nahri™



CERTIFICATION IN

Healthcare Revenue Integrity Candidate Handbook

2023 CHRI CANDIDATE HANDBOOK

About NAHRI/Mission Statement

The mission of **NAHRI** is to enhance the revenue integrity profession through standards, advocacy, networking, and the promotion of shared knowledge and resources.

Certification

The mission of the Certification in Healthcare Revenue Integrity (CHRI) credential is to ensure healthcare revenue integrity professionals are recognized for their due diligence in their field and dedication to professional growth. The CHRI credential can help new and veteran revenue integrity professionals demonstrate knowledge of revenue integrity core competencies. Professionals who earn the CHRI credential have proven their proficiency in rules and regulations, compliance, revenue management, and internal reporting strategies.

The objectives of the CHRI program are as follows:

- Recognize the valuable contributions and knowledge base of healthcare revenue integrity professionals who have proven competency in revenue integrity subject matter through successful completion of the certification process
- Promote knowledge of core skills relevant to the revenue integrity field, including mastery of relevant rules and regulations; ability to perform root cause analysis; aptitude for managing denials and appeals; knowledge of monitoring and auditing practices; assurance of accuracy of charge description master pricing structures and codes; understanding of coding, documentation, and billing requirements; and skill to develop internal reporting strategies that identify trends and solve problems
- Assist healthcare facilities in ensuring staff have the knowledge and experience necessary to perform essential revenue-related job functions and bring value to the organization

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Testing Agency

HCPro and the **National Association of Healthcare Revenue Integrity (NAHRI)** have contracted with Prometric to assist in the development, administration, scoring, and analysis of the CHRI certification examination.

Prometric is a leading provider of technology-enabled testing and assessment solutions to many of the world's most recognized licensing and certification organizations, academic institutions, and government agencies. Prometric supports more than 7 million test takers annually at its testing locations in more than 180 countries around the world. It also supports remote proctoring, allowing candidates to take their exams from their own homes or elsewhere.

Prometric

1501 South Clinton St
Baltimore, MD 21224
Tel: 1-866-PROMETRIC (776-6387)

Learn more at: *https://live-prometric.pantheonsite.io/contact-us*

Test Center Locations

Prometric Test Centers have been selected to provide accessibility to the most candidates in all states and major metropolitan areas. Prometric Test Centers are located throughout North America and internationally, with more than 14,000 locations in more than 180 countries. Specific address information will be provided when you schedule an examination appointment.

Eligibility

Candidates who apply for the examination must meet one of the following sets of requirements:

1. One or more year(s) of experience in healthcare revenue cycle, coding, compliance, or revenue integrity and a bachelor's degree OR
2. Two or more years of experience in healthcare revenue cycle, coding, compliance, or revenue integrity and an associate's degree OR
3. Three or more years of experience in healthcare revenue cycle, coding, compliance, or revenue integrity in the absence of a degree

Application Requirements

Qualified candidates can apply online at chri.simplycertifications.com. Please have your contact information, work and education history, and credit card payment information available when you start the application process. If you have questions about this process, please contact Customer Service at 800-650-6787.

Fees

The fee for the certification application process and examination is $255 for **NAHRI** members and $355 for non-members. Payment may be made through our online system (*chri.simplifycertifications.com*) after your application is completed and approved. While fees are non-refundable, payment will be returned if the application is not approved.

How to Apply

Complete our online application and provide payment information at *chri.simplifycertifications.com*. Make sure you review our eligibility requirements above prior to applying.

Scheduling an Examination Appointment

After you have applied for certification and received notification of your eligibility, you will receive an email from NAHRI explaining how to schedule your exam with Prometric. Candidates may take their exam at a Prometric testing center or via remote proctoring.

If you do not receive your email, or if any information in the email is incorrect or has changed, please contact Customer Service at *customerservice@hcpro.com*.

For candidates taking the exam at a testing center, you can schedule your exam by clicking "Find my Exam" under the **TEST TAKER** tab on the Prometric home page, and searching for the CHRI test sponsor page. Prometric's self-service scheduling tools are the best option to schedule an exam appointment during a time that is convenient to you. Check the **SITE CLOSURE** page for up-to-date information on site closures in your area. Should you require support in booking an exam appointment, contact one of Prometric's global contact centers by clicking on the **CONTACT US** button.

Candidates may also elect to take their exam with Prometric's secure remote-assessment platform, ProProctor™. This allows candidates to take the exam from their own home or other location. To learn more about this option, please visit the **ProProctor** home page.

Candidates are strongly encouraged to schedule online. Should you require additional assistance, Prometric's scheduling number is 1-800-864-5257 (North America only) between 8:00 a.m. and 5:00 p.m. Eastern time on weekdays, excluding holidays observed by Prometric.

Special Arrangements and Testing Accommodations

Prometric makes every effort to provide reasonable testing accommodations that enable all test takers to take examinations on a level playing field. Its *Testing Accommodation Solutions* enable candidates, regardless of a recognized need or challenge, an equal and fair chance to sit for an exam. Prometric works in partnership with NAHRI to ensure that test takers with unique needs have full access to the programs and services available.

Prometric takes pride in the amount of support it provides to test takers. Its comprehensive line-up of testing aides meet most needs, whether they involve special scheduling/timing, location/setting, software, equipment, or the use of personal assistants. A full list of the services and accommodations can be accessed by reading its Testing Accommodations brochure. While requests for testing accommodations must be reasonable, approved (based upon appropriate documentation), and scheduled prior to a test taker appearing for an examination, we are committed to making sure you receive the appropriate accommodations to which you are entitled.

Learn more about special accommodations here: *https://www.prometric.com/test-takers/arrange-testing-accommodations*

Click here to view a list of testing accommodations.

To request a special accommodation, please complete the *Request for Special Examination Accommodations* form available at *https://nahri.org/apply-chri-exam* and submit with your exam application. Your application will be reviewed and processed.

Examination Appointment Changes

If you wish to reschedule or cancel, you must contact NAHRI at *customerservice@hcpro.com* no later than five days prior to your appointment. NAHRI will provide instructions for rescheduling or cancelling your appointment. We recommend you contact NAHRI as soon as possible to give you enough time to receive your instructions and complete your rescheduling or cancellation no later than five days prior to your appointment.

There is no reschedule or cancel fee due to Prometric if you complete your rescheduling or cancellation process 30 or more days before your test date. Prometric charges a fee of $35 if you complete your rescheduling or cancellation process 5–29 days prior to your test date.

You are not permitted to make changes to your exam date or time within five days of your appointment. Four or fewer days prior to the appointment date, the option to reschedule or cancel will not be available and you will forfeit your exam registration and fees if you are not present for the exam.

All examination schedule changes must be made with Prometric online or by phone. A voicemail message is not an acceptable form of canceling or rescheduling an appointment.

Plan to arrive 30 minutes before your scheduled appointment time, whether you are testing in a center or with remote online proctoring.

If you arrive more than 30 minutes late to your scheduled testing time, you will not be admitted to take your online or in-person examination.

Inclement Weather/Power Failure/Other Emergency

Sometimes unforeseen circumstances require a test center to unexpectedly close, including inclement weather, power failures, etc. Should this happen, Prometric will make every effort to contact you so that you don't show up at the center. Prometric will reach out by e-mail and by telephone, so please ensure that the contact information you provide during the scheduling and registration process is accurate.

Should your center unexpectedly close for any reason, you will be contacted by the Prometric rescheduling department within 48-72 hours to reschedule your exam.

To check the status of your testing center location, please visit the **Prometric Site Updates** page, where you›ll find a list of all centers that are closed due to inclement weather or other circumstances.

Preparing for the Examination

The CHRI exam is made up of the following four parts:

1. Education (25%)
2. Compliance (25%)
3. Revenue (25%)
4. Reporting (25%)

Early adopters of the CHRI credential are encouraged to refer to the **full exam outline** to ensure they are prepared for the exam.

How the Exam Was Developed

Healthcare revenue integrity professionals play an integral role in the financial health of their organizations. As this field grows, it is critical to ensure healthcare revenue integrity professionals have a means of demonstrating their competency in core skills relevant to their roles within their organizations. The CHRI credential offers revenue integrity professionals the opportunity to hone and validate their knowledge base while ensuring facilities have a benchmark by which to measure the competency of their staff and to recruit team members who are committed to bringing value to the industry and staying abreast of changes in regulations and best practices.

The CHRI credential committee that developed the exam originated with a group of experienced **NAHRI** Advisory Board members and expanded to include **NAHRI** members from various backgrounds to ensure the CHRI exam outline and content, prerequisites, and recertification requirements meet acceptable industry standards and are properly vetted.

Examination Content Outline and Passing Score

The CHRI examination consists of 140 multiple-choice items, which includes 120 questions used to compute your score, plus 20 questions that are not scored, but are being pretested for future use. Candidates have 2.5 hours to complete the examination. The passing score is 86 correct out of 120 scored questions.

Topics covered by the exam include the following:

1. Education 25%
2. Compliance 25%
3. Revenue 25%
4. Reporting 25%

Exam Preparation Tips

If you are looking for the latest in revenue integrity education, **NAHRI** recommends the following:

- **CHRI Exam Study Guide** (includes CHRI Practice Exam)
- **CHRI Practice Exam** (without Study Guide; recommended for those who would like additional practice attempts)
- **Revenue Integrity and Chargemaster Boot Camp** (**NAHRI** members save $150)
- **Core Functions of Revenue Integrity**
- **The Revenue Integrity Manager's Guidebook**
- **The Chargemaster Essentials Toolkit**
- **Medicare Billing Edits: Solving NCCI and MUEs**

Please note the aforementioned resources were not intentionally developed to mirror the CHRI exam outline, but can prove helpful in staying up to date on content relevant to the revenue integrity profession.

Exam Outline

I. EDUCATION—25%

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—25%

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/denials, 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. Assist in 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 of 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 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 organizationwide 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—25%

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 group (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.

f. 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 initiative 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.

g. 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.

h. 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.

i. 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—25%

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 for 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. Use key performance indicators (KPI) to evaluate the revenue integrity department's successes and failures.
12. Prepare correspondence and reports that substantiate the denial or reductions of hospital (or other healthcare facility) claims.
13. Develop unbilled/without charges reports.
14. Develop problem solutions as part of a process improvement initiative for internal reporting mechanism.
15. Develop quantitative and qualitative performance improvement values/measures.
16. Run data reports to identify trends to help assist with front-end process fixes.
17. Develop scheduled revenue integrity management reports on external developments (which might include reports of industry charging reviews, yearly CPT coding updates, or related issues).

On the Day of Your Examination

Prometric Testing Center

Prometric strives to ensure that all test takers who visit its test centers have a safe, secure, and stress-free experience. In response to the COVID-19 pandemic, Prometric has worked with third-party experts, including epidemiologists from Johns Hopkins University, to modify and enhance its established test center procedures to minimize the risk of transmission and to protect test takers and staff. You can view a complete **list of Prometric Test Center Regulations here**.

We recommend you view the linked video below (less than five minutes in duration) for a detailed overview of what to expect during your upcoming visit to a Prometric test center, so that you will feel more prepared and more confident in your testing experience.

Video: *https://live-prometric.pantheonsite.io/test-takers/what-expect*

It is important to arrive 30 minutes early to your scheduled appointment time to that you have ample time for check-in. Bring a copy of your confirmation email as it contains your confirmation number and your Prometric ID.

Remote Proctoring

If you have signed up for remote proctoring, carefully review your appointment confirmation email. It contains important instructions on test security procedures, a link to install the ProProctor application and perform a system check to ensure compatibility with your computer, environmental requirements, prohibited items and expected examinee conduct, and test center processes.

Remote online proctoring allows candidates to take the exam from the comfort of their own home, but be warned: You will be under the supervision of a proctor who will insist on a full inspection of your testing environment.

Among the noteworthy requirements:

1. You will need a very clean, clutter free workplace free of all pictures, books (except allowed resources), papers, etc. This includes second monitors, and more.
2. Your person will be inspected (sleeves, any areas where clothing could have pockets, behind your ears for possible Bluetooth devices, etc)
3. Your desk and chair will be inspected. Be prepared to move your computer camera around to show the room.
4. Make sure you have your exam number and a driver's license or other ID with a photo
5. Make sure the name on your ID matches the name used to register for the exam

Please read the remote proctoring instructions in your email to avoid surprises.

Identification

You will be required to present one valid, government-issued photo ID with a signature (e.g., driver's license, passport). If you are testing outside of your country of citizenship, you must present a valid passport. If you are testing within your country of citizenship, you must present either a valid passport, driver's license, national ID, or military ID. The identification document must be in Latin characters and contain your photograph and signature.

Failure to provide appropriate identification at the time of the examination is considered a missed appointment, and no refund will be provided.

Security and safety

If you taking the CHRI exam via remote proctoring, please review the Prometric ProProctor User Guide. It contains a helpful list of dos and don'ts, and requirements for your test-taking environment.

You can download and view the guide here.

Prometric no longer requires candidates or test center personnel to wear masks unless required by building management or government mandates. Prometric will continue to allow and encourage the wearing of masks for those who prefer to do so. For more information, visit *Prometric - Secure Assessments & Workforce Development | Prometric*. Test takers must also comply with any other local or federal mandates and guidelines.

Test takers will be assigned a locker number and key to place their belongings, if needed. Test takers will retain the key, and the locker area will remain under video surveillance while the center is open.

Please view the following video for more information: *https://www.prometric.com/test-takers/what-expect*

Examination Restrictions

Candidates in test centers will be provided with a physical, analog hand-held white board; one (1) white board eraser, cloth, or tissue; and up to three (3) dry erase markers of any color. These may be used to as scratch/note taking during the exam.

Remotely proctored candidates will have access to an online scratch pad.

No documents or notes of any kind may be removed from the Test Center.

No questions concerning the content of the examination may be asked during the examination.

Eating, drinking, or smoking is not permitted in Test Centers.

You may take a break whenever you wish, but you will not be allowed additional time to make up for time lost during breaks.

Misconduct

If you engage in any of the following conduct during the examination, you may be dismissed, your scores will not be reported, and examination fees will not be refunded. Examples of misconduct are when you:

Create a disturbance or are abusive or otherwise uncooperative;

Display and/or use electronic communications devices such as pagers, cellular/smartphones;

Talk or participate in conversation with other examination candidates;

Give or receive help or are suspected of doing so;

Leave the Test Center during the administration;

Attempt to record examination questions or make notes;

Attempt to take the examination for someone else;

Are observed with personal belongings; or

Are observed with unauthorized notes, books, or other aids.

Practice Time

Prior to attempting the timed examination, you will be given the opportunity to practice. The time you use for this practice examination is not counted as part of your examination time. When you are comfortable with the computer testing process, you may quit the practice session and begin the timed examination.

Timed Examination

Following the practice examination, you will begin the timed examination. Before beginning, instructions for taking the examination are provided on-screen. The examination contains 140 questions. Three hours are allotted to complete the examination.

If not all questions have been answered and there is time remaining, return to the examination and answer those questions. Be sure to answer each question before ending the examination. **There is no penalty for guessing.**

Candidate Comments

During the examination, you may make comments for any question by clicking on the Comment button to the left of the Time button. This opens a dialog box where comments may be entered. Comments will be reviewed, but individual responses will not be provided.

Failing to Report for an Examination

A candidate who fails to report for an examination forfeits the application and all fees paid to take the examination. A completed application and examination fee are required to reapply for examination.

Following the Examination

After finishing the examination, candidates will receive instant notification of "pass" or "fail." They will be asked to take a short survey of their testing experience. Additional detail on their test performance will be provided in the form of a score report, which includes raw scores by major content category. A raw score is the number of questions you answered correctly. Your pass/fail status is determined by your raw score. Even though the examination consists of 140 questions, your score is based on 120 questions; 20 questions are pretest questions.

In addition to the 120 scored questions, the examination also includes an additional 20 pretest questions. You will be asked to answer these questions; however, they will not be included in the scored examination result. Pretest questions will be disbursed within the examination, and you will not be able to determine which of

the questions are being pretested and which will be included in your score. This is necessary to ensure that candidates answer pretest questions in the same manner as they do scored questions. This allows the question to be validated as accurate and appropriate before it is included as a measure of candidate competency.

If You Pass the Examination

If you pass the examination, you are allowed to use the designation CHRI.

If You Do Not Pass the Examination

Candidates who fail the exam may retest at any Test Center but not more frequently than 90 days between attempts. **NAHRI** will discount the exam fee to $125 for the first retake only, which must be accompanied by an exam application. Subsequent attempts to pass the exam will be at full price.

Scores Cancelled by NAHRI

NAHRI is responsible for the integrity of the scores it reports. On occasion, occurrences such as computer malfunction or misconduct by a candidate may cause a score to be suspect. **NAHRI** is committed to rectifying such discrepancies as expeditiously as possible. **NAHRI** may void examination results if, upon investigation, violation of its regulations is discovered.

Confidentiality

Information about candidates for testing and their examination results are considered confidential. Studies and reports concerning candidates will contain no information identifiable with any candidate, unless authorized by the candidate.

Copyrighted Examination Questions

All examination questions are the copyrighted property of **NAHRI**. It is forbidden under federal copyright law to copy, reproduce, record, distribute, or display these examination questions by any means, in whole or in part. Doing so may subject you to severe civil and criminal penalties.

Maintaining Your Certification

Recertification

The CHRI recertification process ensures that credential holders stay up-to-date on education and regulatory changes relevant to their field. Individuals who hold the CHRI credential must apply for recertification every two years on the anniversary date they passed the CHRI exam, which can be found on the individual's CHRI certificate. Recertification can be completed through our online system (*chri.simplifycertifications.com*). The fee for recertification is $125 for NAHRI members and $225 for nonmembers. Our online system will request payment details after your recertification application is completed and approved.

CHRI credential holders must submit a recertification application with proof of earning 30 CEUs relevant to the healthcare revenue integrity field—15 of these CEUs must be obtained from **NAHRI** or HCPro educational offerings. All CEUs must be approved prior to the training event. CEUs may not be applied for after an event under any circumstances. Individuals may submit no more than 10 CEUs for a single activity from another accredited agency or organization such as AHIMA, NASBA, AAHAM, or HCCA. All CEUs issued by HCPro and **NAHRI** are accepted for recertification.

Only CEU activities completed after a candidate passes the CHRI exam may be submitted for recertification. CEUs must be earned during the two-year period when the certification is valid. Additional CEUs do not carry over to the next renewal period.

Although **NAHRI** strongly recommends submitting 30 CEUs by the two-year exam anniversary date, CHRI certification holders are extended a 45-day grace period to submit their CEUs. Failure to submit CEUs in a timely manner may result in penalties, late fees, and eventual revocation of the CHRI credential. A former credential holder may recertify by reapplying for and successfully passing the CHRI exam.

A percentage of applicants will be audited to ensure that they have met the CEU requirements. Recertification candidates should keep a record of participation in all their CEU-qualifying activities in the event of an audit.


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