When Health Information and Fiscal Management Meet

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HIM professionals have skills that can allow them to contribute to the bottom line in many ways. The author describes areas where HIM expertise can make a difference in evaluating an organization's fiscal performance through analysis of services driven by health information.

HIM professionals, by and large, are not invited to assist financial administration in evaluating an organization's fiscal performance. Unfortunately, the clinical and operational talents of health information professionals may be the missing link in understanding payment changes and denial trends.

Now, more than ever, the activities of the patient financial services (PFS) and HIM departments are so intertwined that organizations should be considering why these departments have not been merged. Further, with the advent of HIPAA and the finalization of transaction code processing, the staffing and activities of financial services departments are diminishing as "front-end" verification activities occurring in registration and secondary billing and "back-end" eligibility efforts are eliminated.

HIPAA enhances the billing and reimbursement processes substantially, leaving routine registration, chief complaint and diagnostic testing coding, primary payer billing, and denial management as the principal activities remaining for PFS. Of these principal areas, three--routine registration, chief complaint and diagnostic testing coding, and denial management--are health information-driven services.

How can HIM professionals lend their expertise to assist in their organization's financial management? This article describes the three key areas where HIM professionals can play essential roles and offers some examples.

Starting at the Beginning: Registration

In the registration area, several activities are perfect for HIM professional oversight: general registration and chief complaint and diagnostic testing coding. Ensuring that accurate information is obtained at the front end drives all billing and data-dependent functions thereafter.

Collecting the proper payer and insurance plan information ensures that claims will not be denied or returned and that appropriate pre-certification processes are followed throughout the patient's stay or encounter. Staffing the registration area with skilled HIM professionals who recognize the importance of data integrity and who are trained in coding will allow for more accurate coding of admitting and testing diagnoses.

Similarly, this staffing pattern could facilitate the triggering of advance beneficiary notices, pathways, and physician documentation guidance for inpatient as well as outpatient encounters.

Assessing the Inevitable: Denial Management

Denials are inevitable. Denial management means limiting the number of denials by whatever legitimate approaches are available to the provider at the time the services were rendered. To perform denial management, an organization needs to analyze the existing denials and assess their causes. Those trained in such techniques as determining root cause and other process improvement analyses will be able to affect the denial volume, thus improving the organization's cash flow.

HIM professionals can provide added value to the PFS team dealing with denials, typically retrospectively. HIM professionals are particularly well suited for addressing denials that are coding driven, such as use of:

- codes

- codes (lacking fourth and fifth digits)
- coding by related providers (ASC versus surgeon billing)
- coding (V codes for some insurers)
- necessity coding concerns
- to comply with intermediary local medical review policies (LMRPs)

Traditionally, billing specialists have handled denials by requesting copies of patient records to appeal the denial, writing off the account, "fixing" the code (a real compliance concern), or referring the denial to the HIM department. Considering the labor effort involved in any of these scenarios, a more direct route would be to sort denials as they are received in the PFS department and route those that are coding related directly to an HIM professional. The HIM professional could be positioned in, assigned as liaison to, or directly over this function in the PFS department.

Timely management of and receipt of all related denials will allow comprehensive analysis to occur. Consider this example: one organization found itself receiving a significant number of denials for invalid codes. It collected denials (nearly 1,000 of them) during a two-month period and determined that the causes were three-fold:

- clinic sites were not providing complete codes (fourth and fifth digits)
- clinics need to update their encounter forms
- "switch" needed to be turned on in the information system to detect invalid codes and reject them at time of entry. While the claims were for relatively small amounts of money (less than $30 each), the volume was tremendous

An experienced coder provided training (and books) to the clinic sites, the encounter forms were updated, and the switch in the system was turned on. Invalid code denials dropped to fewer than 25 during the two months following the fixes, and further analysis continued.

Another example: An institution received multiple denials for low osmolar radiology procedures. Analysis determined that documentation was not present to support the conditions that qualified for this type of media. The required documentation elements were spelled out in an LMRP.

In response, the institution developed a questionnaire to be used by both the referring physician and the treating radiologist to capture the proper documentation to support the use of the procedure and obtain payment for the services. A HIM professional and a PFS professional, both armed with the intermediary's local medical policy and the denials, worked together to enhance reimbursement.

The Story in the Details: Reimbursement Analysis

Reimbursement analysis requires attention to detail and the ability to display and identify trends. In other words, the perfect individual to perform this analysis enjoys both microanalysis and macroanalysis. The documents that require analysis include remittance advices and information system reports.

The process begins with the remittance advice (see "Sample Remittance Advices"), a document that lists all the claims for a given period processed by a specific payer for a given provider. Some payers--Medicare and Medicaid--may have remittance advices that are 20 to 30 pages in length, with 10 or more patient claims to a page.

When remittance advices are received, the PFS department applies the payments, noncovered charges, and denied amounts to the claim to adjust the claim accordingly. Because of the number of claims per remittance, the posting staff may not be prepared to or have the time to analyze the determinations made by the payer. The remittances may then be passed on to another team within PFS or filed with no action taken.

Often the adjustments made are entered with a facility-assigned code to allow for retrospective review. Such codes may include "denied," "non-covered," "cost outlier," "not pre-certified," or "applied to deductible," At the end of the month, the amounts coded to these categories are accumulated, and often the billing information system can generate reports that display the amounts applied to each of these codes.

These end-of-the month reports are invaluable in identifying payers who have inordinately high percentages of adjustments due to reasons that may be within the organization's control. By focusing on a few payers, problems with current processes can be

pinpointed and errors by payers can be quickly remedied.

Of course, the timely review of each remittance may reveal payer payment errors or process failures that could be fixed rapidly, thus avoiding the monthly retrospective review. But when there isn't time to look at every remittance, end-of-month reports may give an organization reason to monitor one or two payers, then look at specific adjustment reasons.

For example, if we see several cases denied due to lack of precertification, we could ask several questions:

- the patients all admitted on the same date? The answer to this question may tell us that on a given date no precertification staff were scheduled to work, so admissions or surgeries occurred without the certification process being completed in a timely fashion
- time of day were the patients registered? The answer to this question may tell us that the toll-free number at the managed care organization is not manned during the hours of these registrations and only faxed requests could be sent, leading us to a possible flaw by the payer. Another finding may be lack of certification staff at this time of day. Alternatively, these patients may be considered "emergency admits" and the organization's process may be responsible for failure to certify within the given contracted period following admission
- the same registrar register these patients? The answer to this question may reveal a training need, especially if the same registrar or registration area registered each of the patients whose claims were denied

Unfortunately, the pace of the PFS department is such that detailed microanalysis time may not be a luxury it can afford with existing staff. However, the right type of person, with some clinical expertise, could do this analysis and query the insurer about the determinations made. This is an ideal position for HIM professionals.

What about the other end-of-the-month reports? Clearly, this is where HIM professionals' trending and data display skills play a most important role. Here's an example: at one organization, a diligently kept receivables spreadsheet was maintained (see "Receivables Analysis"), to which end-of-the-month data was added. This allowed the organization to be able to tell at a glance how much and what percentage of the total receivables was due to one payer. (In fact, this spreadsheet provided information that allowed the organization to respond to New York Times reporters about the perceived slowdown in payment processing by managed care organizations.)

By monitoring receivables, to the organization could see if any payer was slowing payment processing or violating contractual payment requirements. It also helped to pinpoint payers that needed either additional PFS staffing assigned to perform collection follow-up or returned claim/denied claim attention.

At this organization, the PFS staff was split into teams representing major payer types (Medicare, Blue Cross, Medicaid, etc.). The spreadsheet was a management tool to monitor the effectiveness of each PFS team. If one team's work fell behind, staff could be shifted from another team to improve the receivables picture.

This excerpt of the receivables analysis allowed management to tell at a glance which team was managing its unbilled accounts more effectively. In this example, the Medicare unbilled has declined by $1.5 million and 11 percent of the total receivable (billed and unbilled). Another observation is collection lag. PFS exerts many labor hours in follow-up with insurers about claims that have been submitted but not yet paid. The example shows that some additional effort may be required with Blue Cross as the receivables (unpaid bills) are climbing in the 91-180 day range at the expense of the faster pay range of 0-90 days. Graphic representations (bar and line charts, for example) also can be helpful in capturing a "snapshot" of receivables activity for management and administration.

A HIM professional designed the spreadsheet and performed the monthly analysis. This spreadsheet tool, coupled with the efforts of a HIM utilization review driven denial management task force, allowed her to also prepare the notes for the hospital's CEO interview with the New York Times (see "Notes for the CEO").

An Opportunity for the Taking

With everything else HIM professionals have to do today, little time is available to spread out and offer assistance to other departments. However, it is essential for members of our profession to take advantage of opportunities to display the skill set inherent in our training. HIPAA's changes will increase anxiety for those employed in PFS. HIM professionals need to recognize that this is an ideal time to jockey for an expanded role encompassing the PFS functions that will be unaffected by

HIPAA. Demonstrating the qualifications to be clinically and fiscally proficient is one way that we can ensure that HIM leadership will be considered for additional assignments and responsibility in the future.

Receivables analysis

Medicare											
Inpatient	**Unbilled dollars**	**%**	**Age of claim** **0-90 days**	**%**	**91-180 days**	**%**	**181-365 days**	**%**	**365+ days**	**%**	**Totals**
Medicare											
Nov 98	6,342,045	60%	3,289,174	31%	654,990	6%	39,883	0.4%	205,419	2%	10,531,511
Dec 98	4,723,392	53%	3,256,633	37%	333,073	4%	378,534	4%	204,546	2%	8,896,178
Jan 99	7,922,327	65%	3,249,736	27%	212,932	2%	457,683	4%	268,091	2%	12,110,768
Feb 99	8,480,855	66%	3,211,569	25%	231,531	2%	395,508	3%	455,218	4%	12,774,682
Mar 99	5,889,206	58%	3,368,968	33%	261,636	3%	259,539	3%	375,294	4%	10,154,644
Apr 99	5,171,000	56%	3,427,220	37%	266,448	3%	156,619	2%	157,365	2%	9,178,652
May 99	4,751,000	49%	3,881,867	40%	714,477	7%	144,871	2%	142,077	1%	9,634,292
The numbers in purple indicate that unbilled account balance is declining.											

Blue Cross											
Inpatient	**Unbilled dollars**	**%**	**Age of claim** **0-90 days**	**%**	**91-180 days**	**%**	**181-365 days**	**%**	**365+ days**	**%**	**Totals**
Blue Cross											
Nov 98	604,182	19%	1,890,958	58%	403,694	12%	395,000	12%	-33,881	-1%	3,259,953

Dec 98	549,903	15%	2,200,071	58%	546,541	14%	489,158	13%	2,122	0%	3,787,797
Jan 99	762,000	18%	2,059,621	50%	717,983	17%	552,115	13%	47,539	1%	4,139,258
Feb 99	753,171	15%	2,595,451	53%	871,044	18%	601,697	12%	85,409	2%	4,906,772
Mar 99	408,780	9%	2,264,200	49%	1,001,852	22%	882,189	19%	44,834	1%	4,601,856
Apr 99	454,724	11%	1,895,434	45%	1,226,233	29%	576,974	14%	38,195	1%	4,191,561
May 99	677,316	13%	2,831,786	53%	1,221,638	23%	649,312	12%	12,280	0%	5,392,334

The numbers in red indicate an increasing amount of claim dollars are getting older before being paid.

Sample remittance advices

XYZ Medical Center									
Medicare Remittance Advice									
Remit Date:	**07/07/2000**								
Provider:	**123456**								
Bill Type:	**Inpatient**								
Patient Name	Bill Type	Admit Date	Cov Days	Total Charges	Cap Outlier	DRG	Reim Rate	Allowance	Payment
Patient #	HIC #	Dschg Date	Non Cov Days	Cov Charges	Outlier Code	DRG Amt.	G/R Allow	Interest	Coinsurance
	ICN	Patient Stat	Cost Days	NonCov Charges	Cost Outlier	DRG Opr. Amt	Med Ed	Prim Pay	Deductible
		Claim Status	ESRD	Denied	Day Outlier	Capital	Disp Share	Pro Fees	Blood Deduct

Adams, Ann	111	05/20/2000	21	30871.15			15638.00		12517.00
123456789	123456789a	6/11/2000		28974.00					
	200000000000	1	21	1897.15					776.00
							43.00		
Brown, David	110	06/08/2000	0	5223.90					0.00
56789012	34500000c9	06/11/2000	0	0.00					0.00
	30000000000	1	0	0.00					0.00
		4		5223.90					0.00
119-Benefit maximum for this time period has been reached.									

XYZ Medical Center

Sample Problematic HMO Remittance Advice

Remit Date:	**06/07/2000**
Provider:	**123456**
Bill Type:	**Inpatient**

Patient Name	Bill Type	Admit Date	Cov Days	Total Charges	Cap Outlier	Reim Rate	Allowance	Payment
Patient #	Member#	Dschg Date	NonCov Days	Cov Charges	Outlier Code		Interest	Coinsurance
	Clm#	Denied Days	NonCov Charges	Denied	Cost Outlier		Prim Pay	Deductible
		Claim Status	Carve Out	Code	Day Outlier		Pro Fees	

Smith, John	111	03/28/00	11	51757.49		1500.00	16500.00	13200.00
546789	345678	04/26/00	27	21086.18				3300.00
	890000	03/28/00-		30671.31				
		03/31/00		a,d				
		04/04/00-						
		04/11/00		d				
		04/25/00-						
		04/28/00		b				
Denial Codes: a: elective admission, not pre-certified, b: no information received for continued stay certification, c: non-eligible member, d: not medically necessary day, e: under review, f: in appeal, g: untimely submission								

Notes for the CEO

(This excerpt of a memo from an HIM professional to her organizations's CEO details findings performed during reimbursement analysis. These notes helped the CEO prepare for an interview with the New York Times about delays in managed care processing of claims.)

Since December, we have placed more than $2.8 million in inpatient claims into a dispute category because the HMOs have not paid us the contracted rate, denied the entire claim, or denied a portion of the claim. This doesn't even include $2.9 million that we are appealing because of denials by both regular insurers and HMO insurers. The total amount that HMOs owed us at the end of April was $23.2 million. This is 26 percent of our total receivable.

As of April, 36 percent of our outstanding receivable amount remains unpaid for more than 90 days. For us, this means that the HMOs have used more than $8.3 million of our inpatient funds that we could be using for services to our patients.

A large managed care organization has been denying cases without any prior notice to our utilization review department.

We find out that a case that had been precertified at the time of admission will not be paid when we receive their remittance to our claim. In addition, this same managed care plan has been paying us according to a contract that they say went into effect last fall, which we never signed.

A Medicaid managed care plan (which recently assumed responsibility for the Medicaid patients covered by another managed care organization) currently owes us more than $1.2 million. We have a rate agreement with this Medicaid plan, but the payments we see bear no resemblance to that agreement.

This has been happening since January 1999. However, another Medicaid managed care plan has not paid us according to our contracted rate since 1997.

Some of the HMOs are denying days during a stay because they say they are not medically necessary. An example of this is a patient who may have come in as an outpatient for a cardiac cath. Based on the test results, the doctor immediately admits him for cardiac bypass but wants to monitor him for a day or two prior to the surgery. The HMOs are cutting gout those days and not paying. They really are asking us to discharge that patient, knowing that the patient is at risk, and readmit in two days. I can provide you with the names of the organizations that are most notorious for carving out a day here or there.

Web-only exclusive: Visit the AHIMA Library for AHIMA's Web-exclusive Medicare Reimbursement Reference Grid, which offers information on how to bill for healthcare facilities and numerous services, plus supporting regulations and resources.

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