Healthy Idahoans Living in Healthy Communities

Our Mission

To promote and support vibrant, effective community health centers in providing accessible, affordable, and high quality healthcare to all Idahoans

Our Work

Health center administration

We help health centers strengthen business operations through support in financial management, health information technology, emergency preparedness, workforce development and medical, behavioral health and dental practice integration.

Quality improvement

We assist health centers achieve the best patient outcomes through innovative quality improvement programs utilizing the highest clinical standards, fostering patient engagement and coordinating care within the larger healthcare system.

Outreach and enrollment

We help health centers provide health insurance education and enrollment assistance to community members, many of whom face barriers in accessing healthcare.

Governmental relations

We monitor the changing healthcare policy environment and connect health center leaders with elected officials on the local, state and federal levels. We engage with the Idaho Department of Health and Welfare and the Department of Insurance to create strong and lasting relationships.

Network management

We support payment reform and value based reimbursement by collaborating with insurance companies to control costs and increase quality of care.

IDAHO PRIMARY CARE ASSOCIATION

Idahopca.org

Webinar Housekeeping

We are Recording

Mute / Unmute Mics

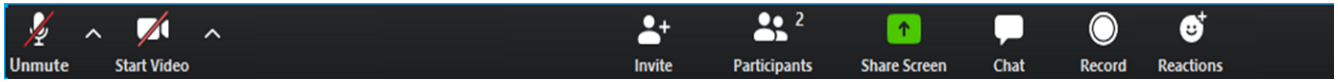
Asking Questions

Evaluations

- Questions?
  - Use the chat function for questions
  - Email: dstewart@idahopca.org

Please mute your microphone to avoid background noise.

Select “Everyone” before sending your chat to the group.



IDAHO PRIMARY CARE ASSOCIATION

Fundamentals for Revenue Cycle Excellence

The Foundation

My Connection to You

- Medicare Intermediary
- Started CCI in 2003
- Compliance & revenue cycle
- FQHC, PCA, NACHC

Excellence

We are what we repeatedly do.

Excellence then is not an act, but a habit.

Aristotle

Foundations for Excellence

- Revenue Cycle Flow
- Business service team
- Materiality
- Process mapping

Revenue Cycle Process Flow

Upstream Functions

Delivery Functions

Downstream Functions

Upstream

- Call Center
- Patient Intake
- Scheduling
- Eligibility verification
- Patient check-in

Note: The above list represents the core functions, not necessarily an all-inclusive list

Delivery

- Office visit / service encounter
- Documentation of the services performed
- Patient follow-up / clinical communication

Note: The above list represents the core functions, not necessarily an all-inclusive list

Downstream

- CPT coding
- Diagnosis coding
- Billing (claims submission)
- Claims follow-up
- Review / re-work rejections & denials
- Resubmit corrected claims
- Insurance payment posting
- Patient statement preparation and submission
- Patient payment posting from statements
- Revenue cycle reporting — Validate
- Communication with upstream and delivery team — Communicate

- Note: The above list represents core functions, not necessarily an all-inclusive list

Business Service Team

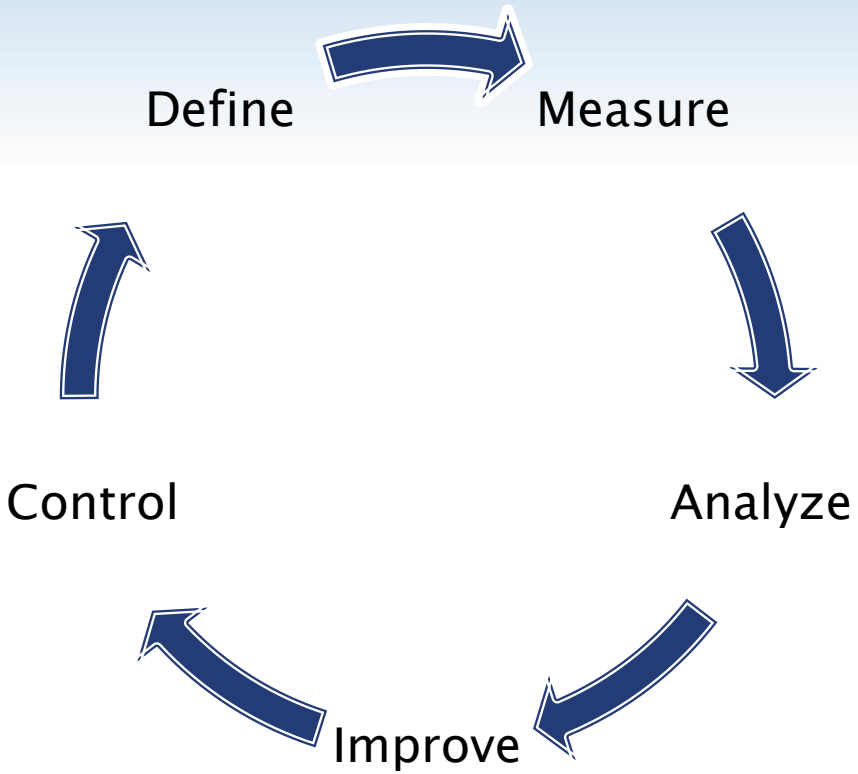
Business Service Team

Front Office
“upstream”

Back Office
“downstream”

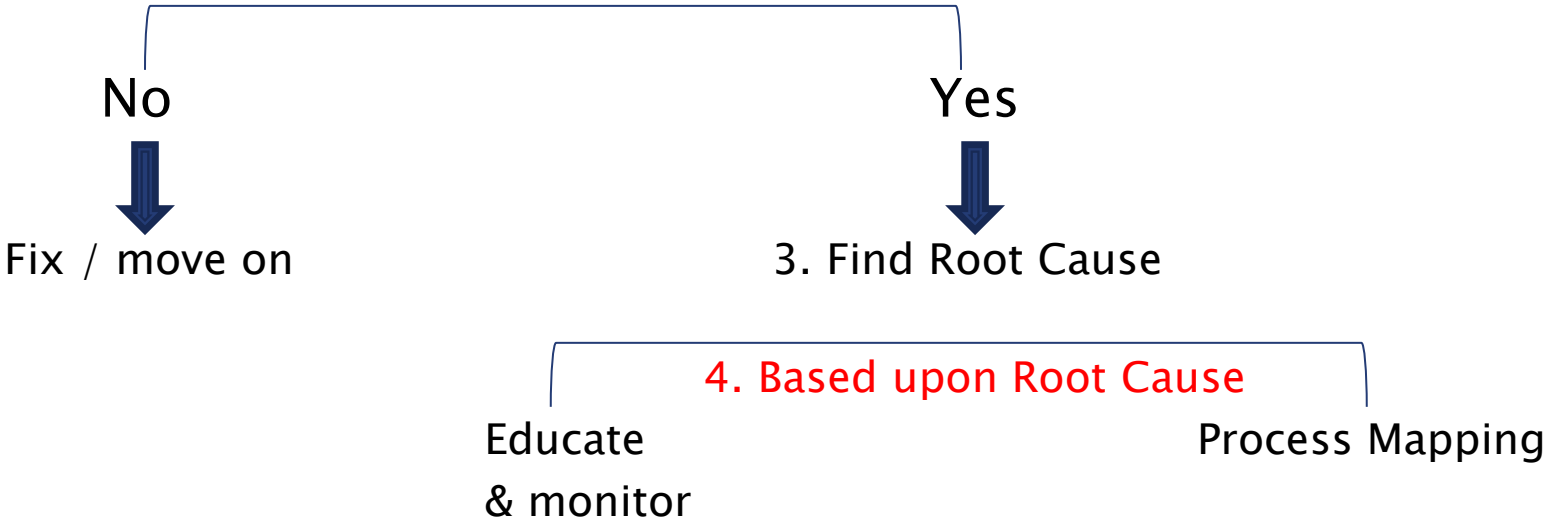
Shared outcome goals

Problem Solving Approach



Process Improvement Approach

1. What is the problem / opportunity?
2. Is it material?



Upstream to Downstream Example

- Downstream Effect
  - Denials reflected on remit / EOB
- Upstream Cause
  - Inaccurate insurance or ID# entered into system
- What happens next?
  - Do you have a standardized process?

Define & Measure

At your Business Service team meetings

1. Denials due to incorrect insurance info
2. Is it material?

- How do we decide if its material?
  a) Volume of services billed
  b) Dollars of services billed
  c) Compliance impact
  d) All of the above

Define & Measure

- Review denial report results
  - Frequency & Pattern
  - Particular scheduler

- 3. What is the root cause?

Process Map

4. Map out our process

- Scheduling position work steps
  - Patient name (new or existing patient)
  - What type of service to be scheduled
  - Preferred contact method – cell, e-mail, etc.
  - Insurance verification status
  - Insurance verification steps (document each step)
  - Patient told arrive xx minutes prior to appt. and bring current insurance card, medications, co-payment, outstanding balance, etc.
  - Patient reminder call or text sent 2-3 days before appt.

Improve Process

Examples of potential improvement opportunities

- Online eligibility tool in PM vs. clearinghouse
- Online portal on a payer website

Processes should be standardized for the team

Monitor & Report

At Business Service team meetings

- Continue to monitor denial reports to verify improvements

Upstream to Delivery Example

- Effect on Delivery
  - Patient calls routed to incorrect place
  - Wasted time for clinicians and patients
  - Patient and/or clinician complaints
- Upstream Cause
  - This is what we are going to solve for

Define and Measure

At our Business Service Team meeting

1. Complaints due to incorrectly routed calls
2. Is it material?

- Interviews
- Phone logs

Phone Triage Process Map

3. Find the root cause – how are we currently answering the phone?

- "ABC Health Center how may I direct your call" or "ABC Health Center, this is XXX, how may I help you"
- Patient states their reason
- Patient is transferred based upon their stated reason

Our problem is patients are routinely stating they need to be transferred to the physician or nurse

Improve Process

- Do we need to amend our process to include:

"May I ask what you are calling in regard to today?"

I need a prescription refilled – direct patient to call their pharmacy, who in turn will call the health center

I need to schedule an appt – call should go to scheduling

I have a rash from the med's – call should go to nursing

Monitor & Report

- Follow-up with clinicians after implementing changes
- Review phone logs

Delivery to Downstream

- Downstream Effect
  - Rejections received due to diagnosis coding specificity
- Delivery Cause
  - Diagnoses not documented at a high enough level of specificity to facilitate accurate coding

Define & Measure

1. Rejections due to unspecified Dx coding
2. Is it material?

- Review Rejection Reporting
  a) Particular provider
  b) Particular service
  c) Both
  d) Neither

Our Current Process

- Provider documents note, assigns diagnosis and CPT code after encounter
- Coder may review and correct CPT, diagnosis, add modifier, etc.
- Claims submitted
- Rejection received from clearinghouse
- Back-office is changing Dx codes and rebilling

Improve Process & Monitor

- Use the evidence-based data to facilitate education with providers and coders
- Continue to monitor as Business Service Team

Within Downstream

- Downstream Effect
  - Insurance A/R balances getting older
- Upstream Cause
  - Some of the “root cause” will be in “upstream” or “delivery”
  - Some process improvement may lie within “downstream”

Define & Measure

At our Business Service Team meeting

1. Insurance A/R aging balances increasing
2. Is it material?

Current Process

3. What is the root cause?

- How do we allocate team resources?
- How are decisions made each day regarding
  - Insurance follow-up
  - Insurance payment posting
  - Reviewing rejections
  - Reviewing denials

Inefficiency downstream delays effective communication upstream – delays improving organizational outcomes

Monitor & Report

- Continue to review at Business Service Team meeting
- Track changes after any process change

Cumulative Effect

- 5 fewer denials / rejections per day on avg.
  - 1300 fewer denials per year
  - @ 5 minutes per denial = 6500 minutes saved
  - @ $100 per claim = $130,000 collected faster
  - How many fewer conversations needed across team?

- 5 calls per day routed correctly = 1300 direct calls per year
  - @5 minutes each instance researching = 6500 minutes
  - @5 minutes calling back the patient, patient then calling back again is another 6500 minutes

  - Patient and employee satisfaction

Facilitating Positive Change

Communicators

- Value is created or destroyed by communication
- Educators do not need to be managers
- Physician / provider education
  - Enormous amount of revenue cycle runs through Delivery
- Super-users of EHR / PM system
  - Virtually all or our workflow runs through technology

Transparency

- Transparency Drives Trust
  - Organizational Outcome over individual preference
  - Use evidence to address opportunities for improvement

Workflow & Staffing Levels

- The work currently done by each person

vs.

- The work that needs to be done by the position to achieve the desired outcome
- Where can the work most efficiently be done to produce the desired outcome?

Standardization of procedural steps
Use of Technology

Hot Spots

- Where do we do a lot of “exporting” of data to then reformat, rework, etc.
- Where do have more manual steps (keying-in data, printing to then scan, etc.)
- Information redundancy between functional areas

Fundamentals Recap

- Revenue cycle operations is like a river
- Process improvement is incremental and cumulative

We all live downstream

Next Sessions

- Join us next Wednesday February 24
  - Peer Group Session
  - Technical assistance

- Join Webinar 2 in our Series
  - Diagnosing the Pain Points on **March 17**

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