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Internal Denial Reporting: Informing Payer Communications

By Sarah Loeffler

To achieve its revenue integrity goals, Saint Francis Hospital routinely monitors denial performance against aggressive benchmarks, mines detailed denial data, and holds quarterly joint management meetings with payers.

Like many organizations, MAP Award-winning Saint Francis Hospital in Tulsa, Okla., focuses keenly on revenue integrity. Routine internal reporting of denial trends not only helps educate staff on appropriate authorization and coding for clean claim submission, but also informs discussions with payers.

Ongoing Monitoring Against Aggressive Goals

Saint Francis revenue cycle staff regularly track percentage of denials to revenue. The organization compares performance with industry benchmarks (see the sidebar on page 2), including peer performance, and has now refined targets to a best practice of less than 1 percent.

"We meet monthly," says Renee Edwards, director of patient financial services for the Saint Francis Health System. "When we start seeing an increase in denials, we communicate with one another about what may be driving the increase—perhaps it's episodic, or it reflects a particular group of claims that we had issues with, or maybe it reflects a problem with a department's understanding of documentation or coding that has since been resolved. Sometimes, it is a particular issue with a payer."

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At monthly meetings, participants explain why benchmarks may be outside of the performance threshold and discuss what they plan to do about it. Thus, the meetings support staff accountability.

Detailed Denial Data

Identifying and tracking trends is core to improvement efforts at Saint Francis. Every payer correspondence pertaining to a claim is posted to the organization's tracking system with a transaction code. Staff can pull a report at any time for a particular payer and view it by specific correspondence—for instance, tracking how many "not medically necessary" denials were received from a specific payer for each month.

During the monthly meeting, staff use the detailed denial data to discuss how current contracts are performing and provide insight into the types of terms they would like to see going forward. "We try to give our managed care manager realistic expectations about what to seek in a

contract and make recommendations for those things that may not be as certain, but for which we should strive anyway. Much of this input, ultimately, is reflected in our contracts," notes Edwards.

Also, when issues come up in existing contracts, staff maintain a folder on a shared drive where they can note the particular challenges. Tracking such information helps leadership strategize about how to avoid the same pitfalls going forward and better contract with the payer in the future.

"Contracts are only as good as they're written," notes Edwards. "Sometimes, it is only after the contract is signed and you've seen how it performs that you realize there are issues or challenges with certain aspects. We want to make sure we have all those details documented, so we don't recreate the problem the next time

around or can circumvent the issues somehow in future contracts."

Quarterly Payer Meetings

Saint Francis Hospital participates in quarterly joint management operations meetings with its payers. Representatives include the managed care director, director of patient financial services, and revenue cycle director. The meetings support relationship building and provide an opportunity for routine dialogue (as opposed to dispute-based communications).

To prepare for the joint management operations meetings, staff bring detailed information about performance trends, with particular attention to payment delays and high-dollar or high-quantity denials. A typical conversation may focus on such things as a chemotherapy drug that keeps getting denied but ought to be

How Does Your Denials Performance Compare with Peers?

One strategy that has helped Saint Francis Hospital in Tulsa, Okla., achieve a denial rate of less than 1 percent is looking at the performance of others and using this information to set specific, attainable goals. An organization's year-to-year performance change tells only part of the picture; viewing performance against comparable peers provides the necessary context for this change.

This need for industry comparable metrics and deeper understanding of revenue cycle performance across the industry has been the driving force behind HFMA's MAP Initiative. "Health care is a dynamic industry, where regulatory change, technology advances, and market pressures continually affect the landscape," notes MAP director Suzanne Lestina, FHFMA, CPC. "Revenue cycle leaders need access to performance benchmarks to better understand their organization's ability to keep pace with this change in key areas affecting financial performance, and to best direct efforts and resources to areas within the organization where they will have the greatest impact."

HFMA's MAP initiative has identified and defined hospital and physician practice revenue cycle benchmarks, or MAP Keys. The full list and definitions are at hfmamap.org/mapkeys.

In addition, organizations can use automation to track and trend performance against comparable peers using HFMA's MAP App. The MAP App allows users to not only target specific levels of performance change, but also calculate what this performance change will mean in terms of financial impact to the organization. To learn more and receive a customized revenue cycle opportunity analysis using HFMA's MAP App, email HFMA's MAP Team at mapapp@hfma.org or visit www.hfma.org/mapapp.

reimbursed. "The payer representatives will either agree that it isn't the way the contract is supposed to be performing and discuss how they will address the problem going forward, or they'll stand firm—and can expect that the item on any new contracts will present issues," Edwards says.

Also key is communication of bad debt by product line. "This information is really useful," she says. "When we ask for an increase, our payers know why. I think that's where a lot of hospitals without data tracking and monitoring end up having a problem: Their contracts may be underperforming—but they don't know why. And then when they ask for an increase, they don't have any information to back up that request."

Another significant benefit to pulling such information for the quarterly meetings is that it keeps the information close at hand. "When the contracts come up for renewal, we can just pull all of the information together and it's ready for the negotiation," Edwards says.

Positioning for Effective Claims Management

How well a hospital tracks and trends claims denials within the organization can prove valuable beyond identifying immediate risk to revenue integrity and

cash flow. Such data can unite the organization around strong payment processes and provide valuable insight—and potential leverage—for communications with payers.

In this way, comprehensive internal denial reporting practices, such as those in place at Saint Francis, go beyond helping to achieve near-term revenue cycle goals. The organization best positions itself for effective claims management over the long term.

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Coding Q&A | By Jennifer Swindle

How Inaccurate Present-on-Admission Indicators Affect Payment

Q: What is the impact of inaccurate present-on-admission (POA) indicators and what is the risk to the facility?

A: Hospitals paid under the Medicare Inpatient Prospective Payment System have been required to submit POA information on diagnoses for inpatient discharges since Oct. 1, 2007. To be considered POA, a diagnosis must be documented as present at the time the order for inpatient admission occurs. A study conducted in 2010 by the Office of Inspector General found that 13.5 percent of Medicare beneficiaries hospitalized in October 2008 experienced adverse events.

Investigators reviewed 5,491 POA indicators on 698 sample claims and found that 3 percent of POA indicators should not have been listed as such.

Although this error rate is relatively low, POA indicators can have a significant effect on reimbursement, as shown in the exhibit below. Based on the Deficit Reduction Act of 2006, facilities are not entitled to higher reimbursement for conditions that are not POA and that may be considered as hospital-acquired conditions (HACs) that affect the patient's length of stay. In assessing the impact of incorrect POA indicators, hospitals

should also keep in mind that the Patient Protection and Affordable Care Act of 2010 relies on accurate POA assignment in some of its pay-for-performance initiatives.

Close monitoring of the accuracy of POA indicators enables hospitals not only to monitor quality of care, but also to create safeguards and policies to help reduce the incidence of HACs.

Training is of key importance. Clinicians should be trained to document all preexisting conditions. Inpatient coders should be trained to accurately capture the POA indicator. And coding and clinical staff should work together to clarify and remedy any deficiencies in documentation.

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Access the Coding Q&A archives at www.hfma.org/rcs. Send your coding questions to Karen Thomas at kthomas@hfma.org.

POA Indicators

Y	Present at time of admission	Payment made when HAC is present
N	Was not present at time of admission	No payment made when HAC is present
U*	Insufficient documentation to determine	No payment made when an HAC is present
W	Clinically undetermined	Payment made when HAC is present
1	Exempt	(Since implementation of the 5010 format, this character is no longer valid; the POA field should be left blank)

*Issues related to missing or unclear documentation should be resolved by clinicians; if documentation is insufficient, the clinician should be queried.

Case Study: Building Exception-Based Workflow and Extracting Management Information in Billing

After overhauling its inefficient billing editing approach, Titus Regional Medical Center dramatically reduced back office workload while increasing its clean claim rate and obtaining needed business intelligence about the entire revenue cycle.

Patient care delivery in acute care hospitals focuses on reacting to current symptoms with immediate ramifications—and rightfully so. Whether it's a reflection of this cultural mindset or a result of the myriad daily challenges of running a major administrative department, health-care financial managers often find themselves managing in a similar fashion. When stretched in multiple directions, the natural tendency is to focus on quick fixes and "fighting fires," instead of taking the time to study issues and implement solutions aimed at systemic, multifaceted problems associated with the revenue cycle.

That's what happened recently to Titus Regional Medical Center (TRMC) in Mount Pleasant, Texas. When slowly mounting, previously undiscerned issues resulted in a $2.5 million write-off of third-party accounts receivable deemed uncollectable, leaders knew that the organization's revenue cycle situation was unsustainable.

By taking decisive action early, TRMC embarked on a path to improve annual net revenues and accelerate cash flow significantly.

Recognizing the Need for Change

Situated 117 miles east of Dallas, TRMC is a 174-bed facility that has been serving patients throughout northeast Texas for nearly half a century. TRMC's clinical mission has never been in doubt; however, the execution of that mission was jeopardized by the lack of focus on recurring and evolving systemic operational challenges related to revenue cycle. The absence of a cross-functional revenue cycle team caused leaders to focus primarily on solving individual problems as they arose, instead of methodically identifying and prioritizing operational improvements designed to improve outcomes and prevent future errors throughout the revenue cycle.

TRMC formed an integrated revenue cycle steering committee and conducted a review of critical processes to determine the source and extent of any significant failure points. Upon discovering shortcomings throughout the revenue cycle, the hospital chose to start improvement efforts in the patient billing process, with four primary objectives:

> Resolve billing issues to accelerate cash flow.
> Reduce the manual effort expended on billing to get claims out the door and reallocate that time to higher value-added activities, such as proactive follow-up and denial/underpayment resolution.
> Identify, capture, and analyze information about errors in the billing process to inform process improvement efforts throughout the revenue cycle.
> Develop a sustainable and repeatable approach to accessing this information to provide a model for similar efforts focused on denials, missing or insufficient clinical documentation, registration errors, and other high-value information sources.

Assessing the Situation

TRMC's problems are not unique. The complexity of new regulations and realities is confusing and daunting. Once-proven approaches now fail to achieve needed results. Staff members do the best they can to manage an increasing workload, but training and tools are limited. And management teams take on more responsibilities within an ever-more-complex environment of increasing interdependencies and limited business intelligence and performance management tools.

After reviewing their operations, TRMC's new revenue cycle management team recognized that the hospital's internal resources were too limited to address these challenges effectively while maintaining the same workload, especially given current inefficiencies. Furthermore, they didn't have the expertise and knowledge of best practices to isolate the problem and engineer a turnaround. They sought outside help to assess the problem, design a solution, and implement the improved processes.

A detailed operational assessment confirmed TRMC's initial suspicions. Many billing activities and edits were inefficient, obsolete, or had been put in place without a deep understanding of the root causes and their overall impact on revenue cycle performance. For instance, it was immediately apparent the staff did not trust the current billing edits in place to catch major payer issues. Therefore, they were holding all claims to perform a manual review for errors they had learned would result in rejections and denials. This lack of an exception-based workflow required dedication of significant staffing resources, which severely limited follow-up activities because the same staff were responsible for both activities. This misallocation of resources caused accounts receivable to age and inhibited the ability to respond to denials and problem accounts.

In short, the electronic billing process had devolved into an electronic parking space for bills awaiting manual review. The staff tried to resolve the errors as early in the process as possible and they strived to improve their operational performance, but they had neither the time nor the expertise needed to isolate and analyze root causes of the errors or to reconfigure billing systems and processes to drive improvements that would stop revenue leakages.

Automating Billing Processes

With backlogs growing, the current processes and management systems could not sustain a healthy revenue cycle. TRMC needed a major overhaul of its processes and technology to improve workflow and allow for more effective use of staff time. This overhaul would take several months, but with millions of dollars hanging in the balance, it was a low-risk investment with high potential for significant financial returns.

The first step in improving revenue cycle performance at TRMC was to perform a root cause analysis for claim submission issues. Using the Pareto Principle (80 percent of the effects come from 20 percent of the causes) as a guideline for isolating the most common causes for claim submission failures, more than 100 configuration and edit changes within the billing system were developed over the course of eight weeks.

To develop the changes, an extensive review of the claim issues that required manual review was conducted. Corresponding billing edits and bridge routines were built into the billing system to codify experiential individual knowledge into automated institutional knowledge. By developing these edits, the staff learned to trust the system and began working from an exception-based perspective. This change greatly improved operating efficiencies as staff learned to work only claims that were stopped by the system and allow all others to flow directly to the claims clearinghouse. This approach also allowed the few remaining errors to be identified in the denial process, analyzed for root causes, and addressed from a systemic perspective, rather than a one-off, claim-by-claim perspective.

The next step was the identification of commonly recurring manual corrections required to address billing edits. When the billing staff manually corrected a billing edit the same way every time, those edits were categorized, and automated routines were developed to perform the necessary data change, eliminating the need for manual intervention.

Finally, a web-based "communication portal" was developed and deployed to allow for the initiation and tracking of key billing clarification requests, such as coding reviews stemming from billing edit/denial, new billing edit requests for recurring issues, chargemaster updates, and account escalation to management. Improved intra- and inter-departmental communication of outstanding claims gave management a straightforward, comprehensive reporting system for unresolved issues, shedding light on the reasons for delays in resolution. Prior to implementing this portal, communications had occurred via e-mail with no mechanisms for tracking or quantification.

Improving the Clean Claim Rate
With new processes and technology deployed, TRMC's staff reduced its billing workload dramatically. Before these improvements, billing activities consumed the time of up to eight FTEs. Now, the billing workload is processed by 1.5 FTEs—a decrease of more than 75 percent—and as much as 200 hours per week has been re-allocated to follow-up and denial management activities. Management now has the information

and operating mechanisms to quantify and prioritize improvement efforts based on rigorous data analysis, not anecdotal evidence. By focusing on the 20 percent of claims that were causing 80 percent of the problems, TRMC was able to track billing activities and categorize errors by reason to reduce issues in a systematic way.
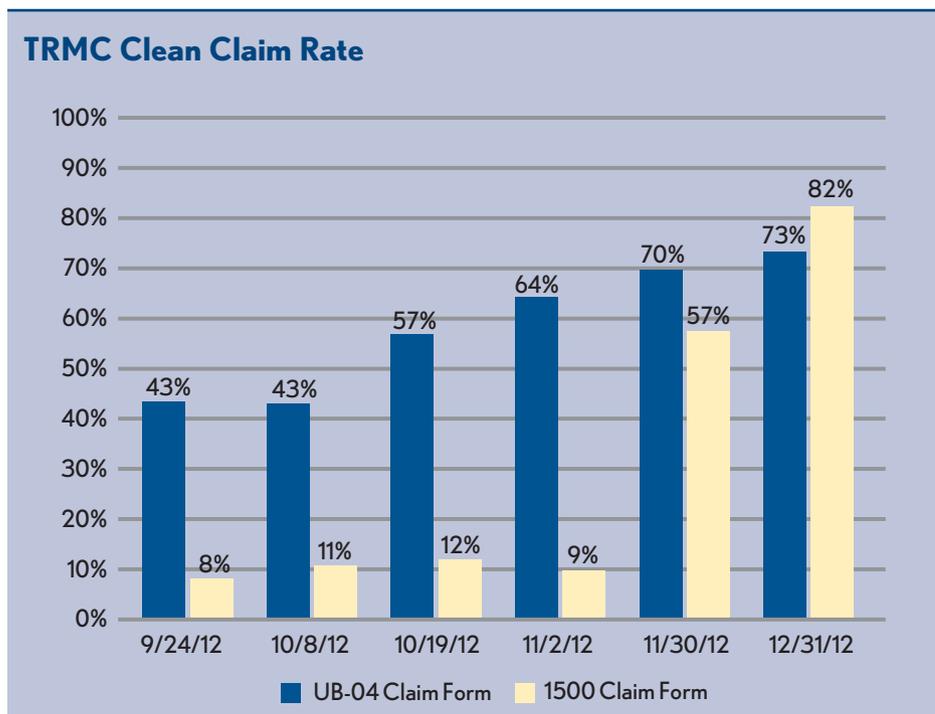
As part of the revenue cycle business intelligence initiative, sophisticated reporting was developed to allow TRMC to easily repeat the categorization and prioritization process. Using the new reporting capabilities not inherent in most electronic billing systems, TRMC management has proactively reviewed billing edit data in regular status reports every two weeks for three months, showing the improvements in error percentage and progressive changes in the top billing errors.

During this time, clean-claim rates, which were effectively zero because of the reliance on manual reviews, reached an average of 75 percent, as shown in the exhibit below. By dramatically improving the clean-claim rate and related billing processes and systems, TRMC reduced overall third-party accounts receivable by 30 percent and third-party accounts receivable over 90 days by 25 percent in a three-month period.

Today, TRMC views its clean-claim rate not just as a billing metric but as a performance metric for functions throughout the revenue cycle, continually using billing edits to identify root causes of errors both within the patient financial services department and upstream. This valuable information is shared with managers outside of the billing function, thereby initiating proactive changes in processes, technology, and resource allocation. This understanding of the clean-claim rate, coupled with rigorous categorization and prioritization of root causes throughout the revenue cycle, will facilitate ongoing improvements to drive the clean-claim rate above the 90 percent target threshold. And that is a great example of continuous improvement in action. ✐

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TRMC Clean Claim Rate

Bar chart showing UB-04 Claim Form (dark blue) and 1500 Claim Form (light yellow) clean claim rates:

Date	UB-04 Claim Form	1500 Claim Form
9/24/12	43%	8%
10/8/12	43%	11%
10/19/12	57%	12%
11/2/12	64%	9%
11/30/12	70%	57%
12/31/12	73%	82%

Payment Portals Can Improve Self-Pay Collections and Support Meaningful Use

Increased electronic engagement between healthcare providers and patients provides significant opportunities for improving revenue cycle metrics and encouraging patients to access EHRs.

By offering user-friendly, online payment portals, providers can better serve the growing number of self-pay patients. In addition, payment portals give providers a way to boost patients' use of portals to access electronic health records (EHRs).

Why Portals Now?

Two factors have accelerated the evolution of online payment options from "nice to have" to "must have": the growth in self-pay patients and the introduction of meaningful use incentives.

More self-pay patients. The number of health savings accounts and accompanying high-deductible health plans has grown significantly in the last four years. As a result, more patients are now paying directly for their healthcare services— and many providers have seen their billing-related costs and accounts receivables levels rise. As millions of previously uninsured patients begin or increase their use of healthcare services starting in 2014 under the Affordable Care Act, this trend will continue.

More EHR requirements. Federal EHR requirements are ramping up. For example, to qualify for incentives under meaningful use Stage 2 requirements released this past August, providers must not only offer an online portal for patients to access their medical records, but a minimum of 5 percent of their patients must actually use it. This is among the more controversial provisions in the Stage 2 requirements because qualification depends on patient action.

Revenue cycle professionals should be highly involved in portal projects. Because many patients prefer to view statements and make payments online, providers can leverage the popularity of online payments to help drive traffic to electronic records. In some cases, that additional traffic could make the difference in whether a provider qualifies for meaningful use incentive pay.

How Portals Improve Revenue Cycle Metrics

Online portals can help improve revenue cycle metrics by reducing billing-related costs and accelerating collections.

Lower billing-related costs. Patients who pay online are more likely to enroll in electronic statement delivery, helping to reduce postage, paper, and printing-related costs. Also, online portals can give patients access to past statements and payment data. This self-service data access means patients can answer many of their own billing-related questions, resulting in fewer incoming calls to

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billing staff. Also, when patients do call, they are often logged into the payment portal, with access to past statements. When both patients and call center representatives can review current and past billing data "live" together, calls are resolved faster and fewer customer-service hours are spent answering billing-related questions.

Faster collections. In a 2012 internal analysis of payments to multiple clinics and hospital systems, 87 percent of all electronic payments were made before the due date during the three-month study period. What's more, 13 percent of all electronic payments were received within five days of issuance, which is virtually impossible for mailed statements and mailed payments. Collection figures were even better among patients who both received electronic statements and paid online. Of these, 93 percent paid before the due date, and 29 percent paid within five days. From a revenue cycle perspective, therefore, the ideal self-pay patient is one who both receives statements online and pays online. By promoting "e-adoption," revenue cycle professionals can help improve collections.

How to Develop a Payment Portal

Providers may choose to develop a payment portal solution in-house or work with a partner. Typically, partners fall into three categories: payment processors, practice management software providers, and statement-processing partners.

In-house solutions may include "built from scratch" customization that offers such advantages as access to past statements and payment data. But on the flip side, in-house solutions also require

ongoing IT support and feature development because web-based technologies and best practices for user interfaces can change quickly. Payment-processing vendors generally offer solutions at the other end of the customization spectrum, with little or no ability for providers to include custom branding or access to past statements or detail beyond the current amount due. These solutions typically feature a button on the provider's website linked to an unbranded third-party pop-up window or external site. Payment-processing vendors can, however, provide useful reporting data.

Working with practice management software providers enhances a provider's ability to link online payment portals with patient EHR portals and offers the benefits of streamlined vendor relationships. Flexibility and custom branding may not be options. However, some practice management software providers may partner with statement-processing vendors (or with in-house developers, for providers with large-scale IT operations) to offer customized solutions. Statement-processing vendors may be able to leverage detailed statement data in solutions that give patients the option to pay on a line-item basis, which can speed up overall collections.

Keys to Deploying a Portal
To the degree that flexibility and customization options allow, the following guidelines may help maximize revenue cycle benefits from deployment of payment portals.

Integrate payment portals with patient records portals. According to a 2012 report from KLAS, an independent firm that analyzes the state of healthcare technology, 57 percent of healthcare providers now offer patient EHR portals (KLAS. *Patient Portals: The Path of Least Resistance.* Nov. 30, 2012). Survey results

showed that providers typically choose patient portal solutions offered by EHR vendors. The best user experience for patients is integration of the EHR portal and the online payment portal, accessible through single sign-on technology. This also benefits providers by driving traffic to the EHR system, potentially reducing demand for phone-based customer service.

Provide access to past statements. Full-featured online payment portals should provide patients access to past statements for record-keeping purposes and to help enable patients to answer their own questions.

Enable line-item payments. Patients are often confused by healthcare statements. By enabling line-item payment options, providers can promote faster collections for those entries a patient understands, thereby avoiding delayed payment of a full invoice until the patient's questions are resolved.

Offer online payment options with no log-in required. Patient statements may be printed with unique identifying codes designed to allow a patient to make an online payment without logging into either a payment portal or EHR system. This is a user-friendly approach that requires minimal effort from patients. Patients simply enter the unique code via a link from the provider's website and are transferred to a payment screen.

Direct patients to intelligent payment screens. When patients use a "no log-in" option as discussed above, ensure that they are directed to pre-populated, or "intelligent," payment screens. This reduces typographical errors that are otherwise frequently introduced when patients are asked to enter their own name, address, balance due, and other identifiers. Elimination of typographical

errors reduces follow-up expenses such as reworking and resending statements.

Integrate online portals with other payment methods. Customer service representatives at the point of service and in customer call centers should be able to see the same information a patient sees when logging into a payment portal. If patients call to make a payment, customer service representatives can then simply enter the patient's identifying information (such as a unique code printed on the statement) and process the payment much as the patient would, if the patient were paying online independently.

Ensure compliance and facilitate reporting. HIPAA compliance is essential, as is compliance with Payment Card Industry standards for electronic payment transactions. Providers should also ensure that data from the online payment system are accessible for use in internal reporting.

Numerous Benefits
Payment portals can provide a high ROI by speeding collections and fostering adoption of electronic statements while providing a better experience for patients and boosting utilization of EHR portals through the use of a single sign-on system. These benefits may not only improve revenue cycle metrics but also contribute to improved patient satisfaction and better relationships between patients and providers.

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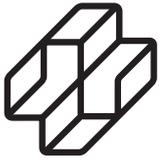
Figures at a Glance

Average Payment Amounts for New Patient Versus Existing Patient Visits, Q4-12

Month	Procedure Description and Code	Service Lines	Average Allowed	Average Paid	% of Allowed Paid	Average Denial Rate
October	New Patient Visit, 99201-05	468,984.00	$261	$175	66.9%	10%
	Existing Patient Visit, 99211-15	3,684,149.00	$369	$243	65.7%	7%
November	New Patient Visit, 99201-05	406,246.00	$260	$175	67.5%	10%
	Existing Patient Visit, 99211-15	3,270,248.00	$379	$251	66.2%	7%
December	New Patient Visit, 99201-05	383,664.00	$254	$172	67.6%	9%
	Existing Patient Visit, 99211-15	3,252,212.00	$378	$251	66.3%	7%

During October through December 2012, existing patient visits brought in more revenue than new patient visits for selected service lines, and had lower denial rates. Across both code sets, providers are being reimbursed on average only 66 percent of what they are allowed.

This information represents billing and reimbursement trending of new patient visits (CPT codes 99201-99205) compared with reimbursement trending of existing patient visits (CPT codes 99211-99215). This data sampling is compiled nationally across all specialties, and represents more than 11 million

ANSI 835 electronic remits during Q4 of 2012.

For more information, email Adam Atwood at aatwood@remitdata.com.

Source: RemitDATA.