Building a Structure to Support Optimal Revenue Recovery

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Reimbursement Matters

Objectives

- Building a multidisciplinary team to support revenue integrity
- Leveraging denials to create bridge between financial and clinical functions
- Establishing a proactive approach to managing denials, audits and compliance
- Providing ongoing education and training on best practices

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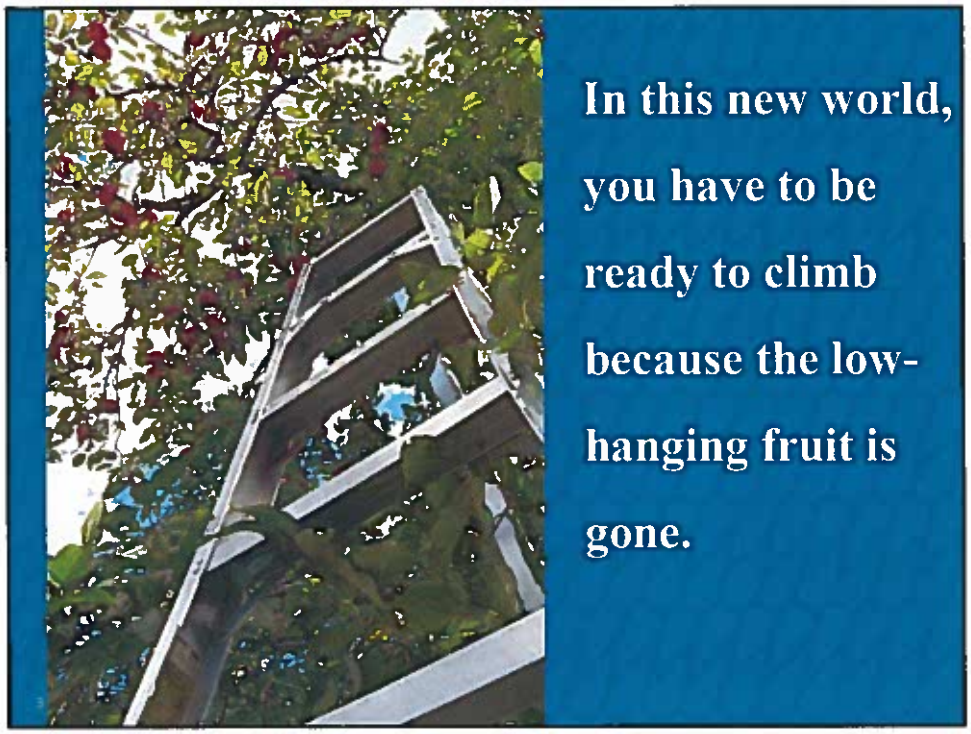
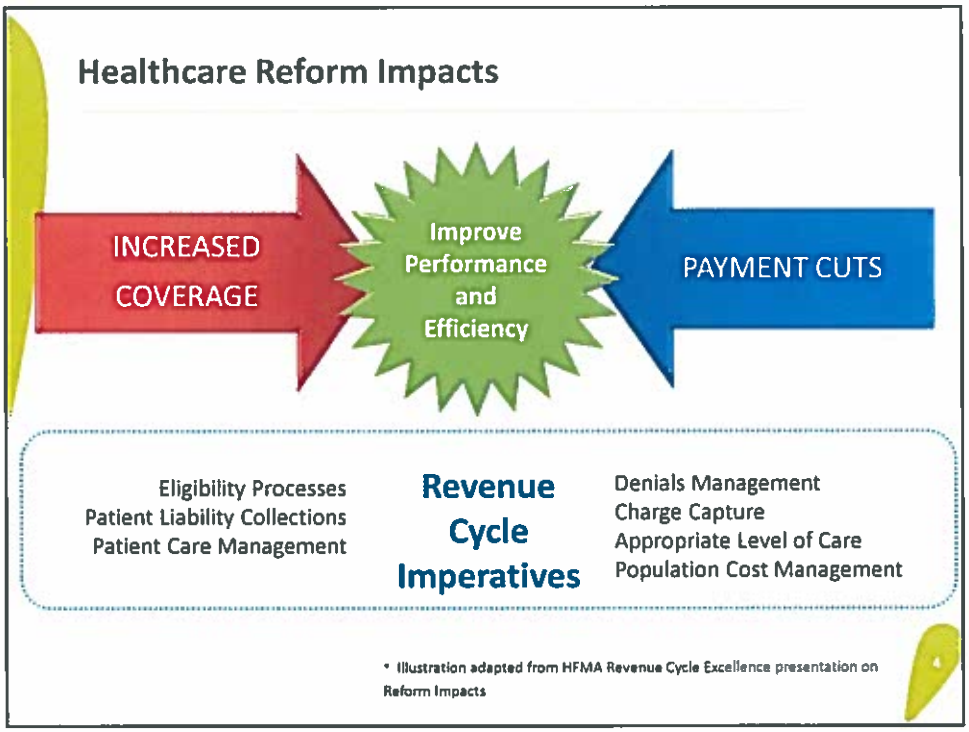

In this new world, you have to be ready to climb because the low-hanging fruit is gone.


Healthcare Reform Impacts
INCREASED COVERAGE
Improve Performance and Efficiency
PAYMENT CUTS
Eligibility Processes
Patient Liability Collections
Patient Care Management
Revenue Cycle Imperatives
Denials Management
Charge Capture
Appropriate Level of Care
Population Cost Management
• Illustration adapted from HFMA Revenue Cycle Excellence presentation on Reform Impacts

Changing Patient Populations

- We feel that flat volume is, in fact, the new normal
- As more care shifts from inpatient to ambulatory settings, projections estimate 17% growth in outpatient services, where hospitals already generate more than half of their revenue.

[1] Standard and Poor, 2013
[2] Modern Healthcare "Shift to Outpatient Care", 08/09/2013

Dramatically Different Payer Behavior

- ACA is expected to contribute to a retail healthcare world where patients will begin to think of themselves as consumers
- The less expensive exchange options will result in higher BAI; not to mention those to choose the penalty for not selecting a plan or those who wait to visit the hospital before signing up
- Healthcare consumers pay more than twice as slowly as commercial payers, and their accounts require more manual intervention
- The future individual exchange population will likely be more difficult to collect from given they are apt to have lower credit scores and fewer household assets

Revenue Cycle Disruption

- ACA Implementation January 1st, 2014
  - What was the real impact?
- ICD-10 preparation and transition
  - Detailed level of coding
  - Reduction in productivity
  - Payer readiness
  - Impact of changes
  - Expect increase in denials
- EHR implementation and financial system migrations
  - Cost
  - Revenue cycle process changes

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Denials Environment

- "We've seen the denials problem increasing .....not really by leaps and bounds but more incrementally," says Barry Franklin, chief financial officer of Parma (Ohio) Community General Hospital. "It's always a problem—when payments are short by $100 here and a $1,000 there, pretty soon you're talking about real money."[1]
- 34.5% of respondents say the problem with getting paid on the first attempt by managed care carriers is getting worse[2]
- "upward trend in denials across the board for the first time since 2008"[3]

[1]Hospital and Health Networks, "Taking the Offense Against Claim Denials" May 2007
[2]Managed Care Information Center, *Executive Report on Managed Care*, 2010
[3] *AMA National Insurer Report Card 2012*

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Shifting Description of Revenue Cycle

- Denials PREVENTION
- LIFE-LONG PATIENT ENGAGEMENT
- UTILIZATION CAPTURE

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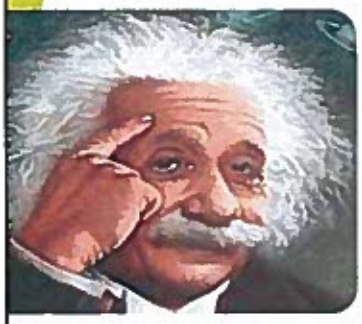
Building a New Structure



"Insanity is doing the same thing over and over again and expecting different results."

- Albert Einstein

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DENIAL PREVENTION TEAM

Shifting focus from Management to Prevention

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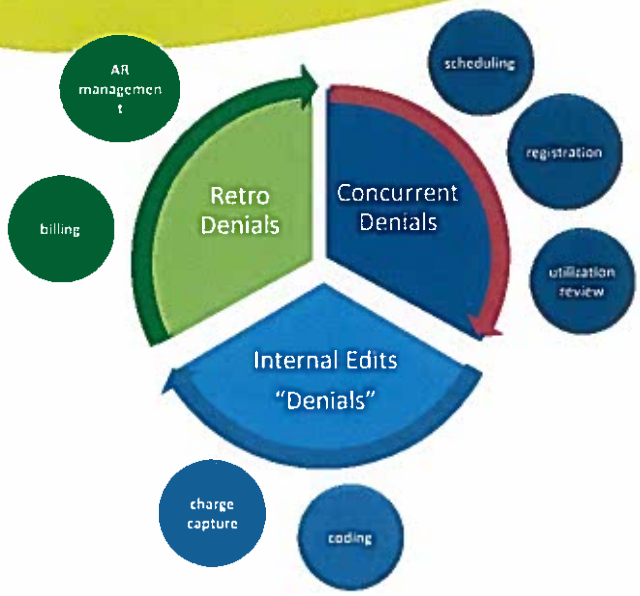
Denials Prevention – Balanced Focus



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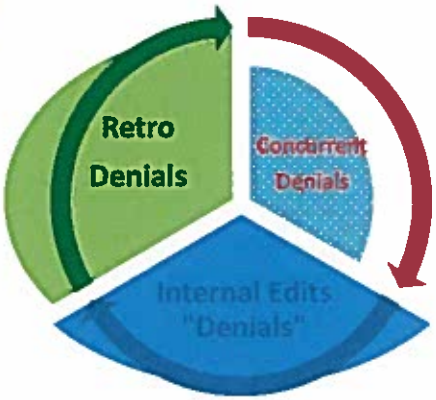
How do most hospitals use their resources?



- Common Practices
  - UR responsible for retro clinical denials
  - Billers responsible for denials
  - Denials sent back to front-end rev cycle departments
  - All denials initially reviewed by entry level staff

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Denial Management to Denial Prevention

- Implementing an effective denial prevention program is the easiest way to generate cash.
- The work has already been performed by the hospital.
- A program focused on denial prevention versus denial management places priority on fixing front end processes through clinical and financial collaboration

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Denial Prevention Program

- Denials are worked by a focused denial prevention team they **ARE NOT** sent back to front-end revenue cycle departments
- The focus of the denial prevention team is **ACTIONABLE DATA** and **CASH COLLECTION**
- Denials are differentiated between clinical and technical
- Data from process is quickly distributed to departments and placed into process improvement and education programs

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Denials Prevention Team Composition

- Primary Focused Team of experts comprised of:
  - Day to day management
  - Nurse Auditors
  - Accounts Receivable/Billing Specialists
  - Inpatient/Outpatient Coders
  - Clerical Support Specialists
- Secondary resources
  - Legal Support
  - Medical Director

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Denials Prevention Team

- A process must be in place between "AR Technical Staff" and "Clinical Staff" – *The Hand-off*
  - Delivery of clinical denials to clinical staff (paper vs. electronic)
    - Nurse Audit request (explanation of problem)
    - RAs/EOBs/UBs
    - Medical records
- Clinical audit inventory must be managed
  - Distribution to clinical staff prioritization methodologies
  - Productivity measurements
  - Clinical outcome reports

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DEPARTMENT ENGAGEMENT
USING EXTERNAL DATA AS A LAUNCHING POINT

Data Capture

"It is a capital mistake to theorize before one has accurate data."

Arthur
Conan Doyle

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Data Capture

- Clinicians are data driven
- Denials data provides feedback about processes from an external source
- Patient care has already been provided and cost has incurred providing incentive for clinical department engagement
- Denials have a clear financial value
- The Denials Prevention Team must be trained to capture accurate Root Cause Data in an actionable way

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Measurements

- Denials are a starting place, including a focus on charge capture will uncover other issues
- Charge Capture issues have also increased with new HIS system implementations
- Charge Capture Measurements
  - Late Charges – identifies lack of control in process
  - Missing Charges – through technology or audit

Measurements

- HFMA MAP Keys
  - Initial Denial Rate – Zero Pay
  - Initial Denial Rate – Partial Pay
  - Denials Overturned by Appeal
  - Denial Write-offs as a Percent of Net Revenue
- Report and Trend Data
  - Total
  - By Payer
  - By Service Line

Data Collection and Analysis

- New data collection and analysis focuses on improving and "tweaking" processes for incremental improvement
- Moves beyond just the map keys and looks at key control points or "switches" in the process
- Can be overwhelming when mapping out all of the places to measure and track data and the key to success in improvement is focus and consistency of reporting

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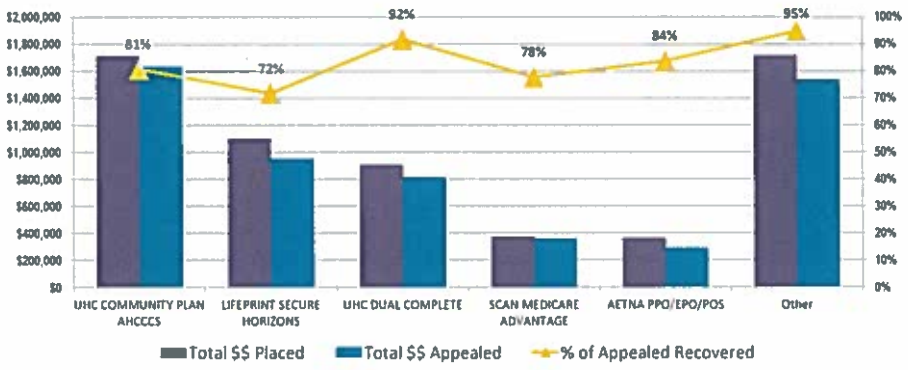
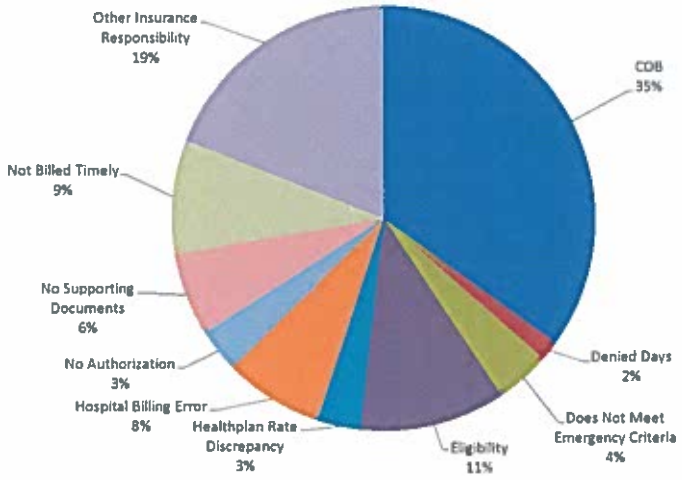
Denials by Payer



Top 10 Short Pay Reasons



Not Billed Timely - Breakdown

Reason		Value	Count
Wrong Initial Payer	$	189,367	42
Late Charges Past Filing	$	269,854	187
Initial Coding Hold	$	29,831	4

- Late charges credited back to department revenue
- Coding and Registration issues reported on revenue cycle reports

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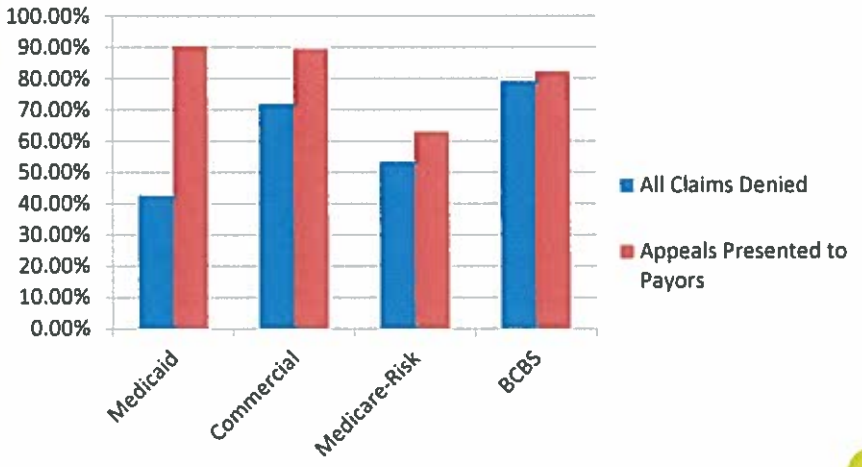
Clarity imperative with "Over-turn" rates



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Overall Denials by Physician: All Denials Inventory

Top Denied Physician by Dollars

VASIQ,MUHAMMAD	83	$540,506.57
GOLPARIAN,MOHAMMAD	40	$165,191.05
TAKYAR,HARINDER K	19	$108,880.27
SAJJAD,MASHOOD	25	$108,110.74
ALAM,MUHAMMAD M	10	$102,730.44

Top Denied Physician by Volume

VASIQ,MUHAMMAD	83	$540,506.57
OKAFOR,JOACHIN U	60	$13,059.45
VELASCO,LOUIS E	51	$10,008.04
VIDAL,OCTAVIO	50	$8,585.22
ADAMS,BRUCE K	43	$7,149.78

SOLUTION COLLABORATION

Building the relationship through problem solving

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Denial Prevention Process

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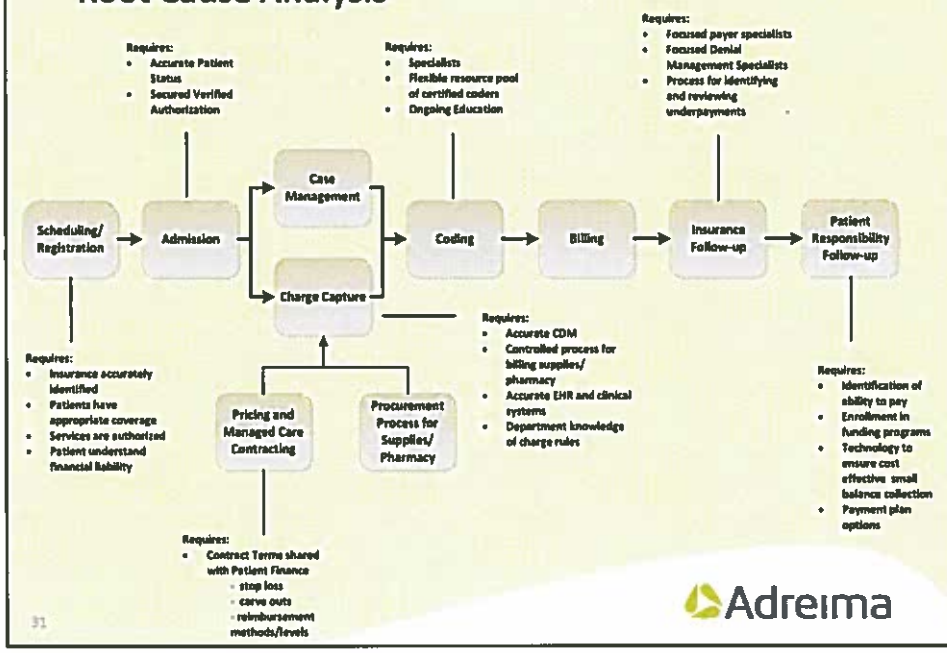
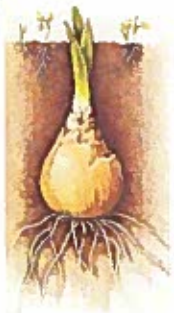
Root Cause Analysis



Expose the Root Cause



- The Denials Prevention Team must be trained to capture accurate Root Cause Data in an Actionable Way
  - Revenue Cycle function failure
  - Clinical Operations function failure

Sample Denials Management Analysis

- **At one hospital system an in-depth review demonstrated that the hospital had specific clinical issues…**
  - **Physician delay in discharge**
    - Patients no longer meeting inpatient criteria and documentation insufficient to support continued stay
    - In cases where the patient is waiting for skilled nursing facility placement, roughly 40% of denied dollars were recovered on appeal/reconsideration
  - **Overutilization of ICU – Under documentation of ICU**
    - Short pays by health plans where the ICU level is not supported by documentation
    - On appeal 32% of denied dollars in this category related to Physician use of ICU were recovered

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Specific Challenges: Elective Surgery

- Scheduled and authorized as outpatient, but made inpatient after the procedure
- The chart contains an outpatient authorization, an inpatient order and the documentation supports outpatient level of care
  - These claims are either being short paid or paid at $0.00
- Very difficult to argue on appeal without documentation of complications
- Addressing these concurrently requires communication between Clinicians, Scheduling and Case Management and updates to EHR

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Clinical Denials Management is an Essential Component of the Revenue Cycle

- Prevents money from being left on the table
- Provides great insight into process improvement opportunities
- Requires specific, detailed processes and resource allocation
- Systems for data analysis and comparison are crucial
- **Strong clinical integration is imperative**

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PERMANENT STRUCTURE

It's who we are, and what we do.

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Team Structures

- Revenue Cycle Steering Committee
- Denials Prevention Team reports to VP of Revenue Cycle or CFO
- Monthly meetings with identified clinical departments
- Denial rates and data incorporate into performance plan

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Development of Cross-Functional Team

- Establish Revenue Cycle Steering Committee
  - Director level representing: Admissions/Registration, Billing, Coding, Revenue Integrity, Scheduling
  - Executive Sponsor
  - Review key metrics each month – Denial Data
  - Review denials data in detail
  - Discuss upcoming department and hospital changes identifying their potential impact on the revenue cycle

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Development of Cross Functional Team

- Engaging Clinical Areas Best Practice
  - Attend clinical meetings
  - Bring data metrics for the specific departments
  - Bring information on upcoming regulatory changes impacting the department
  - Listen and identify financial impacts of discussion
    - New services
    - Become familiar with the way care is delivered
  - Be prepared to be brief

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Preventative Education

- With the clinical areas engaged
  - Create consistent education programs for broader department audience
  - During key revenue cycle changes document and communicate department specific changes
    - Quarterly and end of year regulatory changes
    - Hospital contract changes
    - RAC/MAC focus area changes

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Avoid Analysis Paralysis

- Stick to the key metrics provided
- Create relevant data for the audience
  - Specific department
  - Specific time period
  - Identify outliers or key events impacting data
  - Draw out what is important
- Keep team focused on root cause and improvement – not justification
- Prioritize focus and efforts to ensure acheivement

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A few keys to success include:

- Systems that collect data and processes that translate that data into information
- Front end processes to ensure eligibility, notification and authorization
- Ongoing and timely clinical review and communication with payors
- Contract management & IT systems that accurately calculate expected payments using complex reimbursement formulas
- Integrated denials prevention for both technical and clinical

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Summary

- Denials Prevention is a mind set that does not accept denials as a part of life and provides focus on fixing the problem of denials; not "managing" it ongoing
- Denials Prevention requires engagement with clinical departments which is achieved through data and disciplined structure
- Shifting from Denials Management to Denials Prevention mindset may required additional temporary resources but overtime will minimize revenue loss
- Leverage the Denials Prevention program to engage clinical departments in focusing on Revenue Integrity

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Questions?

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