

“An EMR for the Revenue Cycle” Documenting the Business Side of Care at Saint Joseph’s Hospital of Atlanta

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About Saint Joseph’s

- 410-bed acute-care facility
- Serves metro-Atlanta and surrounding areas
- Partner of Emory Healthcare as of Jan 2012
- One of Southeast’s top specialty-referral hospitals
- Only Magnet-designated facility in Atlanta; one of only 3 hospitals in the world to receive Magnet 4 times in a row
- Challenging margins due to high Medicare utilization and tight margins on Managed Care

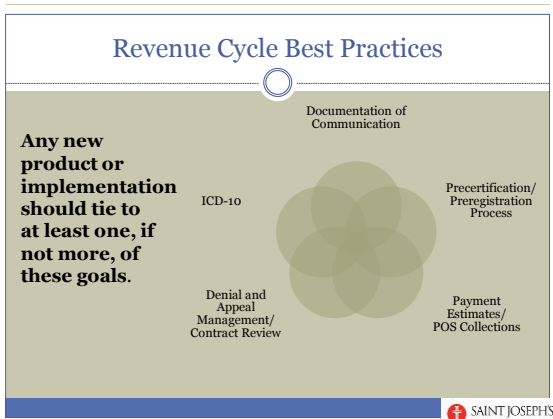


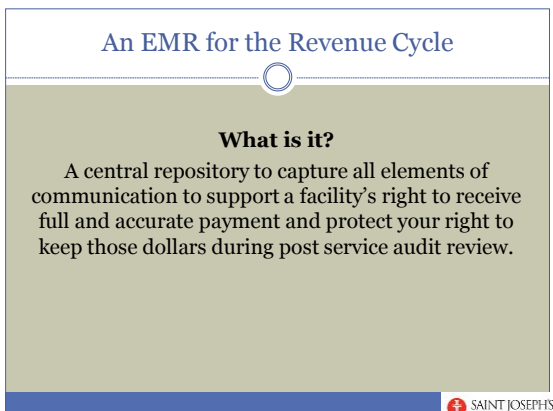
Learning Objectives

- Review current revenue cycle best practices and systems available to support them.
- Evaluate opportunities and methods for documenting activity on the business side of care.
- Consider strategies to leverage documentation for accurate and complete reimbursement.
- Discuss how a central repository for revenue cycle activity can improve workflow between departments.









Why and What to Document?

- Denial prevention
 - Authorizations (phone, web or fax)
 - Verification that no pre cert was required
- POS collections/Back end follow-up & collections
 - OOP estimates, ABNs for Medicare
 - Promises to pay/claim tracking
- Patient satisfaction/Quality assurance
 - Consistent use of scripting, record of encounter
 - Document consistent adherence to Policy/Procedure
- Behavior modification
 - Staff training/retraining
- And much more.....



Managing Communication is Complex!



How do most hospitals document now?

Current State of Documentation

- Hand-written notes
- Typed info from web sites
- Voicemail messages
- Recollection from memory

*This information is subjective,
deniable and disputable.*



The he-said, she-said is over!

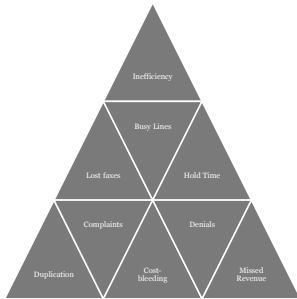
Desired State of Documentation

- Recorded phone call or voicemail
- Capture of web page with date/time
- Fax confirmation with date/time
- Record of notification to another party
- Full audit trail
- Easy to retrieve for future period audits

*This information is objective,
undeniable and undisputable.*



Our Challenges Pre-Solution



Examples of Common “Mis-Steps”

Scenario #1

- Patient Access employee is told by third-party radiology authorization vendor that no pre-certification is required for a CT scan of the chest.
- Patient receives scan and insurance company is billed.
- Business Office receives denial for lack of pre-certification from insurance company.

Scenario #2

- Organization discovers major claims adjudication issue.
- Contract Manager from payer promises to resolve issue.
- Issue is not resolved and claims continue to skew A/R.



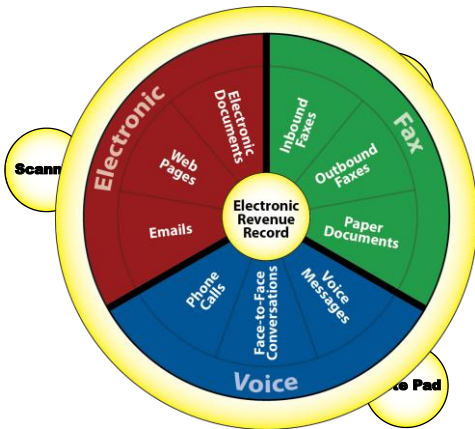
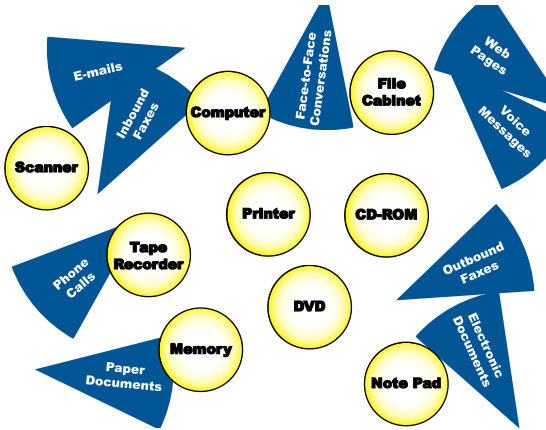
Solution for Correcting Mis-Steps

Electronic Revenue Record (ERR)




Technology-based solution that documents all communication (voice, fax, and electronic) on the business side of patient care (with patients, payers, physicians and between providers).

Records archived in a central repository and automatically indexed to the patient account for processing, routing and retrieval.

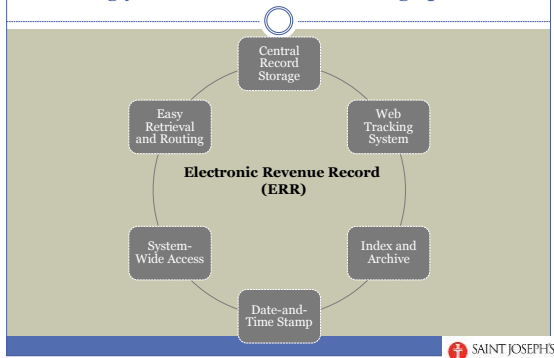




Commonly used communication tools =
multiple storage areas = lost documentation

Voice	Fax	Electronic
		
Inbound Calls	Inbound Faxes	Web Pages
Outbound Calls	Outbound Faxes	Emails
Voice Mails	Paper Documents	Images, Documents
Live Conversations	Notifications	Electronic Forms

Solving your communication storage problem



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The Solution...in a Nutshell

Inbound & Outbound Communication



Record phone conversations with payers, physicians and patients.



Receive and submit fax communication with recordings of such events captured.



Electronically capture website content, emails and images.

Storage & Accessing the Captured Data



On-site server stores communication. Data is indexed by the core patient account numbers via an HL7 data feed.



Data is immediately available for retrieval via ASP-based website; users request transcripts of voice records and/or download and email data files.

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The screenshot shows the Electronic Revenue Record (ERR) software interface. On the left, there is a sidebar with the following sections: "Electronic Records", "Inbound Fax Records", "Outbound Fax Records", and "Voice Records". The main area displays "Search Results" for "Electronic Records - 9 Records". The results are organized into a table with columns: "Date", "Time", "Patient Name", "Phone Number", "Email Address", "Activity Type", and "Activity Date". The table lists several records, including those from "Harris, Nisha" and "Bansal, Nisha". Below the table, there are sections for "Inbound Fax Records - 3 Records" and "Outbound Fax Records - 4 Records", each with a similar table of results. At the bottom, there is a section for "Voice and Video Records - 6 Records" with a table of results. The interface includes various search filters and navigation buttons.

Voice Records

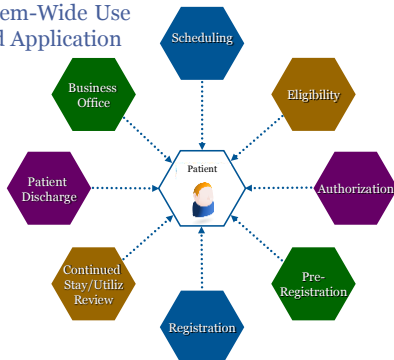
Voice Records - 6 Records

View	MSN	Account #	Admitted	Patient Name	Patient DOB	Entered By	Input	Activity Type
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Hardy, Felicia	14-Apr-2012 4:08 PM	Patient Follow-up
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Hardy, Felicia	12-Apr-2012 5:09 PM	Pre-cert
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Braddock, Betsy	12-Apr-2012 3:16 PM	Pre-registration
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Braddock, Betsy	13-Apr-2012 3:18 PM	Registration
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Braddock, Betsy	13-Apr-2012 1:56 PM	Scheduling
	9587402	1596482	13-Apr-2012	McConkey, Marty	06-Oct-1981	Braddock, Betsy	12-Apr-2012 3:02 PM	Pre-registration

Refresh Notify Worklist Excel CSV

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System-Wide Use and Application



Streamlining Daily Activities



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Our Project Objectives

- Protect revenue with proof of authorization
- Document compliance with payer requirements related to exchange of required information
- Drive performance & productivity with streamlined approach to managing communication
- Overall: Support revenue cycle best practices/ achieve total denial rate < 1% gross

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Suggested Areas for ERR application

- Precertification
- Preregistration process
- Payment estimates
- POS collections
- Verification of claim receipt & promise to pay
- Denial & appeal management
- Contract review/payment accuracy
- Staff education & training

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Precertification/Preregistration Process

- Assure patient has received financial clearance
- Sets expectations for what patient will encounter on the clinical side
- Remove worry; set minds at ease
- Remove mystery from registration process so patients aren't surprised with high out of pocket amounts
- Good for organization and the patient

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Supporting the Precertification Preregistration Process

- Communicate with patient in the method they prefer
- Capture communication, whatever the form (fax, online, phone, face-to-face)
 - Capture faxed estimate
 - Capture order and route to clinical area
 - Record phone calls
 - Document online communication

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Payment Estimates/POS Collections

- Best practice focus on POS cash collections which are increasingly critical to revenue cycle performance

"For each dollar of patient obligation that is not collected at the POS, only 25 cents on average is collected at the back end" – Source: The Advisory Board Company

- Prepare patient's OOP estimate when scheduling encounters
- Record all communication to assure staff follow all protocols and communication is memorialized when needed for future discussions/disputes
- Monitor communication to ensure staff communicate clearly, accurately and ask the right questions in the correct and preferred manner

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Patient Experience and Effective Communication



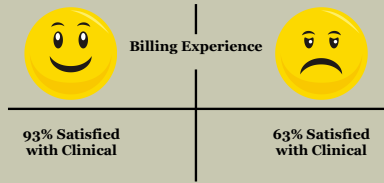
Negative
 Unscripted
 Unclear Expectations
 Missing Info.
 Rapid Fire Instructions
 No Time for Questions
 Confusion
 No Recording for QA
 No Training Opportunities

Positive
 Scripted
 Clear expectations
 Thorough & Accurate Info.
 Slow, Clear Instructions
 Time for Questions
 Understanding
 Recorded for QA
 Training Opportunities



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Link Between Revenue Cycle and Clinical Satisfaction



Source: "Study Shows Link between Patient Satisfaction with Billing Experience and Clinical Satisfaction," Executive Insight, ©2011.

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Managed Care Denials

\$27 billion lost annually to denied claims

1-3% of revenue lost to denied claims

50% of denied claims are never re-filed

67% of denied claims are recoverable

90% of denied claims are preventable

"Using Healthcare Business Intelligence to Improve Revenue Management", Business Intelligence Network; The Regulatory Burden Facing America's Hospitals," American Hospital Association. www.aha.org.

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Underpayments – Identify and Pursue

- Review managed care contracts for interpretation differences & executable clauses
- Review accounts to detect underpayments and underpayment trends
- Document discussions and interpretations
- Determine how you'll identify & pursue underpayments – in-house or outsource?

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Real-Life Scenario

- SJHA identified a large volume of denials for “lack of pre-certification/notification” from a particular payer related to outpatient radiology scans (CT, MRI, PET).
- Almost every denied claim appeared to be pre-certified and had a pre-certification number.
- The payer’s Contracting Department was contacted and several examples were sent for “investigation” as to why the claims were denied.

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Details

- Patient received three CT scans on same date of svc – chest, abdomen, and pelvis.
- SJHA had all three scans fully authorized.
- A recorded conversation was available that clearly indicated that SJHA obtained the pre-certification and had explicitly inquired whether a different precert number was needed for each scan.

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Review of Payer’s Internal Research

Recorded conversation between facility and the Contracting Manager from Payer

PAYOR: Okay, on [REDACTED] the issue on [REDACTED] is when the authorization was called in, it was called in on the IVR.

PROVIDER: Uh-huh.

PAYOR: Everything that was requested was I believe a chest CT.

*Payer says
that only one
of the 3 CT
scans was
authorized.*

PROVIDER: No.

PAYOR: Say again?

PROVIDER: No, that’s not true. I have a transcript that shows that where they list out all three CPT codes for that authorization.

PAYOR: Okay. And based on our research from the IVR information, they’re saying that only one procedure was requested and that’s why the claim was denied because three were done but only one was requested.

PROVIDER: That’s not true. That’s not true.

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Transcript Emailed Immediately to Contracting Manager

This is the transcript header; it contained the patient's name, account number, and time stamps

FACILITY: Saint Joseph's Hospital
Of Atlanta

TRACKING #: 37427

PAYOR: [REDACTED]

PATIENT: [REDACTED]

MEMBER ID: [REDACTED]

T I M E S T A M P

03/25/10 02:52:49 Recording with MCO began

03/25/10 02:53:32 Recording with MCO ended

C A L L T R A N S C R I P T I O N

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Transcript Continued...

This is from the body of the transcript where the authorization takes place; it clearly shows that all three scans were authorized

PAYOR: And I do have an authorization number for you, [REDACTED]

PROVIDER: Alright. It's for all three?

PAYOR: All three of them.

PROVIDER: Really [Inaudible].

PAYOR: [REDACTED] and that authorization number isn't a guarantee of payment. It's also good for thirty days from the date of service.

PROVIDER: Uh-huh.

PAYOR: And, again, it's also good for all three procedures, the CT of the abdomen, the pelvis and the chest, all with contrast.

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A Week Later, Payer calls back...

Payer finally acknowledges that they have a core issue between their third-party radiology vendor and their claims processing system

PAYOR: We reviewed the first seven claims that you sent over, and the information that we have found once we did a deeper dive was consistent with the information that you shared.

PROVIDER: Okay.

PAYOR: So what we know at this point is that there is a breakdown in the transmission of the information that's being sent over from [REDACTED] and the way that it's being received in [REDACTED] system.

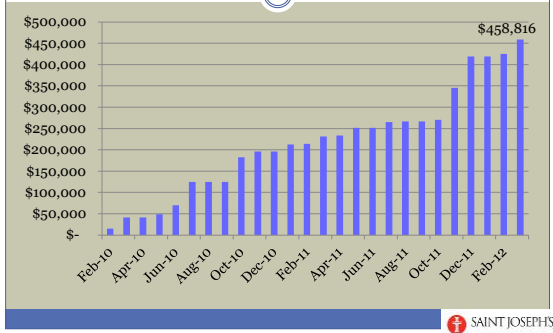
PROVIDER: Okay.

PAYOR: And from what we've been able to tell so far, [REDACTED] is transmitting complete information but in the data feed, for some reason, it's not all coming through.

PROVIDER: Okay.

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Cumulative Payment Recoveries from Overtuns



Results of Project Implementation

- Implemented Dec. 1, 2009
- Results as of Mar. 31, 2012
 - “Cash in the door” = \$458,816
 - 161 accounts, average recoup = \$2,849
 - Average accounts overturned per month = 6.4
 - Prevented denials

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Lessons Learned

- For SJHA, documentation was invaluable to proving compliance with prescribed precertification protocols.
- Without it, inappropriate denials and cash payment delays would have continued.
- Documentation will be used to assure mutually agreeable processes with Managed Care payers and lessen administrative burdens for both payer and provider.

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Conclusions

- Revenue cycle communications are many and varied and far from perfect.
- Misleading and inaccurate information is a significant barrier to achieving revenue cycle best practices.
- Providers can leverage technology to create an Electronic Revenue Record (ERR) and gain valuable ground toward achieving best practices.



Questions?



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