Physicians HIM</td>
<td>Surgical CAPD (Vincari)</td>
<td>Establishing business case to garner project authorization and slotting timeline / resources.</td>
</tr>
<tr>
<td><strong>Provider Clinical Documentation Improvement</strong> initiative to address Physician doc. deficiencies.</td>
<td>Documenting Providers</td>
<td>Iodine</td>
<td>Continued engagement with Iodine and establishment of CDI department under guise of Health Information Management team.</td>
</tr>
</tbody>
</table>
Post-Service Status - People, Process, Technology
Post-Service In Perspective
The Revenue Cycle Program: **Claim & Remit Processing, Denials Mgmt**

<table>
<thead>
<tr>
<th>Function</th>
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<tbody>
<tr>
<td>Claim &amp; remit processing includes all activities required to send a request for payment to a third-party payer for payment of benefits under an insurance policy, and the consequential review &amp; balancing of payor payments. Denials Management includes activity to retro/proactively address claims issues.</td>
<td>• Poor data collection upstream resulting in poor clean claim rate, increased claims edits, and time spent working edits.</td>
<td></td>
</tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td></td>
</tr>
<tr>
<td><strong>Claim submission</strong> &amp; residual edits review/work for payor consumption/review and remit.</td>
<td>Ekerete Akpan</td>
<td><strong>Artificial Intelligence</strong> Claims Processor / Cerner Patient Accounting</td>
<td>Contracting, waiting on Purchasing to contact selected vendor. Cerner will work with AI vendor to determine technical specifics and begin reviewing integration for functional testing.</td>
</tr>
<tr>
<td><strong>Certify Health System for Medicare/Medicaid Behavioral Health services</strong> to grant ability to submit and receive payment for services rendered.</td>
<td><strong>Patient Financial Services</strong></td>
<td><strong>Behavioral Health Certification</strong></td>
<td>Completed, analyzing collections &amp; denials</td>
</tr>
<tr>
<td><strong>Certify Health System for Public Health Behavioral Health services</strong> to grant ability to submit and receive payment for services rendered.</td>
<td><strong>Integrated Care / Managed Care</strong></td>
<td><strong>Behavioral Health Certification</strong></td>
<td>Completed, analyzing collections &amp; denials</td>
</tr>
</tbody>
</table>
### The Revenue Cycle Program: Claim & Remit Processing, Denials Mgmt

Claim & remit processing includes all activities required to send a request for payment to a third-party payer for payment of benefits under an insurance policy, and the consequential review & balancing of payor payments. Denials Management includes activity to retro/proactively address claims issues.

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</thead>
<tbody>
<tr>
<td>Claim &amp; remit processing</td>
<td>• Poor data collection upstream resulting in poor clean claim rate, increased claims edits, and time spent working edits.</td>
<td>Evolent (County Care Claims processor) &amp; CCH are analyzing 15,000 denied claims totaling $22 million. 1,600 outpatient accounts valued at $1 Million have been found to overstate A/R as the additional charges will not be reimbursed in these ‘split bill accounts’ since the encounter rate has been paid.</td>
</tr>
</tbody>
</table>

### Process
- CountyCare denial analysis: to evaluate RARC / CARC codes to address existing edits and denials while implementing proactive measures for future submission.

### People
- Ekerete Akpan

### Technology
- Invision

### Status
- Patient Financial Services
## The Revenue Cycle Program: **Payer Payment Analysis**

### Function
Payer Payment Analysis includes the ongoing review of payments to manage terms of existing payor agreements while at the same time identifying patient demographics and insurance marketplace for expanding contractual agreements.

### Problem
- No Contract Management solution in place today.

### Process

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<tr>
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<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekerete Akpan</td>
<td>Dr. Robert Sumter</td>
<td>Tested using actual 837/835’s; rate sheets built reflect expected reimbursement amounts, balancing accurately for IL Medicaid/Medicare.</td>
</tr>
<tr>
<td>Managed Care Contract Specialists</td>
<td>Cerner Contract Management</td>
<td></td>
</tr>
</tbody>
</table>

### People
- **Ekerete Akpan**
- **Dr. Robert Sumter**
- **Managed Care Contract Specialists**
Next Steps & Discussion
Optum Charge Description Master (CDM) Services & Software

• **Background:** Cook County Health awarded Contract #H18-0042 to [Optum](https://www.optum.com) for a Charge Master assessment, a Charge Capture Audit and Charge Master Software that allows for internal review and maintenance of the hospital Corporate Charge Master (facility and professional fees). Maintenance software allows a consistent review of coding and billing elements which are necessary for compliance with Medicare regulations, as well as optimization of revenue and timely reimbursement.

• **Purpose:** Intended to identify charging deficiencies for improved Charge Capture, Revenue Recognition & Increased Reimbursement.

• **Scope:**
  - CDM Assessment - review of CPT/HCPCS, Modifiers, Revenue Codes, Pricing, etc.
  - Charge Capture Audit (Chart to Bill) - audit of 100 claims (20 Inpatient & 80 Outpatient).
  - Enterprise Charger Master Expert (eCME) - software for continued analysis & maintenance.
What to Expect by March 20th

1. Kick-off of Revenue Integrity program
2. Kick-off of Integration with Artificial Intelligence (AI) Claims Processing vendor
3. Medical Necessity Phase 2 Go-Live
4. Prior Authorization Phase 2 Go-Live
5. Premium Eligibility Testing Completed