WEB FEATURE

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reengineering the claims management work flow

UPMC uses automation and an exception-based work flow to focus collectors on activities that have the greatest impact on the bottom line.

Ten years ago, leaders at UPMC, Pittsburgh, took on a daunting challenge: to speed up the claims cycle and accelerate their cash flow while keeping staffing in check. Today, they credit their success to automation and continuous performance improvement.

By implementing new technology and work flows, UPMC has cut billed days in accounts receivable (A/R) from 42 to 29 days, with a 79 percent reduction in the percentage of A/R aged more than 90 days. At the same time, by identifying and correcting inefficiencies, leaders have helped UPMC become a better partner with payers.

Other organizations like UPMC are looking for ways to make their billing and claims management processes more efficient. UPMC's experience highlights several strategies revenue cycle leaders can use to focus their valuable resources on the activities that matter most to the bottom line.

AT A GLANCE

- UPMC has developed an automated claim-status reporting tool that helps speed up the revenue cycle in its 20-plus hospitals.
- UPMC has reduced billed days in A/R from 42 to 29 days over the past few years.
- The percentage of A/R older than 90 days has dropped from 31 percent to 6.5 percent.
- UPMC increased net revenue managed per FTE from $41 million to $62 million, a 51 percent increase over three years.
- Having more substantive data on the status of claims has helped UPMC improve its relationships with payers.

Choose the Right Tool

Integrating billing and claims management solutions across multiple hospital environments is a common challenge for revenue cycle leaders, particularly as consolidation accelerates in many markets. Unfortunately, standardizing policies and procedures usually is not enough to maximize efficiencies in the revenue cycle.

Like many health systems that have expanded in recent years, UPMC had at one point used multiple patient-accounting systems across its 22 hospitals. Back in 2004, UPMC leaders were searching for an integrated solution that would give staff on different patient-accounting systems better information about claim status transactions so they could work smarter and faster.

Unable to find a solution on the market, they built their own. Specifically, revenue cycle and finance leaders at UPMC worked with the health system's IT team to develop a web-based tool that automatically retrieves payers' payment and denial information on claims as soon as one day post-billing, thereby significantly reducing the amount of time that collectors need to manually enter each payer's portal to research a particular claim.

Until UPMC developed and implemented the automated tool, revenue cycle staff had relied on the limited information they received from standard electronic data interchange (EDI) claim status transactions. But this approach meant that collectors might not know that a claim was partially denied until the payer remits were posted 30 or 45 days post-billing. Also, the EDI denial reason was not detailed enough for the staff to understand the real issue that needed to be corrected, meaning staff had to log into each payer website to obtain the detailed denial information for their follow-up activities.

With the enhanced claim status transaction tool, collectors can work on denials more quickly and proactively correct claims that may trigger similar denials. UPMC's leaders had two primary goals in developing the tool: to build it around payer processes and to automate as much of the process as possible.

Build the tool around payer processes. UPMC's web-based technology emulates how A/R staff traditionally work when visiting payers' portals to locate critical information, such as a payer's allowable amount, patient liability, and proprietary reasons for denial. The tool uses "screen scraping" to automatically collect screen data from multiple payers' portals and then present it in a standard, easy-to-read format.

When building the tool, revenue cycle leaders convened a committee that included the lead collector and other A/R and finance staff. Their goal: to understand each payer's internal process for processing claims. Specifically, they asked the following questions about each payer:

> What information is typically available on the payer's portal?

ABOUT UPMC

UPMC is the first integrated delivery and health finance system in western Pennsylvania. Based in Pittsburgh, UPMC operates 22 academic, community, and specialty hospitals and employs more than 3,500 physicians. Its insurance division covers more than 2.5 million lives. UPMC is currently ranked No. 13 on the *U.S. News & World Report* Honor Roll of America's Best Hospitals.

HIPAA EDI TRANSACTIONS: PAYER PORTAL COMPARISON

Payer	277 / 835	Payor Portal
Payer A	**16: Claim/service lacks information needed for adjudication.** Additional information is supplied using remittance advice remark codes whenever appropriate.	**REJ:** Itemized bill required. Resubmit with itemized bill.
Payer B	**96: Noncovered charges.** At least one remark code must be provided (may comprise either the NCPDP rejection reason code or remittance advice remark code that is not an alert.)	**SF:** This claim is being denied because our records indicate you have primary medical insurance with another company (other than Medicare).
Payer C	**95: Plan procedures not followed.**	**1005:** These benefits were reduced due to failure to obtain pre-certification approval as outlined in the plan.
Payer D	**16: Claim/service lacks information that is needed for adjudication.** Additional information is supplied using remittance advice remark codes whenever appropriate.	**E5904:** Final benefit determination cannot be made until we receive specific requested medical information.

Source: Ovation Revenue Cycle Services and UPMC, 2015.

A typical ANSI 277/835 notification might include reason code 16, which simply states that the claim lacks information that is needed for adjudication. Yet code 16 requires different actions for different payers. UPMC's automated tool provides a greater level of detail derived from payers' portals, so collectors can determine what is needed to resolve an issue.

- What was the payer's standard payment timeline (for example, how long did the payer usually pend claims)?
- When should staff members follow up on pended claims? (For example, if the payer usually paid in 20 days, a staff member might be prompted to follow up at 25 days.)
- What information should the tool report so collectors can resolve an account without having to log into the payer's portal?

With answers to these questions for each payer, the UPMC team could then design a tool that would best reflect payers' standard practices. For example, one payer typically made the status available on its payer portal one day post-billing. The payer also typically paid claims in 15 days. Based on this information, the team designed the tool so staff would see the following data fields for that payer: the payers' allowable amount, the patient liability, line-item denials, and the proprietary reason for denial.

The team also wanted richer, more actionable data from payers' portals than standard HIPAA ANSI 277 EDI responses, which tend to be rather limited. ANSI 277 responses lack meaningful specifics, such as payers' proprietary remark codes and verbiage, and information on pending/suspended claims. UPMC designed the tool to provide richer denial data directly from payer's portals.

That said, the team faced some challenges in designing the tool. For example, each payer website is different, making it difficult to standardize consistent follow-up timeframes. Payer websites also make different data elements available, and staff can use their knowledge of those different elements to get the claim resolved and paid more quickly.

Automate wherever possible. To minimize staff busywork, the team designed the tool to automatically search out what is needed on the payer's portal and then submit the missing information to the payer the same day when possible. For example, the tool can automatically locate itemized bills and medical records from UPMC's health information management (HIM) system and send them through the payer portal—without any manual intervention from staff.

Work by Exception

In recent years, many hospitals and health systems have added A/R staff to manually check claims status on payer portals—a process that helps speed the revenue cycle but increases overhead. When hiring more staff is not an option, revenue cycle departments may wait as long as 45 days to touch claims in the hopes that most will be paid by then. But there is a high cost to playing this waiting game: The inability of these organizations to quickly work their denials impedes their cash flow and, in many cases, prevents them from discovering the root causes of denials.

That is not the case for UPMC, where the claims status transaction tool has enabled staff to build an exception-based work flow and get claims paid more quickly. This type of work flow allows staff to focus on the accounts that require some type of intervention—i.e., the "exceptions." Today, UPMC's collectors touch only 11 percent of overall claims, while the remaining 89 percent are automatically scheduled to pay or autocorrected by the tool.

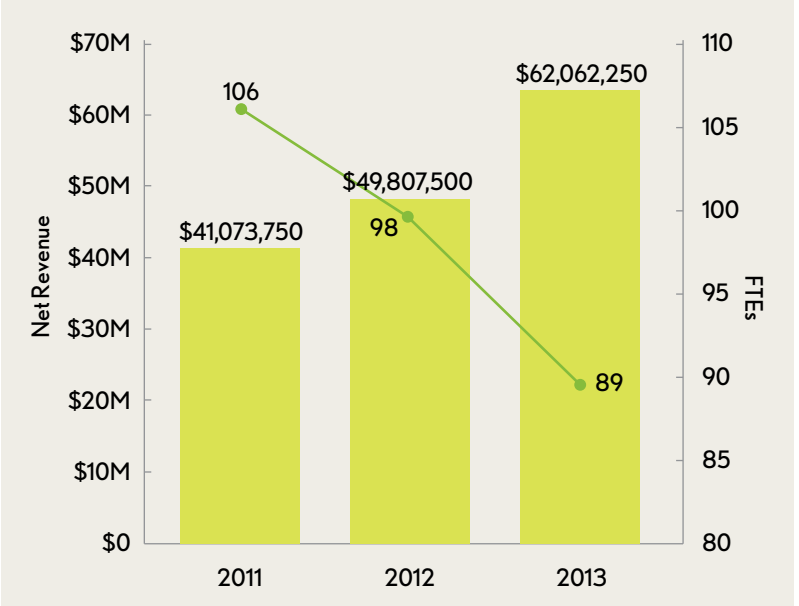
Here is a closer look at how the exception-based work flow works: In those instances (roughly one in 10) where the tool cannot automatically resolve a denial by locating itemized bills and medical records from UPMC's HIM system, the claim is sent to a staff member's queue. Staff members receive an explanation of why the claim was denied, allowing them to research and locate whatever missing information is needed to satisfy the payer (e.g., coordination of benefits information).

UPMC attributes its success in establishing this exception-based work flow to the following best practices.

Provide adequate training to build trust. One of the greatest challenges in implementing an exception-based work flow is getting staff to trust the process. Getting them to learn how to let go of their previous, manual work processes and fully embrace the tool requires focused training up front. For this purpose, UPMC's leaders wrote extensive training documents, and supervisors provided a group training session on each key payer as well as one-on-one coaching, when needed.

Start working denials one day post-billing. Because the tool provides claim status one day post-billing, A/R staff can focus immediately on claims for which the status is either *denied/no pay* or *claim not found*. At day one, staff can work on the 2 percent of claims with a denied/no-pay status to determine the cause and find a solution. Depending on the payer's history, revenue cycle managers may send the 1 percent of claims not found to their staff's work queues or they may choose to wait a few days.

UPMC CASE STUDY: IMPROVEMENT IN NET REVENUE PER FTE, 2011-15



In three years, UPMC realized a 51 percent Increase in net revenue per FTE, with a concurrent 16 percent reduction in FTEs.

Ten days post-billing, 86 percent of claims from UPMC's top four payers are in a paid status, so staff never have to manually "touch" these accounts. Instead, staff can focus on the 5 percent of claims with a denied/no-pay status and the 1 percent of claims not found.

However, it took some time to get the staff up and running on the tool. Repetitive training and listening to concerns yielded acceptance.

Focus staff on the tasks that best fit their expertise. Supervisors review staff report cards to determine which collectors are the most efficient and which seem to have the strongest knowledge base. From there, they can segment the work so that staff members work at their highest level. UPMC's more experienced collectors tackle the more difficult accounts, giving less seasoned staff the opportunity to learn while working on less challenging tasks.

Prioritize based on line-item denials. UPMC built its technology to provide specifics on line-item denials—which are not clear from high-level ANSI codes. The tool prioritizes line-item denials based on the net dollar amount denied, so managers can direct staff to focus on activities that are most important to the bottom line. For example, the tool will not send a $10 line-item denial into a staff member's work queue. On the other hand, a line-item denial for a $10,000 will become a top priority.

Share the results. Using the tool and an exception-based workflow has significantly improved staff productivity as well as revenue at UPMC. At 30 days post-billing, 91 percent of claims from UPMC's top four payers are typically paid, and denials have been brought down to just 1 percent—and since have remained flat, with little variation. In FY03, denials peaked at 6 percent. In FY07, denials hovered under 2 percent. Since FYI3, denials have been less than 1 percent. UPMC's performance is in sharp contrast to other organizations that may not know about their denials until day 30 or day 45 post-billing.

Since 2011, UPMC's hospital revenue cycle has realized the following noteworthy results:

> 51 percent increase in net revenue per FTE, from $41 million to $62 million, despite reducing FTEs 16 percent

> 34 percent increase in claims managed per FTE, from approximately 39,682 to 53,182 in a three-year time period

> 79 percent increase in FTE productivity, from approximately 42.5 accounts per day to 76 accounts per day

A Focus on Continuous Performance Improvement

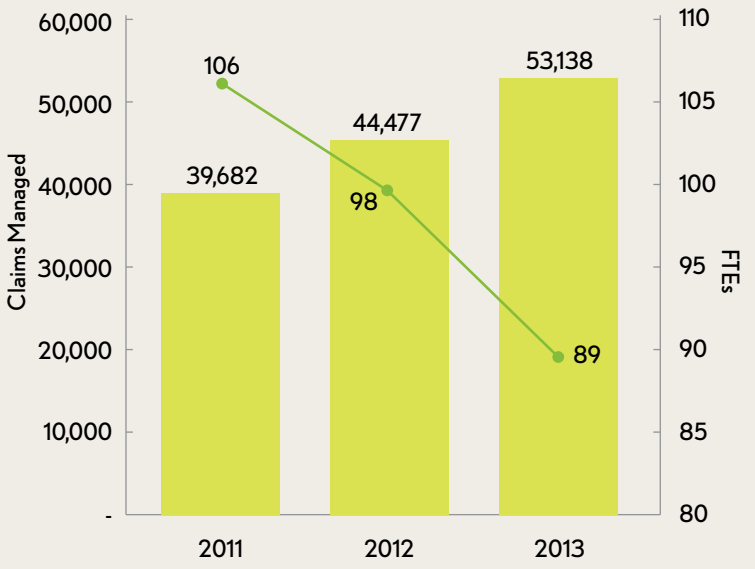
UPMC's leaders have implemented several strategies involving a focus on continuous performance improvement to help them build on their early successes in improving revenue cycle efficiencies.

Keep an eye on the trends. The tool's ability to gather proprietary payer codes makes analyzing chart trends and identifying potential opportunities for improvement easier for leaders than such a task would be using only remittance codes on EDI 835 transactions, which the lack standardization needed to identify root cases for denials. Typically, supervisors review trends such as the claim approval versus denial rate each day. Other metrics, such as denial trends, may need to be checked only weekly.

Share metrics with departments. UPMC's business office also runs a monthly denials report to share with revenue cycle directors and department heads so they can collaborate on solving billing issues and getting cleaner claims the first time. For example, the monthly report might uncover payer denials for experimental investigations or off-label use of a drug. Understanding the causes of these payer denials can help clinicians understand the financial implications of treatment decisions for patients.

Create a forum so staff can share ideas. The best collectors often are too busy working their claims to step out of their zone and offer suggestions for improvement. Each month, the management team meets with staff to identify opportunities to automate or refine processes. For example, staff feedback helped design a faster work flow for uncovering partial authorizations, such as when a payer authorizes two observation days but denies any additional days.

UPMC CASE STUDY: IMPROVEMENT IN CLAIMS MANAGED PER FTE, 2011-15



In three years, UPMC realized a 34 percent increase in claims managed per FTE.

Share Lessons with Payers

Having access to payers' proprietary portal information, rather than just the ANSI 277 transaction information, gives providers greater transparency on payer issues. When UPMC suspected that one of its largest payers was sending payments to patients that should have gone to UPMC, the health system built a data field and created an alert in the tool. UPMC's leaders were shocked by how often the payer made this error; armed with data, they worked with the payer to quickly correct the issue.

Using the tool can help uncover inefficiencies that affect payers' revenues as well. By bringing these issues to light, UPMC has positioned itself as a strong partner with payers. For example, data reports revealed that one payer was denying a portion of claims for medical necessity based on

issues related to medical records. After UPMC's staff worked the denials manually, the health system's revenue cycle leaders saw that the issue represented overhead costs for both organizations and shared the information with the payer. The payer not only eventually paid 90 percent of those claims, but also was grateful for the information, recognizing that if the problem was happening with UPMC, it was most likely occurring with all of its providers, and noting that this finding reduced the work for its medical reviewers and, in turn, saved money.

Brace for the Future

As health systems face continued pressure on margins, their leaders require better strategies to reduce their staff's manual workload and accelerate their cash flow. At UPMC, leaders' focus on getting the billing and claims management process to run smoothly led to the in-house development of technology for handling eligibility, coding, and denials. From the time it began developing the technology 10 years ago through FY14 UPMC saw its net patient revenue per FTE increase from $5.2 million to $13.8 million, even as FTEs in the hospital revenue cycle were reduced by 23 percent (from 475 to 368), with most of these employees being redirected to other areas of the health system.

The future will bring even more challenges for healthcare leaders as Medicare's payment timeline stretches, ICD-10 is fully implemented, and the percentage of self-pay patients rises in many markets. In the face of such challenges, leaders whose organizations adopt exception-based workflows and automated tools will be best-positioned to transform their revenue cycles—and protect their bottom line. ■

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