Certification in Healthcare Revenue Integrity (CHRI)
Exam Outline

I. EDUCATION *30 items (16 recall/10 application/4 analysis)*

a. Rules and Regulations

1. Provide expert advice in coding guidelines and conventions.
2. Provide guidance on correct coding processes to clinical departments and facilities.
3. Remain current with regulation changes and related operational processes by attending coding conferences, workshops, or in-house sessions for updated coding information.
4. Maintain a current knowledge base of regulatory law, insurance contracts, utilization review criteria, acute inpatient criteria, and Medicare/Medicaid regulations.
5. Plan and perform in-services to nursing, physician, or clerical personnel regarding processes, updates or reviews relating to audit findings and/or regulatory compliance.
6. Review outcomes of rules and regulatory information provided to physicians and/or clinical leadership.

b. Coverage

1. Apply medical necessity and appropriateness guidelines to medical service proposals to prevent claim denials or to support revenue recovery.
2. Provide physicians and hospital (or other healthcare facility) staff with information relating to insurance coverage or the case management process.

c. Communication

1. Assist clinical departments, coding departments, and other departments to identify/fix/prevent coding errors based on coding guidelines and edits.
2. Communicate governmental and accreditation body standards for documentation of department's services and coverage.
3. Communicate with finance/revenue departments about financial implications of denials/appeals management.
4. Educate staff and physicians on the appeals/denial process.
5. Educate management and the hospital (or other healthcare facility) staff about internal or external audit findings and outcomes.
6. Meet with the managers and staff to instruct and inform them on the findings and recommendations of quality assurance reviews and audits.
7. Present results of audit/charge evaluations to managers to inform them of findings, documentation, and recommendations for improvement.

8. Respond to feedback to resolve any related charge/coding issues or problems that occur in, or are identified during, an audit process.
9. Communicate with hospital (or other healthcare facility) financial officer(s) about revenue impacts from denials, appeals, or policy changes during meetings.
10. Provide expert advice or decisions to ancillary departments in response to question on charges, reversals, reimbursement, assistance on hold, or other revenue integrity questions.
11. Work with physician fee schedule leadership to evaluate impacts on accounts receivable of physician-billed services, or to evaluate impacts of assisting physician-billed services with issues related to billing and denials.
12. Conduct training for hospital (or other healthcare facility) personnel on revenue integrity functions.
13. Coordinate with revenue integrity analysts to complete various inquiries by departments to ensure accurate and timely responses.
14. Develop effective relationships among internal/external stakeholders, colleagues, and staff in order to build trust and lead individuals/teams through change initiatives.
15. Develop presentations, reports, memoranda, or other communications on revenue integrity.
16. Present in-services to nursing, physician, or clerical personnel regarding processes, updates, or reviews relating to audit findings and/or regulatory compliance.
17. Provide education and advice on facility charge capture, revenue optimization opportunities, documentation, and/or coding guidelines to hospital departments.
18. Provide formal or informal education to leaders or staff in other disciplines on revenue integrity topics.
19. Train hospital (or other healthcare services facility) personnel on denial prevention and denial prevention maintenance.
20. Train revenue integrity personnel on revenue integrity updates, skills, or tasks.
21. Work collaboratively with revenue integrity director to develop educational materials for nurse managers, department managers, or other departmental staff to keep them up-to-date and in compliance with governmental documentation, coding, or charge capture rules.
22. Provide formal or informal education to leaders or staff in other disciplines on revenue integrity topics.
23. Advise departments on how to minimize lost charges/ denials using a combination of clinical and reimbursement expertise.
24. Assist in resolution of billing edits that are holding patient claims from billing, by reviewing the medical records and other applicable documentation with response and education back to requester.
25. Communicate with medical and administrative departments about billing issues and required solutions.
26. Perform coding and billing reviews with nurse managers, department managers, and other departmental staff to identify opportunities to improve charge capture through better documentation or use of departmental information systems.
27. Inform other personnel about how billing is done in new special billing situations.
28. Analyze data in order to identify areas of opportunity and provide feedback to the appropriate areas.
29. Communicate charge description master (CDM) changes to the hospital departments and administration, patient accounting, or others who are impacted by the change.

30. Communicate external developments affecting the revenue integrity process.
31. Inform management or billing staff of changes to government or private payer local coverage determinations (LCD) and national coverage determinations (NCD)—may include Medicare LCDs and NCDs.
32. Provide feedback to providers regarding missing, incomplete, unspecific, unclear, or conflicting documentation.
33. Provide recommendations based on focused audit findings.
34. Provide revenue integrity analytics data to relevant personnel.
35. Recommend improvements and corrections to prevent future revenue losses and to take advantage of opportunities as part of a scheduled periodic review process.
36. Work with managers and directors to ensure proper pricing, description codes, and coding for new procedures or changed procedures.
37. Work with managed care department to manage or receive updated payer contracts and fee schedules.

d. Research

1. Maintain a current knowledge of payer regulations regarding reimbursement.
2. Maintain up-to-date job knowledge through professional reading, conferences, and seminar attendance.
3. Serve as primary service line expert for all charge related inquiries and issues and proper usage of charge codes.
4. Study internal documents to maintain current knowledge of the CDM, clinical charging procedures, or related systems for the production of a bill/claim.

II. COMPLIANCE *30 items (16 recall/10 application/4 analysis)*

a. Denials and Appeals

1. Respond to payer compliance audits with next-step recommendations and improvements.
2. Engage physician's assistance in denial appeals and appeal documentation.
3. Represent hospital (or other healthcare facility) for external audits and appeals/denial, including for government or private payers, charge/cost denials, and for authorizations denials.
4. Prepare correspondence or reports in response to requests from third-party payers for additional clinical information.
5. Correct hospital (or other healthcare facility) bills or claims to overcome initial denials.
6. Deny hospital (or other healthcare facility) bills or claims based on non-compliance with requirements.
7. Inform healthcare services of medical necessity and appropriateness guidelines to prevent claim denials and to support revenue recovery.

b. Monitoring and Auditing

1. Evaluate documentation during scheduled, systematic utilization reviews.
2. Ensuring compliance with applicable healthcare services standards.
3. Enforce compliance of all healthcare services as it relates to medical necessity guidelines.
4. Review hospital (or other healthcare facility) departmental accounts for compliance documentation.
5. Audit hospital (or other healthcare facility) claims to evaluate the merits of denying or reducing payment.
6. Audit medical records against charges and claims to make corrections and improvements in charge capture, coding accuracy, billing, medical necessity, or documentation.
7. Audit patient charts and medical records to evaluate adequacy of clinical documentation, compliance, reasons for treatments, billed services/items, coding, payments, operations, or completeness of bills.
8. Develop and conduct an audit plan for the periodic, scheduled (or other department-independent) audit of institutionwide revenue integrity.
9. Provide input to compliance for the inspector general auditing.
10. Perform focused audits within hospital departments to identify areas of revenue opportunity and noncompliance based on revenue integrity-identified trends or department requests.
11. Ensure that all policies, both system and revenue integrity department, are current and compliant and required revision is performed in a timely manner.
12. Evaluate qualifications of personnel for revenue integrity recruitment or placement.
13. Report errors or issues in the CDM.
14. Respond to inquiries from third-party payers, customer service representatives, reimbursement, or revenue integrity on whether all charges are supported in the patient's medical records.
15. Review medical records for accuracy and billing compliance.
16. Provide information to ancillary department contacts to get revenue holds released.

17. Complete focused charge review assessments for assigned clinical departments and/or service lines to ensure that charges are generated in accordance with established policies and time frames.
18. Identify charge trends to identify needs for focused revenue integrity reviews of specific departments.
19. Perform ancillary service quality assurance reviews or departmental audits.
20. Perform revenue integrity impact analysis in response to coding, reimbursement, or other changes.
21. Perform risk reduction activities in response to risk.
22. Review hospital (or other healthcare facility) department medical record documentation for improvement opportunities as part of a scheduled periodic review process.
23. Perform continuous quality assurance performance reviews.

c. Analyses

1. Analyze changes to billing rules, coding rules, and regulations by using reference materials, internet sources, seminars, and publications.
2. Pre-review accounts being audited by government or private payers. Analysis and reporting need to be added.
3. Problem-solve revenue/charge-related issues using automated billing systems.
4. Evaluate revenue holds to identify holds that might be released by immediate action.
5. Analyze claim edit issues and trends for root cause resolution (which may include CDM corrections or other process improvements).
6. Evaluate current charging and coding structures and processes in clinical departments to ensure appropriate capture and reporting of revenue and compliance with government and third-party payer requirements.
7. Perform a risk analysis of your facility's and physicians' coding, treatment, documentation, or other practices.
8. Use data and reports to perform root cause analysis to identify areas where the process may not be working effectively or efficiently.
9. Analyze changes to billing and documentation rules and regulations by utilizing appropriate reference materials, internet sources, seminars, and publications.

d. Policies and Procedures

1. Develop revenue integrity policy and procedures. Continuously evaluate revenue integrity or denials management policy and procedures.
2. Manage organization-wide policies and procedures for compliant revenue charging activities of all ancillary departments.
3. Participate in management committee to set standards, policies, operations, or standardization.
4. Develop revenue charging, coding, documentation, or compliance guidance.

e. Project/Program Management

1. Coordinate work to stay within the confines of the facility's/company's compliance program policies.
2. Implement governmental and accreditation body standards for documentation of department services and coverage.
3. Facilitate/participate in development of policies and procedures for improving processes, strengthening controls, reducing revenue leakage, enhancing revenue, or improving cash flow for the hospital (or other healthcare facility) to support revenue integrity.
4. Contribute to scheduled, periodic compliance improvement initiatives.

5. Develop problem solutions as part of a process improvement initiative for compliance-related initiatives.
6. Make recommendations for new services or redesign of current services.

III. REVENUE *30 items (20 recall/10 application/0 analysis)*

a. Charge Description Master (CDM)

1. Ensure the accuracy of pricing structures and codes as required by local, state, and federal regulations.
2. Manage changes to the CDM that may be based on incorporating new charges/services identified by departments, third-party changes, government or private payer requirements, internally generated changes, or coding updates.
3. Organize a detailed, annual review of the CDM that includes code updates, improving description changes, or ensuring the nomenclature reflects the procedures performed.
4. Revise revenue codes to support proper billing in concert with other managers.
5. Use medical records, hospital (or other healthcare facility) bills, and the CDM or price list for revenue purposes.
6. Coordinate CDM error findings with CDM team.
7. Identify changes needed to CDM as a part of a scheduled periodic review.
8. Maintain department CDM files.
9. Conduct periodic CDM reviews (including external reviews) to update and ensure integrity of the CDM.
10. Update the electronic CDM based on input from the revenue integrity managers.
11. Work collaboratively with the revenue integrity director to review and update the CDM.
12. Perform a strategic pricing review and comparison within the service lines and modalities.

b. Coding and Documentation

1. Evaluate medical record documentation to generate clean claims that prevent denials and facilitate compliant coding/billing.
2. Use coding guidelines and conventions to solve revenue integrity problems.
3. Identify shifts in diagnosis-related groups (DRG) volumes and assignments for situations or cases that may require revenue integrity intervention.
4. Partner with coding director or coding manager regarding issues related to diagnosis of denials, modifier denials, or other revenue integrity coding issues.
5. Provide scheduled (e.g., quarterly, annual) changes for inpatient prospective payment systems (IPPS), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), or outpatient prospective payment systems (OPPS) to all ancillary departments or the revenue cycle steering committees.
6. Provide directives to departments to update quarterly CPT or HCPCS.
7. Solve revenue integrity problems based on the documentation from process improvement initiatives or internal reporting mechanisms.
8. Prepare correspondence or reports on clinical information, utilization, or quality of care using the medical records in coordination with the attending physicians.
9. Identify physician or clinic practices that require improved documentation by using hospital (or other healthcare facility) information systems or financial department information.
10. Interpret government or private payer LCDs and NCDs (may include Medicare LCDs and NCDs).
11. Apply government or private payer LCDs and NCDs (may include Medicare LCDs and NCDs).

c. Billing

1. Arrange for the timely completion of medical records in accordance to the facility's late charge policy.
2. Work directly with patient financial services regarding patient charging/ billing inquiries.
3. Resolve billing edits that are holding patient claims from billing, by reviewing the medical records and other applicable documentation.

d. Edits

1. Resolve claim edits using review of medical records and charge credits/modifiers.
2. Review charges posted in the accounts receivable system to ensure accuracy for type of case, type of procedure, coding/billing rules, charges, or otherwise as needed.

e. Charge Capture and Charge Reconciliation

1. Analyze charge capture audit reports to verify that appropriate charges have been posted to patient accounts according to diagnosis and related procedure codes.
2. Develop charge documents to reconcile charges to items/services documented in the medical record.
3. Evaluate late charge reports as justified or unjustified.
4. Review for charge capture charges on outpatients from a review of the medication administration records.
5. Identify opportunities for capturing additional revenue in accordance with payer guidelines.
6. Identify services that are reimbursable but are not being coded.
7. Interact with clinical department directors to monitor charge capture functions across all entities.
8. Review hospital (or other healthcare facility) departmental accounts for charge capture.

g. Project/Program Management

1. Analyze revenue integrity departmental needs.
2. Determine revenue integrity personnel assignments and priorities.
3. Develop a key performance indicator (KPI) system to evaluate the revenue integrity department's successes and failures.
4. Develop standard operating procedures (SOP) for revenue integrity operations or actions.
5. Lead cross-functional revenue integrity projects.
6. Lead individuals or teams effectively during change of organization, processes, or technology.
7. Lead the denials management team in the organization of or prioritizing of claims denials and recovery.
8. Make recommendations for new services or redesign of current services, as appropriate, based on revenue integrity factors.
9. Manage appropriate resources as necessary to ensure successful revenue integrity program/project outcomes.
10. Manage implementation of required changes or new processes in revenue integrity department(s). (This may include regulatory or payer guideline implementation.)
11. Manage the documentation of the results of revenue integrity special project work.
12. Manage the flow of revenue integrity data, reports, or assistance to finance department personnel; projects; audits; or other efforts to correct problems or enhance services.

13. Manage the implementation of improvements to the revenue integrity analytics data or processes.
14. Manage the resolution of large-scale issues that impact both hospital (or other healthcare facility) and corporate-level revenue integrity operations.
15. Provide revenue integrity feedback, internally or externally, on proposed organizational or system changes that will affect revenue integrity or functional improvement.
16. Provide revenue integrity input to projects on drug formulary, HCPCS, or related areas.
17. Recommend revenue integrity improvements based on special project findings.
18. Develop detailed scope and plans for revenue integrity improvement projects.
19. Develop educational programs on revenue integrity.
20. Document unjustified late charge reports for process improvement initiatives.
21. Contribute to scheduled, periodic revenue improvement initiatives.
22. Develop action plans to improve revenue integrity.
23. Develop problem solutions as part of a process improvement initiatives for revenue-related initiatives.
24. Develop recommendations to improve reimbursement, to decrease re-work, or to streamline processes.
25. Develop specifications to modify existing charge capture applications to reduce charge-related claim edits/rejections.
26. Lead process improvement efforts in the hospital (or other healthcare facility) to drive improvement in the overall revenue cycle process.
27. Organize input from internal/external stakeholders to ensure successful revenue integrity projects are executed.
28. Participate as revenue integrity representative in related quality improvement efforts.
29. Participate in complex revenue integrity improvement projects.
30. Facilitate the rebilling of any project in coordination with the compliance and revenue departments.

i. Payer Contracting

1. Review with relevant departments the impacts of coding changes required by third-party payers.
2. Negotiate with managed care providers regarding “lesser of payments.”
3. Propose changes to CDM for consistency with payer contracts or regulations.

j. Research

1. Interact the revenue cycle personnel to obtain quantifiable results related to denials and appeals.
2. Identify need for improvements in the revenue cycle related to analytics, data mining, and operational reviews.
3. Identify potential or actual revenue/charge related issues using automated billing systems.
4. Research reimbursement issues or trends.
5. Identify opportunities to improve revenue generation, decrease manual intervention, and streamline processes.

k. Finance

1. Analyze charge capture audit reports to verify that revenue has been routed/recorded in the appropriate department/cost center.
2. Maintain current information based on comparative pricing and sensitivity relative to market changes.

3. Work with finance to evaluate departmental budgetary requirements in order to set pricing in accordance with the facility's strategic plan.
4. Provide revenue integrity support for assigned cost centers within service lines.
5. Evaluate accounting records or balance sheets for revenue integrity errors, opportunities, or need for changing methods.
6. Propose institutional or departmental revenue integrity goals.

IV. REPORTING *30 items (14 recall/10 application/6 analysis)*

a. System Logic

1. Provide feedback regarding system identification of reimbursement/claims issues and charge capture opportunities.
2. Provide feedback regarding charge screens in the electronic medical record (EMR).
3. Provide feedback regarding user documentation for software usage in revenue integrity functions.
4. Assess the accuracy of all charging vehicles (could include clinical systems, clinical dictionaries, encounter forms, or other charge documents).
5. Evaluate feasibility of automating front-end and back-end solutions.
6. Recommend automating front-end and back-end solutions.

b. Internal

1. Generate clinical denials/appeals database reports.
2. Identify denials/appeals database trends.
3. Conduct periodic review of revenue integrity cycle dashboard.
4. Conduct trend analyses to identify patterns in audit requests and outcomes for medical necessity, coding, or billing practices.
5. Develop integrity management reports based on internal data.
6. Develop and manage reports for the "candidate for bill" meeting with ancillary departments or revenue-cycle steering committee.
7. Develop special reports for ancillary departments or the revenue cycle steering committees regarding annual changes IPPS or OPPS.
8. Develop special reports or directives for ancillary departments regarding charges, reversals, reimbursement, or other revenue integrity issues.
9. Develop standard quick standardized revenue integrity reports.
10. Develop and manage standard reports that record revenue integrity metrics needed for departmental monitoring.
11. Develop and provide reports to ancillary departments regarding charges, reversals, reimbursement, or other revenue integrity issues.
12. Use key performance indicators (KPI) to evaluate the revenue integrity department's successes and failures.
13. Prepare correspondence and reports that substantiate the denial or reductions of hospital (or other healthcare facility) claims.
14. Develop unbilled/without charges reports.
15. Develop problem solutions as part of a process improvement initiative for internal reporting mechanism.
16. Develop quantitative and qualitative performance improvement values/measures.
17. Run data reports to identify trends to help assist with front-end process fixes.
18. Develop scheduled revenue integrity management reports on external developments (which might include reports of industry charging reviews, yearly CPT coding updates, or related issues).