CLINICAL SAFETY & EFFECTIVENESS
COHORT # 21  TEAM 8

Registration Denials

Educating for Quality Improvement & Patient Safety
The Team

CS&E Participants

- **Division**
  - La-Keisha Harrell, MBA - Business Administrator, Primary Care Center
  - Cassandra Martin, MBA - Practice Manager, UTHP Primary Care Center
  - Dedra Denay Garcia - Benefit Coordinator-Lead, UTHP Ortho MARC
  - Wilma Ware - Medical Office Billing Clerk Intermediate, UTHP ADM Registration
  - Alicia Wienckowski - Supervisor Patient Accounts, UTHP ADM Registration
  - Ray A. Bell II – Manager, Business Office Healthcare UTHP

- **Sponsor Department**: UT Patient Financial Services
  - Edward “Toby” Kennerdell, Sr. Director Patient Financial Services, UTHP ADM Executive Administration

- **Facilitator: CS & E Program**
  - Yvonne B. Davila, BSN, RN, CHCQM, ALHC, CLNC

TIME'S UP!
What We Are Trying to Accomplish?

AIM Statement

Decrease Initial Registration denials from 36% to 16% in the UT Health Primary Care Clinic on or before December 31st.
Patient Scheduling Insurance Verification Work Flow Diagram

Pt Calls Clinic to Schedule appt

New Patient

Established Patient

NP

Est Pt

Registration Process
- Patient Info (demos)
- Guarantor Acct (billing info)
- Coverage (insurance info)

Review pt sidebar & warnings

CVU Benefits Input/Updated

Patient Check-in @ Front Desk

Review Pt Interactive Face Sheet
Verify pt
Verify guar
Problem Statement

The Primary Care Center had $270k+ worth of registration denials in FY17, creating additional work for the clinics and CVU.

- Technology (FLOW-Simplify)
  - Insurance company selection confusion
  - No telephone language selection (language barrier)
  - E-verification Experion
  - PCP inaccurate or not listed
  - Incorrect insurance company info
  - Incorrect insurance company
  - Demographics not updated
  - Subscriber info incorrect
  - Incorrect guarantor

- Process, Policies, Procedures (Sort, Order, Shine, Standardize, Sustain)
  - Calls in que/5% abandonment rate
  - Incomplete ins info obtained
  - Card copies not made
  - Call Center coverage/skill sets
  - Same day add ons
  - Appts not scheduled by type
  - E-verification Experion
  - Order of insurance
  - Free text insurance field

- Training (Standardize, Calibrate, Software Enhancements)

- People (Education, Training, Credentials)
How Will We Know That a Change is an Improvement?

- Registration Process
  - Re-work and same day add-ons
  - Coverages linked to appointment
- Financial impact
  - Total number of initial registration denials
- Work queue volume
  - Number of patients in the queue (new/established)
  - Number of patients already e-verified
- Insurance Process
  - Coordination of Benefit (COB)
  - Filing Order
What Changes Can We Make That Will Result in an Improvement?

- Standardizing the Registration Process
  - *Insurance Information*
    - Coordination of Benefits (COB)
    - Filing Order
  - *Type of Insurances*
    - PPO/HMO
    - Medicare/Medicaid

- Software Enhancement
  - *EPIC form router request*
  - *Loading more insurance plans in EPIC*

- Check List
  - *Facesheet to verify demographics and insurance information*
  - *Job Aids*
Claim Cycle

Clean Claim

- Patient Seen in Clinic
- Claim Generated
- Payment received within 30-60 days

Claim with Errors

- Patient Seen in Clinic
- Claim Generated
- DENIED by Insurance
- Follow-Up Team Review
  - Up to 120+ days for payment
- • Claim
  • Coding
  • Coverage
  • Provider
  • Registration
- • Conducts Research
  • Contacts patient
  • Contacts Clinic
  • Resubmit Claim

Note: If a claim is denied, it should be reviewed up to 120+ days for payment.
Most Common Registration Denials

Claim with Errors

- Patient Seen in Clinic
- Claim Generated
- DENIED by Insurance
- Follow-Up Team Review
- Up to 120+ days for collect payment

Coordination of Benefits

Eligibility (Filing Order)

- Claim
- Coding
- Coverage
- Provider
- Registration

Follow-Up Team Review

Up to 120+ days for collect payment
Understanding Differences between Insurance Plans

■ HMO- Health Maintenance Organization
  – *Network of doctors and hospitals that have contracted rates*
    ■ Must see provider in network
    ■ Coverage restrictions (visits, treatments, tests, referrals, authorizations)
    ■ Must see assigned PCP
    ■ Referrals required for specialty visits (ex: Ortho, Imaging, Derm)

■ PPO- Preferred Provider Organization
  – *Network of doctors and hospitals that have fewer restrictions than HMO*
    ■ Not required to see provider in network
    ■ Fewer coverage restrictions
    ■ No assigned PCP
    ■ Referrals not required for specialties
Let’s Talk About Medicare – Traditional Medicare

■ Traditional Medicare (known as Part A&B)
■ Works similar to PPO
■ Medicare A- Inpatient
  - Hospital, Skilled Nursing Facility
  - Home Health, Hospice coverage
■ Medicare B- Outpatient
  - Clinic, DME, Labs
  - Imaging, Mental Health
Medicare – Replacement & Advantage Plans

- Insurance plan that is a replacement to traditional Medicare
- Medicare coverage will show active and current, but keep reading

Examples of plans:

<table>
<thead>
<tr>
<th>Advantage by Superior Health</th>
<th>Humana Medicare HMO &amp; PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>AETNA Medicare</td>
<td>Molina Medicare</td>
</tr>
<tr>
<td>Allegian Advantage</td>
<td>UHC Medicare (FKA SEC HORIZON)</td>
</tr>
<tr>
<td>Amerigroup Medicare</td>
<td>United Health Care Medicare</td>
</tr>
<tr>
<td>BCBS Medicare Advantage</td>
<td>Wellcare</td>
</tr>
<tr>
<td>CARE Improvement</td>
<td>Wellmed</td>
</tr>
<tr>
<td>Healthspring MCR (FKA Bravo)</td>
<td>Wellmed Amerivantage HMO</td>
</tr>
</tbody>
</table>
Medicare – Supplemental Plans

- Insurance plan that will cover traditional Medicare deductibles or co-insurance

- Traditional Medicare is always primary insurance & Supplemental plan is always secondary

  - Filing order:
    - Primary: Medicare
    - Secondary: Supplemental plan
      - AARP
      - Continental Life
      - Mutual of Omaha
Background Data
Pre-Intervention

Primary Care Center
All Initial Registration Denials by Category-Pre-Implementation
FY17 June-August

- Registration Denials
  - $62,850.20
  - 36%
- Provider Denials
  - $7,151.76
  - 4%
- Coverage Denials
  - $33,143.81
  - 19%
- Coding Denials
  - $33,811.06
  - 20%
- Claim Denials
  - $35,537.08
  - 21%

All Initial Registration Denials by Category-Pre-Implementation FY17 June-August
Pareto or Registration Denial Types
Data Source: FY17 June - August

- Not Covered by Payor: 137 occurrences (48.9%)
- Denied Record, may be Covered by Other Payor: 71 occurrences
- Expenses Incurred Prior to Coverage: 26 occurrences
- Patient Can't be ID as Our Insured: 25 occurrences
- Expenses Incurred After Coverage Terminated: 21 occurrences

Total: 256 occurrences
## Implementing the Change

### Action Plan

**Aim Statement:**
Decrease Initial Registration Related Denials from 36% to 16% on or before December 31st

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Language Barrier (phone tree does not offer language selection)</td>
<td>Update Phone Tree Language / Language skilled agents</td>
<td>Call Center Mgmt Leadership</td>
<td>Redesign the Process Minimize prolonged calls conferencing interpreter line</td>
<td>TBD</td>
</tr>
<tr>
<td>Strong</td>
<td>Insurance Company Selection Confusion Free test insurance field</td>
<td>Remove Generic Plans and Load Additional Plans</td>
<td>CVU Form Router Request</td>
<td>Simplify / Reduce Incorrectly Input Carriers</td>
<td>November</td>
</tr>
<tr>
<td>Strong</td>
<td>Incomplete Insurance Information</td>
<td>Generate weekly report on missing PCP (temp) Update EPIC to add Hard Stop for PCP Field (perm)</td>
<td>Epic</td>
<td>System Change Prevent Claims from Denying due to missing PCP</td>
<td>11- Oct</td>
</tr>
<tr>
<td>Strong</td>
<td>Increased TAT on coverage verification</td>
<td>Standing meetings communicating trends</td>
<td>CVU / PCC</td>
<td>Correct issues immediately, Decrease unnecessary rework, Share knowledge, Improve TAT of coverage verification</td>
<td>November</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Other areas pulled to assist with incoming calls</td>
<td>Increase in Staffing</td>
<td>Call Center Mgmt Leadership</td>
<td>Decrease abandoned calls / Eliminate error by speed due to calls holding in queue</td>
<td>November</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Incorrect guarantor assigned, Coverage not assigned to appt, Demos not updated, Insurance card copies not made</td>
<td>Enhance documentation &amp; accurate registration</td>
<td>Scheduling/ED Staff</td>
<td>Delaying coverage verification Network</td>
<td>October</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Incorrect filling order/COB, Medicare Replacement/Supplements Errors</td>
<td>Cognitive Aid</td>
<td>PCC Staff</td>
<td>Standardize training and process</td>
<td>Week of 11/9</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Incorrect filling order Demos outdated</td>
<td>Facesheet Front Desk will Print Facesheet for Patient to Verify Demographics and insurance information</td>
<td>Front Desk</td>
<td>Check list</td>
<td>Week of 11/6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Standardized training refresher training</td>
<td>Insurance Concepts training</td>
<td>All Current Staff - incoming New Hires</td>
<td>Standardize training and process</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Results/Impact

- Educated staff on different types of insurance plans and coverages
- Increased awareness on the importance of insurance information (Primary/Secondary)
- Streamlined the processes between CVU and the clinics
- Created practice wide insurance training
Registration Denials

Registration Denials for June-December 2017

Intervention
Results/Impact cont’d

Initial Registration Denial Codes (109/22)
Pre & Post Implementation
June 2017 - December 2017

Goal 20%
Change 24%
Difference of 4%

PCC
Percentage

$43,227.96
$32,920.24

-24%
Reviewing Background Data Post-Intervention

Primary Care Center
All Initial Registration Denials by Category
FY18 October-December

- Claim Denials: $59,387.91 (28%)
- Coding Denials: $29,873.52 (14%)
- Coverage Denials: $53,982.65 (26%)
- Provider Denials: $7,220.24 (3%)
- Registration Denials: $60,931.45 (29%)
Maintaining The Gains

- CVU Insurance Concepts Class for all new employees
- Monthly Updated job aid training classes for both CVU and clinics
Return on Investment

■ FY17 Initial Registration Denials
  - **PCC** totaled $266,990
    ■ Total Write-Offs 9.53% or $25,435 (**Lost Revenue**) or 1 FTE
  - **UT Health Physicians** totaled $2,244,658
    ■ Total Write-Offs 12.60% or $282,998 (**Lost Revenue**) or 11 FTEs

Potential PCC Revenue Savings

$41,231
What’s Next

■ Tackling Other Clinics

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Fiscal Calendar 2017</th>
<th>Fiscal Year 2018 Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE CENTER</td>
<td>$267,610.71</td>
<td>$240,764.79</td>
</tr>
<tr>
<td>RADIOLOGY</td>
<td>$221,634.63</td>
<td>$235,640.10</td>
</tr>
<tr>
<td>ORTHOPAEDICS</td>
<td>$230,665.52</td>
<td>$232,203.00</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>$147,411.00</td>
<td>$205,868.88</td>
</tr>
</tbody>
</table>

■ Implement an insurance training for all UT Health staff
  - Create/Update Job Aides
  - Educate Clinic Managers on using Form Router Request

■ Increase interaction with the Clinics and CVU
  - Initiate a monthly meeting between clinics and CVU to discuss any issues that need corrective action
Thank you!