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Memorial Health

AAHAM
Front End Operations: Challenges & Developments

Analysis & Action Steps by one Organization

April 25, 2024

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Agenda

Organizational Overview,

Leadership & System Opportunities,

Billing Assessment

Operations Integration – Revenue Cycle

(Access for hospital and Clinic)

(Billing Information and Sharing)

(Coordination between All Access / HIM / Billing / Customer Service / Admin)

Prosser Memorial Health, Dealing w/ Growth

Characteristics

- Critical Access Hospital (CAH),
- 3 Rural Health Clinics (RHC),
- 1 Specialty/ENT/Surgical Clinic,
- 1 Dermatology Clinic,
- $116M Net Revenue, $135M 2024 Budget,
- 60+ Providers + Rad & Path.

Operations

- 20-30% Growth annually for 7 years,
- Substantial provider growth/turn,
- Stable/Dynamic Sr. Leadership,
- Leadership Changeovers in:
  - Sr. Clinic leadership & management,
  - Patient Access management,
  - Billing management

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Access Assessment

Clinics – Don't:

- Have depth of coverage, front staff pulled for other duties,
- Know how to register accurately,
- Read/know how to read RTE messaging, what to if down,
- Have a training program,
- Answer the phones,
- Take more than 7-8 patients/day.

Hospital/Access Resources Don't:

- Have subject matter leads,
- Extensive training or QA program,
- Have depth of resources,
- Auth process/validation/ revalidation for surgery of scheduling,
- Adequate phone system tools,
- Adequate reminder process,
- RC departments don't partner.

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Clinic Assessment

Providers

- Most take 1-hour appointments,
- Don’t double book,
- Open slots for walk-ins at end of day, so if nobody scheduled providers went home early, and then a walk-ins come,
- Limited provider coverage,
- Front desk adjusts provider schedule,
- No cross-clinic payer enrollment.

Operations

- Front staff took care of patients, pulling from desk duties,
- Training was “sit-down and do one or two” from somebody who didn’t have formal training,
- Each clinic front desk did what they wanted,
- No update to system changes,
- No reporting of outcomes,
- Seldom answers the phones.

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Clinic Action Plan

Providers

- Negotiate 20/20/40-minute appointments, increasing patients seen,
- Move up walk-in times,
- Providers don’t go home early,
- Bolster provider coverage and time slots for more capacity and coverage across clinics.

Operations

- Rely on Patient Access (PA) for registration training/oversight,
- Work w/ patient PA to develop authorization team by clinic,
- Front desk doesn’t adjust schedule,
- Staff to volumes (provider/staff),
- PA to coordinated Access backfill,
- Partner with RC & Billing for feedback/improvement process.

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Access Action Plan

Clinics

- Develop call center to answer all phones (100-200/day per location),
- Develop Registration training plan, teach/audit.. How to read RTE,
- Develop referral/auth team with leads/oversight,
- Provide interim staffing for sick calls/etc. (rob Peter, pay Paul for front facing customer service and volume accommodation).

Hospital

- Training & QA process led by leads for referrals, auth, reg,
- Implement surgery ins. & auth. Re-validation 3 days prior to surgery. Will reschedule if needed,
- Centralized reporting, expanded team size, regular training programs,
- All new hires get trained right,
- Partner with RC & Billing for feedback/improvement process.

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Access Volumes and Outcomes

Call Center Stats 1st Mo/Last Mo.

Call Center Performance Analysis: Depts. In Call Center							
Before Call Center		Call Count	Call Length	Abandoned Count	Abandoned Call %	Voice Mail Count	VM Call %
Total		17,477	1.38	311	1.78	4,547	26.02
specialty		3,029	1.05	53	2.41	840	27.73
therapy		1,205	1.37	29	0.97	496	41.16
net		13,243		229	1.7%	3,211	24%
March 2024 Performance							
Total		18,370	1.18	281	1.53	2,077	11.31
specialty		3,649	1.37	13	0.36	547	37.44
therapy		1,461	1.42	48	3.29	-	0
net		13,260		220	1.7%	1,530	12%
March % of Start		100%	86%	96%	96%	48%	48%

Narrative:

- Call volume =,
- Call length down 14+%,
- Abandoned rate down 4%,
- VM count down 52%,
- VM called back from 25% to 99%

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Access Working with RC & Billing

- Joined weekly call for Access/Billing related process impacts,
- Initiated agenda report out at weekly Rev Cycle Leadership & CFO,
- Monthly denial deep dives with RC Director,
- Bi-weekly meetings with Clinic Leadership, Payer enrollment, and RC leadership to cover operation needs and provider changes/additions,

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Denials by Owner

Denial by Dept. Trend	Months --->>>																		
Count of Invoice Number	Colum																		
Functional Area	22.10	22.11	22.12	23.01	23.02	23.03	23.04	23.05	23.06	23.07	23.08	23.09	23.10	23.11	23.12	24.01	24.02	24.03	Grand Total
ADT/Registration	276	264	247	224	236	316	266	252	406	327	301	337	287	351	338	247	405	471	5,551
Authorization	129	128	121	73	54	107	81	95	95	62	73	77	60	93	70	80	64	75	1,537
Billing Office	1,418	1,341	1,869	1,706	1,684	2,279	1,873	1,647	2,310	1,685	2,007	1,739	1,900	3,621	2,516	2,207	3,015	3,394	38,211
Charging Related - Pharmacy					1														1
Coding	174	155	215	186	196	272	209	220	266	202	208	235	246	233	285	194	375	388	4,259
HIM/Coding & Abstracting	2	1	1	1	1	4	3	2				2	1	1	2	3	2	2	28
(blank)	399	469	595	426	409	630	556	534	905	565	598	567	680	599	677	524	1,145	771	11,049
Grand Total	2,398	2,358	3,048	2,616	2,581	3,608	2,988	2,750	3,982	2,841	3,187	2,957	3,174	4,898	3,888	3,255	5,006	5,101	60,636

Trends

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Denials by Payer / Reason related to Rev. %

Denials by Payer and Reason

Count of Invoice Number	Column La								
Row Labels	Commercial	Medicaid	Medicaid HMO	Medicare	Medicare HMO	Other	OTHER GOVERNMENT	Worker's Comp	Grand Total
Additional Documentation Needed	339	1	1,759		109		4	43	2,255
Additional Info Needed	483		8		45			1	537
Adjudication			5		22				27
Authorization	656	103	382		496		48	192	1,877
BENEFIT MAX	46	1	46	113	54				260
Billing	247	1	214		51	2	13	293	821
Billing Error	924	104	2,033	3	601	4	179	975	4,823
Bundled	1,738	85	1,167	338	398		5	1	3,732
Coding	1,382	250	1,001	47	301		40	29	3,050
Contract Related	149	1					3		153
Coordination of Benefits			1						1
Duplicate	2,343	333	1,752	12	353		53	99	4,945
EXPERIMENTAL	150		1		15				166
Informational	762	146	2,049	4	148		1	4	3,114
Medical Necessity/Level of Care	411		18	635	555		3	1	1,623
Miscellaneous	1								1
Missing Claim Information	1,477	841	3,823	228	571	2	33	195	7,170
Non-Covered	2,290	1,726	2,876	2,648	1,391		35	92	11,058
Provider Enrollment/Credentialing	66	47	187	13	9			213	535
Registration/Eligibility	4,102	1,956	1,449	504	1,295	4	239	679	10,228
Timely Filing	436	683	761	30	51	1	15	10	1,987
(blank)	587	217	924	28	257		143	117	2,273
Grand Total	**18,589**	**6,495**	**20,456**	**4,603**	**6,722**	**13**	**814**	**2,944**	**60,636**
% of Denials	31%	11%	34%	8%	11%	0%	1%	5%	100%
% of Revenue	29%	4%	26%	19%	14%	0%	1%	2%	97%
Note difference is self pay 3% and rounding.									
Difference between Gross Rev% - Denials %	-1%	-7%	-8%	11%	3%	0%	0%	-3%	
Look into but may be ok									
High alert									
Moderate alert									
Mostly OP meds on OP, look at, possibly automate up front adjustments									

Denials By Owning Source/Category

Denials by Source Responsibility based on 835 Transaction Codes (18 Months)								
Count of Invoice Number								
Row Labels	ADT/ Registration	Auth	Billing Office	Charging Related - Pharmacy	Coding	HIM/ Coding & Abstracting	(blank)	Grand Total
Additional Documentation Needed			2,255					2,255
Additional Info Needed							537	537
Adjudication			27					27
Authorization	164	1,537					176	1,877
BENEFIT MAX							260	260
Billing							821	821
Billing Error			4,797				26	4,823
Bundled			3,629				103	3,732
Coding			179		1,819	28	1,024	3,050
Contract Related							153	153
Coordination of Benefits			1					1
Duplicate			4,945					4,945
EXPERIMENTAL					151		15	166
Informational			47				3,067	3,114
Medical Necessity/Level of Care					1,623			1,623
Miscellaneous				1				1
Missing Claim Information			7,053				117	7,170
Non-Covered			9,896		666		496	11,058
Provider Enrollment/Credentialing			160				375	535
Registration/Eligibility	5,387		3,235				1,606	10,228
Timely Filing			1,987					1,987
(blank)							2,273	2,273
Grand Total	5,551	1,537	38,211	1	4,259	28	11,049	60,636
Denial %	9%	3%	63%	0%	7%	0%	18%	100%

Denials By Type and Reg Person

Denials by Reg person and Reason	Months---->>																		
Count of Invoice Number																			
Row Labels	22.1	22.11	22.12	23.01	23.02	23.03	23.04	23.05	23.06	23.07	23.08	23.09	23.1	23.11	23.12	24.01	24.02	24.03	Grand Total
[redacted]								1											1
197 - 197-Pmt den/rdcd, no precert/auth/notif.								1											1
GALVEZ, MARICELA A	1																		1
197 - 197-Pmt den/rdcd, no precert/auth/notif.	1																		1
[redacted]	3	5	12	9	7	9	14	17	6	2	1	2	6	9	4	3	11	4	124
15 - 15-Dnied, auth # missing or invalid.	1				1	1													3
197 - 197-Pmt den/rdcd, no precert/auth/notif.	2	5	12	9	6	8	14	17	6	2	1	2	6	9	4	2	11	2	118
243 - 243-SVCS NOT AUTH BY NETWORK/PRIMARY CARE PROV																1		2	3
[redacted]	2	10	4			1	2	5	2		2		1		1	1			31
197 - 197-Pmt den/rdcd, no precert/auth/notif.	1	9	4			1	2	4	2		2		1		1	1			28
243 - 243-SVCS NOT AUTH BY NETWORK/PRIMARY CARE PROV	1	1						1											3
[redacted]	1											1	1	3	1	3	2		12
197 - 197-Pmt den/rdcd, no precert/auth/notif.	1												1	3	1				6
243 - 243-SVCS NOT AUTH BY NETWORK/PRIMARY CARE PROV												1				3	2		6
[redacted]	4		1	1	1	2	1			1		2	2	3	5		2	3	28
197 - 197-Pmt den/rdcd, no precert/auth/notif.	4			1		2				1		2	2	3	3		2	3	23
243 - 243-SVCS NOT AUTH BY NETWORK/PRIMARY CARE PROV			1		1		1								2				5
[redacted]	12	2	9	1		3			1										28
15 - 15-Dnied, auth # missing or invalid.		1																	1
197 - 197-Pmt den/rdcd, no precert/auth/notif.	12		9	1		3			1										26
243 - 243-SVCS NOT AUTH BY NETWORK/PRIMARY CARE PROV		1																	1
[redacted]							1	1		1	1								4
197 - 197-Pmt den/rdcd, no precert/auth/notif.							1	1		1	1								4

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Denials By Owning Source Registration

Dept. Source and Reason								
Count of Invoice Number	Column Labels							
Row Labels	ADT/ Registration	Authorization	Billing Office	Charging Related - Pharmacy	Coding	HIM/Coding & Abstracting	(blank)	Grand Total
Provider Enrollment/Credentialing			160				350	510
Registration/Eligibility	**5,387**		**3,235**				**1,606**	**10,228**
Additional Documentation Needed			1					1
Coding							2	2
Non-Covered							5	5
Registration/Eligibility	5,387		3,234				1,599	10,220
Timely Filing			**1,987**					**1,987**
Timely Filing			1,987					1,987
(blank)							**2,273**	**2,273**
Additional Documentation Needed							8	8
Authorization							191	191
Coding							689	689
Contract Related/Bundled							35	35
Medical Necessity/Level of Care							20	20
Miscellaneous/Other							679	679
Missing Claim Information							1	1
Non-Covered							162	162
Provider Enrollment/Credentialing							278	278
Registration/Eligibility							129	129
Timely Filing							81	81
Grand Total	**5,551**	**1,537**	**38,211**	**1**	**4,259**	**28**	**11,049**	**60,636**

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Denials, Access by Denial Code & Location

Denial Code	Count
109 - 109-Not cvd by payor. Snd to crrct payor	1,677
19 - 19-Denied, liability of Wrk Cmp carrier.	49
20 - 20-Dnied, inj/ill cvd by liab carrier.	31
21 - 21-Denied, liablty of no-fault carrier.	8
24 - 24-Chgs cvd under capit agrmt/mgd care.	326
26 - 26-Expenses incurred prior to coverage.	419
27 - 27-Expenses incrrd aftr cvg terminated.	1,133
31 - 31-Denied, pat cant be id as our insrd.	300
B11 - B11-Not cvrd by this payor, xferrd.	1,444
Grand Total	**5,387**

Location/Patient Type	Count
Emergency	942
Extended Hospital Outpatient	49
Hospital Ambulatory Surgery	256
Infusion Series	28
Inpatient	177
Newborn	84
NM Series	20
Observation	47
Other Series	28
Outpatient	1,622
Provider Based Billing Outpatient	430
Rural Health	1,517
Specimen	57
Swing Inpatient	8
Therapies Series	122
Grand Total	**5,387**

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Denial Drill Down

Overall

- Department, trend and monthly,
- Insurance company and reason,
- General group and owning area,
- Area Drilldown:
  - Reg area (coding, billing, etc.),
    - Reg person,
    - Insurance,
    - Reason code
  - Select accounts for audit/deep dive,
  - Manager/systems person researches,
  - Corrective Action,
  - Rev Cycle report out, logged.

Access Findings

- Don’t attach insurance to claim,
- Don’t sequence insurances,
- Don’t know how to read Real Time Eligibility (RTE),
- Don’t know how or don’t connect to insurance website to check coverage, benefits when RTE is down,
- Auth need validation,
- DX and PX matching for auth,
- Need for training and discipline.

No More “They fix it in Billing”

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Questions:

- What if I could…….
- Can I look at this by coder, by provider, by insurance, by, by, by –**YES**
- What are your circumstances,
- Do you have the information,
- How do you target your focus points,
- What have been some of your success stories,
- Do you have a story as a patient……

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Thank you!

Its an honor to present to you and learn from your expertise and experiences.

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Addendum:
Reminder Call System:
I am excited to announced that Monday, April 15, we will go live with the Artera Patient Reminder platform. This user-friendly system replaces our current patient reminder system.

The following departments are part of the phase 1 implementation:

Outpatient Departments:

Diagnostic Imaging:

- CT
- ULTRA SOUND
- SCHEDULED XRAY
- ECHO
- MRI
- MAMMOGRAMS
- WOUND & INFUSION
- CARDIO-PULMONARY STUDIES

WOMENS HEALTH ULTRASOUND

Clinics:

- Benton City /Benton City Behavioral Health
- Grandview /Grandview Behavioral Health
- Prosser /Prosser Behavioral Health
- Occupational Medicine
- Physical Therapy
- Orthopedics
- Podiatry
- General Surgery
- Cardiology
- Gastroenterology
- Urology
- ENT
- Nephrology
- Women's Health
- Dermatology

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Reminder Call System Attributes:
New features of the Atera platform include Text and phone calls:
Our patients will be asked at time of check in if they prefer text or phone call reminders. This will trigger us to add the phone number into the correct field.

Text reminders:
Patients will receive an "appointment card" text within 15 minutes of scheduling their appointment. If they are not signed up with MyChart that message will provide them a link and code to create their account.
They will receive a 7-day reminder IF they confirm at that time, they will not receive another reminder until the day before. The 1-day prior reminder will give them the link to check in via My Chart.
If they do not confirm at 7-days, they will receive a 3-day reminder and then a 1-day reminder. On the 1-day reminder they will be prompted to call and cancel their appointment and we can inform them of our **No Show Policy**.
Every text message (clinic only) will have a link to the No show policy and if they are not enrolled in MyChart a link and code to sign up (every appointment type).

If an appointment date or time is changed, they will receive an updated text.
If the location is changed, they will receive an updated text.

In the event of a NO show, they will receive a text asking them to call and reschedule along with a link to the No Show policy (for outpatient clinic patients).

If the patient does not provide a cell phone or does not want text messages, they will receive a reminder phone call with the same guidelines as the text messages: i.e.: 7-day, 3-day, 1-day, location or time change, and the No Show Policy.

When a patient chooses to change their appointment or cancel it will send a text to the assigned group and we will be able to communicate with them via text to reschedule or cancel all together.

Phone reminders:
Patients will follow the same algorithm as the text but will only receive reminders at 7-day, 3-day, 1-day. date, time or location change.

Training for those staff that will be impacted by these changes begins this Thursday.
The text messages and phone calls will be in the patents preferred language.

This system was built-out to interface with our instance of Epic. After talking to others who have moved to this platform, we should see a significant decrease in the number of No-Shows we've been seeing at the clinics as well as higher enrollment in MyChart!

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