Insights and actions for successful results

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How smaller organizations use patient experience best practices to improve competitive edge

Pete Thompson

From pre-service and onsite financial counseling to the business office, revenue cycle has become the brand ambassador for hospitals and health systems.

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• patient experience •

How smaller organizations use patient experience best practices to improve competitive edge

Pete Thompson

Five strategies can make the difference.

At UConn Health, the chief revenue cycle officer decided to experience a typical patient journey. By following patients a few days and months after their care, she identified two opportunities at this academic medical center in central Connecticut.

> Use of video monitors throughout the facility to capture and highlight excellence in clinical areas as well as in patient financial experiences.

> Engaging patients about what to expect after care — the billing process in addition to medical information. UConn Health offers patients the opportunity to discuss the billing process and payment options, which promotes a positive patient response.

It's this type of attention to patient experience that can offer smaller healthcare organizations and health systems a competitive advantage over larger providers in the area. Ultimately, revenue cycle leaders like those at UConn Health recognize that the revenue cycle is not just about revenue but also about patient engagement. Finding ways to appeal to patients as consumers can put a smaller hospital on a level playing field with larger health systems.

At every point in the patient journey, besides care delivery, revenue cycle has an opportunity to enhance patient experience. Faced with competition from large healthcare organizations, many small health systems offer financial payment options to ensure patients seek care when needed. As part of the process, trained professionals are available for financial conversations at all points in the journey.

Successful strategies to improve competitive advantage can be framed in five Cs — convenience, culture, communication, C-suite leadership and commitment.

Convenience. We find that convenience takes on two forms. First, consider the convenience of accessing care. Smaller providers must initially focus on price-competitive service lines that best fit community needs. Once they determined the services they can provide at competitive prices, smaller providers can create partnership strategies for the service lines they don't offer. Those may include telemedicine or video consultations with specialists or referral arrangements with other local healthcare providers.

The second form is convenience in the patient-care experience. Leverage technology to ensure the entire patient experience is as painless as possible — scheduling,

5 Cs to improve competitive advantage

Convenience. Look at your facility with fresh eyes. Identify an easy win to promote payment options or make the patient financial process easier.

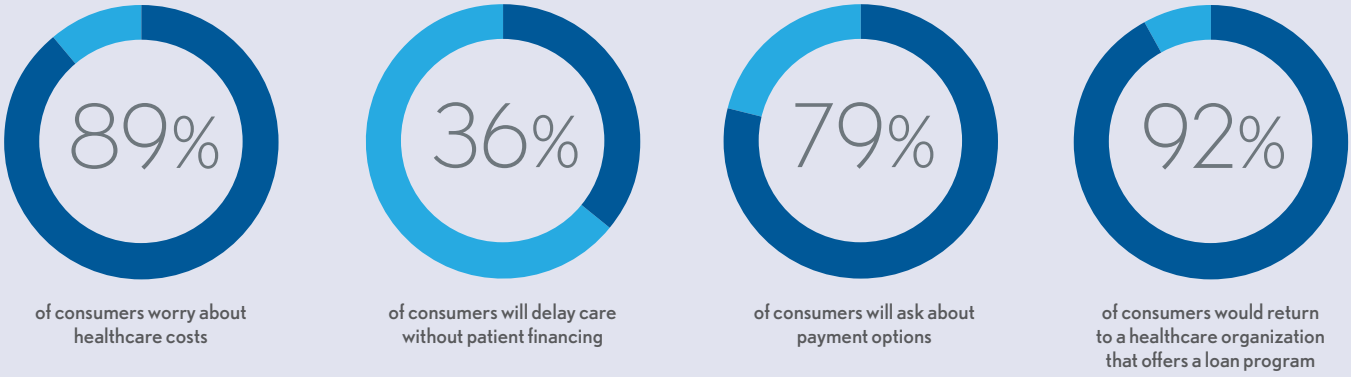
Culture. Think about how staff interact with patients beyond a single experience of care. Focus on their long-term wellness.

Communication. Recognize that patients want to know what they'll owe for care. Adopt a "pre-service to next-service" mentality to communicate payment options throughout the care and payment cycle.

C-suite leadership. Buy-in and action are crucial and pave the way for everyone on the team to be engaged and empowered.

Commitment. Patient loyalty makes the difference between market share and open beds.

Consumer trends in healthcare payment financing



Source: 2018 Healthcare Consumerism study, ClearBalance. Used with permission.

getting price estimates, providing care, and understanding and paying bills.

Culture. Though culture can have many contexts, the importance of patient engagement in value-based care requires that healthcare organizations look at healthcare delivery from a patient's perspective. For example, Mosaic Life Care in St. Joseph, Missouri, focuses on patient experience, including awareness of language used in patient interactions. Healthcare jargon such as "episode" or "encounter" has been removed in favor of more common language. Talking with patients in everyday language promotes a more personalized, small-town service from smaller providers.

Communication. As revenue cycle teams develop strategies to boost competition, it is important to improve estimation processes and proactively discuss payment options, ideally before services take place. The key is to balance strong communication with accounts receivable (A/R) goals. To meet that strategy, one Minnesota health system invested in training financial counselors and worked with the marketing department to ensure financial policies, payment options and payment methods are consistently communicated across all points of patient engagement. This approach tends to generate more questions during the registration process, but it results in more informed patients and an increase in patient payments — up front and on the back end.

C-suite leadership. Though similar to culture, C-suite leadership is focused on ensuring organizational leaders support revenue cycle teams. In smaller communities, it is critical that C-suite leaders connect with other community leaders to ensure transparency and foster a sense of local ownership for the long-term financial health of their health system.

For example, MaineGeneral Health often saw its patients drive south to Boston for care. Revenue cycle leaders recognized they needed to find ways to keep patients closer to home. A key tactic was revamping its patient financing options through a third-party vendor. When the system switched from managing long-term payment plans internally to outsourcing, the change also affected employee payment options. Recognizing employees are just as important a patient constituent group as non-employees, the CEO advocated to communicate the change and assure employees throughout the transition.

Commitment. Patient loyalty depends heavily on earning their commitment to support and return to your health system. By engaging in proven, proactive strategies, it's possible to secure commitment from patients. Health system leaders find that offering zero-interest patient financing has been a key driver for loyalty and word-of-mouth referral. According to ClearBalance's 2018 Healthcare Consumerism study, 92% of patients very likely will return to a health system because of the availability of long-term patient financing, and 89% will refer family and friends. Knowing that they have a way to affordably manage their out-of-pocket medical costs, patients can focus on the care experience.

Finally, health systems should align with their patient experience and financial goals. Smaller community providers don't have to spend their way to a better patient experience. By focusing on the five Cs and ensuring their strategies put the patient first, these providers can provide patient experiences that promote loyalty, deliver optimal payment and offer a leg up to compete with larger health systems.

Learn from best-in-class organizations and industry thought leaders about the latest revenue cycle practices. Save the date for HFMA's Revenue Cycle Conference, March 30–April 1, 2020, in New Orleans (hfma.org/rcc). •

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Building a coding integrity department

Making sure that an account has integrity from start to finish is not only ethical, it has a trickle-down impact to finance, decision-making, clinical protocols, research outcomes and external reporting.

Prior to internal and external entities scrutinizing individual codes and abstracted data, a healthcare system's main inpatient coding quality focus may have been ensuring the DRG was right. If the DRG was correct, hospitals would get accurately paid by payers for the care provided, and high-level quality reporting was directionally accurate.

Organizations may include up to 25 diagnoses codes and 25 procedure codes per account. It's not just about accuracy of the codes used for DRG classification — it is about complete, accurate and consistent coding as these codes are used for research, data analytics, state reporting, clinical registry reporting and population health, among other areas.

For example, consider mortality index ratings. Every hospital has to monitor this data and evaluate whether their mortality rate is higher than it should be or not appropriate based on its patient population. The DRG could be accurate, but if the organization did not identify that the patient was receiving palliative care and/or the palliative care code was not sequenced to the top 25 codes, it may impact observed-to-expected mortality.

Every code on the patient's account needs to be represented accurately — it needs to correspond to the clinical documentation and have integrity.

How coding integrity came about

When the U.S. switched from ICD-9 to ICD-10, most hospitals believed they would see a dip in DRG coding accuracy rates in the 85%-87% range, which could result in huge revenue loss.

To remain ahead of the curve from a quality and education standpoint, organizations that trained medical coders and medical coding quality review personnel in advance were able to keep accounts moving, and when ICD-10 went live, overall DRG coding quality levels remained stable.

By outsourcing production coding, or "first touch" coding, to third-party companies, healthcare systems are able to devote more resources utilizing data science to review accounts that were flagged as having a potential coding or charging error. This allowed for limited resources to review the *right* charts versus casting a wider net and reviewing many accounts that were already accurate.

Hospitals may not use the term "coders" anymore. Many coders are not just coding; they are evaluating the integrity of the codes and abstracted data associated with each patient.

This was a major shift from an industry tendency to code accounts and directly submit them to payers, relying on retrospective coding reviews to identify any coding errors. Instead, hospitals could review accounts more than once prior to billing to ensure every code and corresponding charge was accurate prior to billing.

Therefore, hospitals may not use the term "coders" anymore. Many coders are not just coding; they are evaluating the integrity of the codes and abstracted data associated with each patient.

As systems begin to detect patterns and learn from previous patients' charts, the philosophy of traditional production coding and retrospective auditing has shifted to evaluating the integrity of the codes and data prior to bill submission.

For example, consider a transcatheter aortic valve replacement (TAVR) patient. As a fairly new evolution to the way cardiologists and cardiovascular surgeons perform minimally invasive heart procedures, it is a high-dollar DRG and a high-dollar device procedure. If the organization newly implements a procedure at its facility, there would need to be processes put into place to ensure that each item associated with the TAVR is captured and that the facility is being paid appropriately and the codes accurately reflect the patient's care.

With coding integrity, specialists can ensure that if a TAVR is coded, there is a device charge associated with the account in addition to a procedure code. And if it is not, an assignment can be put into place to flag every TAVR procedure to ensure charges line up. This may also work in reverse, if a TAVR charge is associated with the account but no corresponding procedure code is present, the account may be stopped before billing to ensure the appropriate procedure code is placed on the account.

The possibilities of workflows and assigned account reviews are endless to ensure code and charge accuracy, as well as coders' abilities to translate clinical data to patient encounters so hospital records are up to date.

Recognizing importance

Making sure that an account has integrity from start to finish is not only ethical, it has a trickle-down impact to finance, decision-making, clinical protocols, research outcomes and external reporting. If an organization has multiple incorrectly coded

accounts, it could lead to additional audits, compliance risks and fines.

Furthermore, it is important for an organization to ensure proper sequencing when reconciling and validating diagnosis for the respective DRG to provide accurate payments when a hospital's patient population is comprised of more severely ill patients.

Historically, coding reconciliation follows the CMS standards for ensuring that the coded information matched the health record. CMS follows the Medicare Severity-DRG (MS-DRG) classifications that are predominately based on the following:

- The sequencing of the principal diagnosis
- The presence or absence of complications and/or comorbidities
- The presence of major complications or comorbidities
- The occurrence of a procedure(s)
- Patient gender and discharge disposition

Some states and payers are moving to an All Patient Refined DRG (APR-DRG) model, which was developed to further reflect complexity. It not only ranks the DRG but evaluates illness severity and mortality risk — two more levels to evaluate when ensuring code integrity.

Regardless which classification system is used, the key objective is to ensure that patient claims are supported by the actual clinical documentation and exact procedures and treatment performed. Having the documentation to support the claim is absolutely essential.

Intersecting priorities

Coding integrity specialists go into the medical record to ensure that all clinical notes on patient charts match up to the assigned codes to represent the proper diagnosis and treatment.

Setting up routine monthly meetings between revenue integrity and coding integrity can help explain discrepancies between accounts and drilling down to see if charges were built incorrectly causing them to be associated with an incorrect code.

An example would be when patients show up in tracheotomy reviews when a charge was built for a trach-tube instead of a G-tube and should have been coded as a gastronomy patient. Revenue integrity and coding integrity would work together to ensure the process is updated and going forward, the correct codes match the correct charges.

Another example is when a patient was stabilized and transferred to another facility for a higher level of care. Because accurate coded data extends beyond diagnosis and procedure codes, coding integrity would partner with revenue integrity and case management to validate patient admission, discharge and transfer data that influence outcomes, such as where the patient was admitted from or discharged to (e.g., another acute care facility, skilled nursing facility, rehabilitation facility).

Building from the ground up

Coding integrity is an integral part of the revenue cycle and should align with an organization's overall strategic mission. Determining where there are initial gaps in the integrity of coding will help decide where to focus efforts.

Traditionally, a coding integrity department is comprised of a coding integrity director, coding integrity managers, inpatient coding integrity specialists and outpatient coding integrity specialists.

The director typically reports to health information management. However, the director should have routine communications and interactions with the CFO, clinical documentation improvement leadership, chief medical officer and clinical leaders with responsibility for quality, clinical data abstraction and registries.

Employees should be trained, either through the American Health Information Management Association or another certified program on pharmacology, disease management and marrying clinical information to code assignment. In addition, coders should have a Certified Coding Specialist (CCS) or Certified Coding Associate (CCA) credential — two of the most recognized certifications in the healthcare industry — each requiring 20 hours of annual education.

Continuing education is a critical component for a coding integrity department to stay current on updates, compliance rules and regulations. Narrowing down time every week for coders to discuss niche accounts and fine-tuning skills beyond preliminary reviews will set a team up for success in adherence to documentation and validation guidelines.

In addition, a well-balanced coding quality review team that retrospectively reviews accounts processed by each coding integrity person on a monthly basis is key to identifying errors or opportunities to improve coding accuracy. •

For more information, contact Parallon (business.solutions@parallon.com).

Getting to the root causes of denials

Denise Wilson and Tracey A. Tomak

Know the 10 to 12 diagnoses codes that payers focus on.

Despite dedicated efforts, the steady rise in claim denials is a mounting concern for hospitals, health systems and physician practices. A proactive approach to denial and audit data can help providers prevent errors that lead to denials, and reduce financial loss and increase resource efficiency. Here are three trends to know:

1. *Clinical validation.* There has been an increase in clinical validation denials based on a combination of clinical indicators and coding references by the payer. Placing clinical validation under the coding umbrella complicates the appeal process.

2. *Payer targets.* Payers tend to focus on 10 to 12 diagnoses. Knowing those focus areas is critical to flagging records for more in-depth review. Use of data analytics to identify the diagnoses that show the highest denial rates and revenue risks is the foundation for building a proactive denial prevention and appeal strategy.

3. *Managed care contracts.* Breaking down silos extends beyond coders and physicians to include managed care. Organizations are increasingly focused on how diagnoses are defined and the impact on payer denials.

Reason code 50: Distinguishing between reason, issue and root cause

Reason code 50 definition – Non-covered: Not medically necessary

Denial issue:	Root cause:
› Wrong setting. › Lack of approved diagnosis for test/service. › Lack of documented prior conservative treatments. › Maximum billable units exceeded. An example would be a payer who denies the medical necessity of a total knee replacement because the medical record sent to the payer during audit did not include physician office notes documenting prior conservative treatments such as pain medication or physical therapy.	› Documentation does not support inpatient level of care – lacks documentation of purpose of inpatient admission. › Lack of documented specificity in reason (sign/symptom/diagnosis) for service. › Lack of documentation on the facility record. For example, physician office notes may describe pre-operative testing and conservative treatments, but this documentation is not readily available in the facility record to substantiate payer denial or audit. › Authorization number missing on claim. › Unaware of medical policy or documentation not supporting the need for more units – lacks supporting documentation for excessive units. › Charge or coding error – lacks covered diagnosis for this service per National Coverage Determination (NCD), Local Coverage Determination or Clinical Policy Bulletin (CPB). An example of a root cause would be the release of information vendor sent the hospital medical record in response to an audit request without requesting the necessary corresponding physician office medical record that contains the documentation of prior conservative treatments.

Source: Intersect Healthcare. Used with permission.

Reason, issue and root cause

Telling the story of why a denial happened begins with understanding the reason, the issue and ultimately the root cause. Claim Adjustment Reason Codes (CARC) are used to communicate a reason for a payment adjustment — a claim or service line was paid differently than it was billed.

One of the most common reasons cited is "not deemed a medical necessity by the payer." But what is the true issue? Denials can be related to coding, documentation or incorrect status. While CARCs and audit issues describe why the payer or auditor is not paying for a service or claim, the root cause is the confirmed or potential internal failure that caused the payment variance.

Whereas denial or audit issue data is typically readily available and easily identified through claims data analysis, identifying the root cause requires internal analysis of the medical record, charges and the billed claim to determine the potential root cause or internal failure. Root causes should be defined operationally to determine the level of analysis required internally.

The importance of specificity

The root cause should be written to enable the reader to act on a specific cause with little additional study. For example, writing, "Documentation does not support inpatient level of care," is a broad statement and could encompass many problems, yet it is often used as a root cause. While the denial issue is intended to be a broad category, the root cause should be specific to pinpoint the problem that needs to be corrected to prevent the denial from recurring.

For example, a root cause could be lack of two-midnight documentation for a traditional Medicare admission. Another specific root cause could be lack of documentation of recovery sooner than expected, which would be required for an inpatient traditional Medicare admission that doesn't pass the two midnights.

Root cause versus reason codes

To avoid denials, it is important to collect valid data based on actual root cause rather than simply relying on the reason codes

The benefits of a technology approach to denials management

- Determines the root causes of payer denials
- Captures coding and clinical validation changes
- Provides targeted education on the front end of the revenue cycle
- Increases knowledge of payer contract terms to mitigate risk
- Moves from payer denial management to prevention
- Centralizes workflows for unified denial management and appeals

are returned by payers on 835 remittances and explanation of benefits. When properly collected, analyzed and reported, this information can be used to:

- Identify patterns and trends that inform denial management strategies.
- Define the service site and type, payer and physicians where issues originate and offer education to decrease denials.
- Establish specific contract terms regarding payment and appeal rights.

A multidisciplinary model

Root cause analysis requires breaking down silos through a multidisciplinary approach that promotes honest discussions about processes and re-education. The goal of data analytics is to identify and quantify preventable errors on the front end before they become denials on the back end.

To achieve that goal, a core team should include leadership from coding, patient access, utilization management, managed care, revenue cycle, clinical documentation improvement, health information management, legal, compliance and other areas. Provide ongoing education and bring payers into the conversation. •

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HFMA's Chicago Seminars focus on revenue cycle, value-based payment and chargemaster strategies

Erika Grotto, CHFP, CRCR

At the core of revenue cycle performance is a focus on the patient, says Sandra Wolfskill, a consultant, who will be presenting Dec. 5-6 on revenue cycle essentials with Lucy Zielinski, managing partner, Lumina Health Partners. The rise of high-deductible health plans and an emphasis on consumerism and price transparency have resulted in a patient population that is hungry for information. Providers need to talk with patients about their financial responsibilities so there are no surprises when final bills arrive.

"Even a ballpark or a range will help patients understand where they fit in," Wolfskill said.

Staff must learn new skills, and they need to be trained to respond to patient questions. More healthcare organizations are setting up patient call centers and other resources to share information about financial responsibility, Zielinski said.

"We talk about increasing access to care. I think we have to increase access to the revenue cycle," Zielinski said.

New payment models also require a focus on individual patients. It's important to identify patients with chronic conditions who fit into specific value-based payment programs and then code their care appropriately, so they are counted as part of the correct programs, Zielinski said.

An emphasis on integration

Merger and acquisition activities over the past several years have left many health systems with several legacy organizations still using their own processes, Zielinski said. As stakeholders are coming together to integrate care, revenue cycle managers should be looking at their processes to ensure the entire organization is in sync.

"Revenue cycle has to follow suit in being integrated so providers of care are getting paid for what they're doing," she said. Revenue cycle processes are different for acute care and ambulatory care, so it's necessary to find a way to bring those processes together as care is integrated.

Key performance indicators

One key idea for Zielinski is that different stakeholders focus on different key performance indicators (KPIs). For example, physicians care about KPIs that determine how they are paid, such as relative value units. Front office staff care about clean claims but may not be focused on margin.

"Every stakeholder group cares about different things, and KPIs have to be aligned for each group," she said.

The role of technology

The session also will focus on technology to improve performance. Having artificial intelligence (AI) is essential to success in today's revenue cycle, Wolfskill said. Automating processes provides efficiency and data that managers can use to improve results. However, it's also essential to know what to look for in the data. "AI will find the issue for you. It won't tell you how to fix it," she said.

For example, AI can tell an organization which health plans are not responding to claims. A duplicate claim is unlikely to get good results; however, a conversation with the health plan could help an organization figure out where the process breaks down and take steps to remedy the issues.

Healthcare finance professionals can register for the two-day HFMA Seminars, Dec. 5-6 in Chicago at hfma.org/events. •

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• figure at a glance •

Taking patient experience beyond clinical care

David Shelton

Research shows that hospitals delivering a better patient experience are more profitable. As a result, it is critical for providers to continually improve the patient journey (Betts, D. "Better patient-reported experiences = more hospital profitability," *MedCityNews*, May 31, 2017).

Patient experience was once shaped primarily by clinical interactions. Now, as patients pay more out-of-pocket healthcare costs, financial services also influence patient experience, perceptions and actions. Patients who have an engaging financial experience, including services such as cost estimation, appointment reminders, financial counseling and payment options, are more likely to pay their bills in full and rate the overall episode of care in a positive light

For example, Montefiore St. Luke's Cornwall Hospital in New York had a large share of self-pay patients. By improving patient experience and payment processes, the hospital went from collecting about $400,000 in timely payments annually to increasing payments by nearly $2 million in 2019, a five-fold increase (LaPointe, J., "Pre-Access Center Collects More Patient Financial Responsibility," *RevenueCycleIntelligence*, May 20, 2019).

The hospital adopted centralized scheduling, cost estimates, prior authorizations, insurance verification and payment planning *before* care. Scheduling, preregistration and authorization times dropped significantly, patients got to appointments faster and payments increased. •

Hospital patient experience initiative improves KPIs

For Montefiore St. Luke's Cornwall Hospital in New York, transforming patient access reduced scheduling and authorization time while increasing patient payments.

	Targeted KPIs 24 months Post-Live	**Actual KPIs** 24 months Post-Live	**2019 results**
Scheduling in minutes	10	15	10
Minutes per pre-registration and collections calls	6	8	5
Authorization minutes per account	10	15	12
Average monthly point-of-service cash collections	$100,000	$113,134	$162,081

Source: PatientMatters. Used with permission.

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