HIPAA & Revenue Cycle Compliance: A New Approach to Denials Management

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Part I: Profile & Industry Perspective

Part II: HIPAA Administrative Simplification Provisions

Part III: CBI Denials Management Program

Part IV: Data Mining & 835 Analysis
Part I: Profile & Industry Perspective
Veterans Health Administration (VHA)

- Largest integrated health provider in the U.S.
- 138 medical centers and health systems, 820 community based outpatient clinics
- Submits roughly 10 million claims annually
- Receives medical care reimbursements from more than 1,700 insurers
Profile: VHA’s Claims

- Claims for FY04 exceeded $3.3 Billion
- No Medicare Reimbursements
- Medicare Adjusted Value = $1.5 Billion
- Third Party Collections = $960 Million
Denials Management: Industry Perspective

- 90% of denials are preventable
- 40 – 50% of denials are recoverable
- Study conducted in 2002: denials represent 11% of providers’ gross charges
- Study conducted in 2004: 5 – 20%
What is a Denial?

• Variance in industry reports likely comes from lack of standards...consider the variables:

  – Full Denial
  – Reduced payment on line items
  – Processed Claims
  – EDI Rejects
  – Provider Error
  – Payer Error
Denials Management: Industry Perspective

• Revenue cycle deficiencies represent the primary cause for reduced insurance carrier payments and claim denials.

• Claims denials recognized as a direct effect of diminished revenue integrity and related processes.

• Revenue integrity is contingent upon compliance with established revenue cycle processes & core financial management standards.
Part II: HIPAA Administrative Simplification Provisions
Healthcare Transaction Standards

• Requires Healthcare Providers to conduct ALL HIPAA transactions electronically in the X12N Standard

• Requires Health Plans to conduct ALL HIPAA transactions electronically in the X12N Standard

• Requires Healthcare Clearinghouses to conduct ALL HIPAA transactions electronically in the X12N Standard

• Requires Compliance with all other HIPAA Rules when electronic transactions are conducted
Healthcare Transaction Standards

Transaction Standards:

- Claim/Encounter: 837
- Payment and Remittance Advice: 835
- Claim Status/Response: 276/277
- Referral and Authorization: 278
- Enrollment/Disenrollment: 834*
- Eligibility request and response: 270/271
- Premium Payments: 820**
- Pharmacy: ANSI NCPDP v5.1

* 834 The VHA does not seek premium payments
** 820 The VHA does not enroll individuals from an employer
Healthcare Transaction Standards

Registration:
- Eligibility Inquiry (270)
- Eligibility Response (271)

Verification Function:

Utilization Management:
- Certification Request (278)
- Certification Response (278)

Utilization Management:

Billing and Collections:
- Pharmacy (NCPDP)
- Claims/Encounter (837)
- Status Inquiry (276)
- Status Response (277)
- Payment/Remittance (835)

Claims Processing:

Treasury:
- Bank
- Bank

Treasury
Healthcare Transaction Standards

Key VHA Initiatives — VHA Compliance with Electronic Transactions and Code Sets by October 2003

• e-Business Initiatives
  – e-Payments (Third-Party Lockbox)
  – e-II&V (Insurance Identification & Verification)
  – e-Claims Enhancements (HIPAA EDI Claims I&P Enhancements)
  – e-MRA
  – e-Pharmacy Claims (NCPDP Connection for Pharmacy)

• Code Set Versioning
VHA Assists Industry Leaders to Come in Compliance with ASPs

- Provide contingency plan for health plan side of VHA
- Work with clearinghouse and payers to address implementation issues
  - Keep Dialog Going
  - Provide Ongoing Support to Issues
- Practice “tough love” approach to health plans who refused to follow HIPAA requirements
  - HIPAA Program Management Office
  - Collaborative Relationship with OGC
Part III: CBI DM Program

The Basic Principles
Goals for Denials Management Project

• Develop a dual-function compliance monitor and performance measure to evaluate revenue cycle efficiency for national roll-out.

• Develop a standard operating procedure for monitoring insurance carrier explanations of benefits (EOBs), coordination of benefits, and claim denials.

• Utilize emerging technologies to analyze insurance carrier responses to claims and identify patterns of non-compliance billing activity and inconsistent payment trends.

• Establish an enterprise level compliance alert system to notify compliance officers of identified patterns, outlier claim denials/payments, and carrier offsets.
Denials Management: Linkage to Proper Oversight

• Medical Director’s (or CEO) Fiduciary Responsibility

• Internal Controls
  – Claims denials result from inefficiencies in core business processes
  – Business process outcomes can be affected using appropriate internal and management controls

• Policies & Procedures

• Communication

• Inappropriate Technology
CBI Laboratory Concept

- The VHA Compliance Office has partnered with The Veterans In Partnership Healthcare Network (Michigan, Indiana, & Central Illinois) to establish a Denials Management and Compliance Control Laboratory.

- Recruited a Network level auditor

- Senior Executive support: Denials Management and Compliance Control seen as a revenue enhancement tool.

- Initial analysis conducted at a single health system. Then expanded to include a total of 7 health systems (8 medical centers & 23 outpatient clinics).

- Using historical data to improve current operational performance.
The Six Sigma Approach

• Define
• Measure
• Analyze
• Improve
• Control
6-σ: Define Claims/Denials Universe

• Scope

• Standard Definition for a Denial

• “A claim submission, or line item on a submitted claim, that was not paid or for which payment was significantly reduced.”
6-σ: Measure – Volumetric & Financial Impacts, First Run Yield

• Assessing volumetric impact
  – Value
  – Baseline

• Assessing financial impact
  – Value
  – Baseline

• First Run Yield
  – Value
  – Baseline
6-σ: Measure – Key Business Metrics

- Cost-to-Collect
- Gross Days Revenue Outstanding (GDRO)
- Aging Accounts Receivable
- Uncollectibles as % of Gross Revenue
6-σ: Analyze - The 835 Transaction

- Analyzing 835s allows for systematic rollup of data previously gathered only through hands-on auditing.

- Analysis may be conducted virtually...the need for on-site review is greatly diminished.

- VA has received more than 5 million electronic remittance advice transactions from 124 payers.
6-σ: Analyze - Analysis Considerations

- Units of measurement - In a one-dimensional analysis, how do we sort the data?
  - Adjustment Reason Code
  - EOB Status (Denied/Processed)
  - Payer/Health Plan
    - Medicare or Non-Medicare Eligible?
    - Working Elderly? Federal Employee?
  - Clinic
  - CPT
  - Provider/Credentials
  - Etc. …
6-σ: Analyze – Reason Codes

- ANSI provides 206 adjustment reason codes for payers to utilize when adjusting the allowable amount or actual payment on a claim.

- Adjustments can be made at the claim level
  - Deductibles
  - Co-pays & Coinsurance
  - Out-of-Network Penalties
  - Policy Termed

- Adjustments can be made at the line level
  - Procedure code inconsistent with diagnosis
  - Non-covered charges
  - Payment included in allowance for another service
6-σ: Analyze – Reason Codes

• Reason Codes of particular interest
  – 96 Non-Covered Charges
  – 11 Diagnosis inconsistent with Procedure
  – 62 No pre-cert/prior authorization
  – 88 Collection against receivable created by prior overpayment
  – 100 Payment made to patient
  – 18 Duplicate claim/service

• Adjustment Reasons are accompanied by adjustment Amounts. By rolling up this data we can establish which reason codes are affecting our AR.
6-σ: Analyze – Code Mapping

• In most cases, the reason codes can be mapped to specific revenue cycle components. Thus, as we quantify reason code frequency, we quantify risk occurrence per cycle component.

• There are more than 500 ANSI Line Item Remark Codes that further define reason code assignments by insurance carriers.

• We are currently working to map sets of line item remark codes and adjustment reason codes using a Cartesian Key system.
  – (e.g. \{Reason,Remark\}="Coding")
6-σ: Improve - Infrastructure

• Although facilities had active Compliance & Business Integrity Committees served by executives and senior level staff, there was no forum for front line managers to address issues arising from compliance audits.

• Auditing & Monitoring Subcommittees were chartered. Recommendations are rolled up through the CBI committee to the hospital director.

• Critical Milestone
6-σ: Improve - Infrastructure

• Specific Charge:
  – Receive reports & recommendations from Auditor
  – Make recommendations to full CBI Committee relative to actions required to remediate compliance exceptions discovered during routine monitoring & auditing
  – Recommend unit assessments and internal control reviews
  – Monitor hospital actions in response to focused audits, indicator reports, control reviews & prove audits.
  – Identify & share best practices within the Network
6-σ: Improve - Infrastructure

• Membership
  – Hospital Compliance & Business Integrity Officer
  – Network Auditor
  – Hospital Revenue Coordinator
  – Hospital HIM Manager
  – Hospital Business Office Manager
  – Technical Advisor

• Result: effective solutions are developed…that unit level managers can “live with.”
6-σ: Control – Compliance Action Plans

• When systemic weaknesses or “barriers to compliance” are found the Compliance & Business Integrity Officer requires the completion of a service level Compliance Action Plan (CAP).

• Components
  – Education
  – Policies & Procedures
  – Systems Evaluation
  – Monthly Reporting

• Unit Managers responsible for implementing a CAP are required to provide documentation of completion of the unique requirements set forth relative to each component of the CAP.
Institutionalizing Denials Management

- Payer Mix
- Diverse Managed Care Models
- Culture of accountability
- Teamwork
Part IV: Data Mining & 835 Analysis
A Closer Look at the 835

• The 835 allows us to “roll-up” look at denials at the regional and corporate levels and illuminate respective areas of concern.

• Utilize latest business informatics technology and apply mining techniques to uncover hidden trends in the data.
DM Cubes - Goals

• Leverage the power of VA’s IT infrastructure to assist in enterprise-level analysis efforts.

• Provide real time indicators, snapshots, and dashboards for senior executives

• Event-triggered modeling reports to alert CBI officers of patterns of inappropriate billings/denials.
  – Fact Table: 835 Transaction
  – Dimensions: Time, Location, Insurance Type, Charge Type, Provider Type, Clinic, CPT

• Provide dynamic reports with granularity to the bill/SSN level
Warehousing 835 Data

• Link up 835 data with other stovepipe data sources
  – Procedure
  – Coding
  – Billing
  – Accounts Receivable

• Exporting Data:
  – Transactional vs. Static Database

• Bringing 835 data into VHA’s Data Warehouse
Data Mining and OLAP

• On-Line Analytical Processing (OLAP)

• Data Mining
  – Classification
  – Clustering
  – Association Analysis
  – Sequence Discovery

• OLAP is used to verify hypothetical patterns, while mining is used to uncover them.
Data Cubes

- The cube concept
- Slicing & Dicing CPTs, Providers, Clinics
- Drilling down to find causal factors
- Drilling through for case specific data
To-Be: Decision Support & On-the-Fly Reports

- Easy to learn and use
- Latest technology
- Users can create their own library of reports
- Assists in Probe Reviews
- Data piped in daily from EDI Clearinghouse

Web Reporting

OLAP

Statistical Analysis

Spatial Analysis
Critical Points

• Implementation of ERA allows for high level analysis of billing/payment patterns.

• Revenue Cycle Effectiveness Indicators

• Laboratory/Six Sigma Approach to Billing Compliance

• Utilize IT resources to automate whenever possible
Thank You!