Outpatient Oncology Revenue Capture

The Journey of Discovery

by Colleen Allen, R.N., M.B.A., and David Smeenk, M.S., R.Ph.

ILLUSTRATION/EYEWIRE

✔ Intervention Checklist

- ☐ Rejection process modified
- ☐ Administrative adjustment process changed
- ☐ Pricing adjusted when necessary
- ☐ Ongoing review/implementation of medical necessity rules (bill scrubber editor, Local Medical Review Policy, or LMRP)
- ☐ Physician and staff education rules disseminated
- ☐ Resource manager position established
- ☐ Financial counselor(s) increased
- ☐ Proactive outpatient (OP) structure supported
- ☐ Access to indigent programs promoted
- ☐ Medication use evaluation studies conducted

Under today's complex and changeable reimbursement system, too many hospitals are *not* billing for everything to which they are entitled. Many hospital staff members mistakenly believe that Medicare and private insurer rejections are a minor problem and too burdensome to track or appeal. Hospitals often are not able to keep up with rapidly changing regulations, coding, and billing procedures. The result can be catastrophic to a hospital's financial bottom line.

With the advent of the ambulatory payment classification (APC) payment system, medical necessity rules, and changing revenue and code requirements, the task of achieving a "clean" claim has become daunting. All the right information plus insurance verification and benefit coverage must be present to prevent claims from being rejected.

Each step of the revenue cycle, from registration to collection to posting the claim to the correct account,

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provides opportunities for errors. A system of checks and balances must be instituted, and a clinical review should occur before account adjustments take place.

To improve its own bottom line, the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (also known as "The James") developed a task force to investigate and improve how it recorded all revenues and reimbursement, tracked denials, and submitted claims for payment. The James, a Comprehensive Cancer Center in Columbus, Ohio, and a business unit of The Ohio State University Medical Center (OSUMC), is a freestanding cancer hospital with several hospital-based ambulatory clinics. The James provides a full range of oncology services that include research options in an academic setting.

Recognizing the Problem

In mid-2000, hospital administration was alarmed to find a rapidly deteriorating financial situation at The James. Operational realities were challenging the existing structures and processes involved in patient care delivery. A dramatic change from inpatient to outpatient care had occurred, shifting chemotherapy, lab studies, and other treatments previously administered in the inpatient setting to outpatient clinics. This challenged the existing support and clinical systems, which were not designed to capture the unique and required aspects of outpatient encounters.

Patient volume was escalating and treatments were becoming increasingly complex. There was heightened awareness of inadequate outpatient structure and resources. At the same time, expenses had increased dramatically, principally due to the high cost of chemotherapy drugs.

The hospital administration knew that potential revenue dollars were substantial and needed to be captured. Unfortunately, the hospital's financial systems, designed to track inpatient charges and encounters, were not flexible enough to adjust to changing outpatient/ambulatory demands.

In addition, the rules governing billing and claim submission and subsequent reimbursement had become more complex. Multiple monthly encounters with expensive treatments had to be tracked. Charges had to be accurate, the treatment plan had to be documented, and diagnostic codes to support medical necessity had to be assigned to produce a "clean" claim and optimize reimbursement.

Meeting these complex demands required finding personnel knowledgeable in oncology services, medical record coding, and the related regulatory requirements. Clinical competency in the outpatient setting (medication management and invasive line care, for example) was critical to coordinate safe patient care services with the complex treatments. The James required medical records professionals skilled in assigning appropriate cancer codes, and financial and billing experts who could modify existing systems to include these codes and other changes in reimbursement protocol.

On top of the need for additional resources, The James recognized that its systems and the associated support had to be redesigned. From pre-registration to payment posting, there were multiple opportunities for error. For example, gathering the information required for reimbursement, insurance carrier pre-certification, or primary physician referrals were complicating the pre-registration process. Errors on insurance forms were crippling bill submission and delaying payments.

The advent of APCs mandated highly specific code requirements on claims. Codes were often linked to support medical necessity; if one code was incorrect, payment was rejected. The claim then had to be researched for accuracy, changed, and resubmitted.

Addressing the Costs of Outpatient Drugs

The organization's expenditures for outpatient drugs were increasing alarmingly—from $1.4 million in 1998 to more than $9.3 million in 2001. A small group of administrative staff met to discuss and review reimbursement claims involving high-cost agents. An initial study identified five specific high-cost drugs used in the OSUMC system. Three of the five drugs were used extensively in the oncology population: paclitaxel ($1.8 million), epoetin alfa ($1 million), and filgrastim ($885,000). Two others—octreotide ($645,000) and pamidronate ($425,000)—were also recognized by The James as high cost agents in calendar year (CY) 1999.

For each of these drugs, an evaluation of the net gain or loss related to the patient's total account was conducted. Looking specifically at epoetin alfa, The James had a gain of $277,000 in revenue from the inpatient setting, but administering the drug in the outpatient setting produced a loss of $110,000. Because a gain in revenue had been expected from patients being treated in the outpatient setting, the finding was both unexpected and alarming. A drill-down by payer was conducted to determine if the loss was from a specific group, and a sample of patient accounts by payer was reviewed to determine the source of losses from that payer. Overall, the initial study indicated that reimbursement in general had fallen dramatically short of the billed amount on the claims.

Clearly, the hospital administration needed to focus on drug reimbursement. A task force was formed that included key personnel from the pharmacy, nursing, medical information management, the finance/business

What If Your Senior Staff Is Not Listening?

by Mary Lou Bowers, M.B.A.

EVEN IF YOU ARE NOT ABLE to get the attention of the senior administration, you can do a lot to improve your cancer outpatient program's financial results. There are three ways to make a difference: 1) increase your revenues, 2) decrease your costs, and 3) improve cash flow or bring in payments faster.

Increase your revenues by reviewing your chargemaster and making sure all billable items are accounted for. Review your charge amounts and make sure that the charge is sufficient to cover the cost of the treatment and provides a profit margin. Remember to include all costs, even those that are for bundled items and overhead. Overhead includes your department's needs, the hospital allocation, bad debts, and indigent care. When you know that your charges are adequate and you are set up to charge for every service you provide, then you should examine how your staff records the charges for their services. Periodic staff training is critical and can be done in your department. Make sure staff knows how each service they provide is supposed to be entered onto your encounter form (whether manual or electronic).

Decrease your costs by examining your operational processes. Are you maximizing the workflow and thereby the efficiency of your staff? If not, use your staff to help you improve the operation. Check the level of staff performing each function and evaluate the paperwork required and/or the entries on the screens that are needed. Small efficiencies do add up. These tasks are not new; but the day-to-day "stuff" often keeps us from getting a clear idea of how well our processes work. You will probably need to get other departments, such as admissions or medical records, to cooperate.

Clean billing means clean claims, which equals faster payment. Cash flow is important to the hospital. To find out if you have a cash flow problem, talk to the Patient Accounts manager. If you do have a problem, collect information on what types of errors appear on your claims and figure out a way to prevent them. Create a protocol for charge preparation and capture that can be easily followed and includes solutions to the problems you found.

If you examine these three parts of your program on a regular basis, you can identify areas in which you need help and improve your bottom line, even if the service staff is not as involved as you would like them to be.

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PHOTOGRAPH BY PHOTODISC

office, administration, value analysis, and resource management. Their number one priority was to scrutinize outpatient/ambulatory claims involving high-cost agents and discover ways to increase revenue capture and optimize reimbursement.

The task force met biweekly, and researched the current claim process, medical necessity rules, coding requirements (including "bill scrubber" and payer expectations), and cost-to-charge ratios. It created an action plan that provided both immediate "quick fixes" and a proactive, long-term redesign of the system. The focus was on teamwork and education.

The Discoveries

One of the first steps taken by the task force was to find a way to measure whether its actions were effective. To do so, it identified a number of key financial indicators, including the percentage of claims rejected by bill scrubbers, days in accounts receivable, administrative adjustments, and cash receipts.

When task force members reviewed the current claims process and discovered the complexity of creating a clean claim, submitting it for payment, and tracking the payer's response, they were shocked.

Documenting medical necessity was an area that needed significant improvement. First, physicians had not been educated about documentation requirements nor was there a process to explain medical necessity documentation for specific patient accounts. When the task force investigated, it found that few members of the staff understood the medical necessity rules and local medical review policies.

Second, when medical necessity rejections were returned to the medical record coders for other required diagnostic codes, the claims were often returned with no changes. Questioned charges were removed and the "stripped" claim was resubmitted for payment. Clinical review was not a part of this process. Physicians and administrators were not aware of the problem, and the revenue lost as a result of such practices was extensive.

In addition, no one had been tracking rejection reports or reporting them to administration.

Coders, highly educated about inpatient care, were less familiar with outpatient, oncology-specific coding and medical necessity rules. The rules were changing rapidly and the organization lacked the communication network to keep key stakeholders current.

Task force members also learned that all claims were being passed through a bill scrubber, a commercial software program that screens claims for correct entries in certain fields and applies medical necessity rules that are payer dependent. The bill scrubber was rejecting a staggering 37 percent of the claims it reviewed. The task force identified a number of reasons for these rejections, including incorrect revenue codes and the fact that information included in the electronic medical record was not

being referenced when the record was coded. Additionally, the company that created the bill scrubber had not updated the system to include the expanded medical necessity regulations and the newest codes found in the local medical review policy in a timely fashion

Figure 1. Cash Receipts (in Thousands)

Quick Fixes

The task force developed an action plan with a timeline and identified immediate quick fixes, such as correcting revenue code errors, reviewing accounts for medical necessity documentation and resubmitting claims when possible, and making sure the bill scrubber vendor updated the medical necessity codes in a timely manner.

All claims rejected for lack of medical necessity received a clinical review, which included a search for appropriate documentation. No charges were removed from accounts until the clinical review was finished. Accounts that required interventions were tracked, reimbursement collection was logged, and bimonthly reports of these results were sent to administration and members of the health care team.

In addition, the task force started a campaign to educate the coders and the medical staff about medical necessity rules. Laminated cards with information on medical necessity documentation requirements were created and distributed to everyone who came in contact with claims.

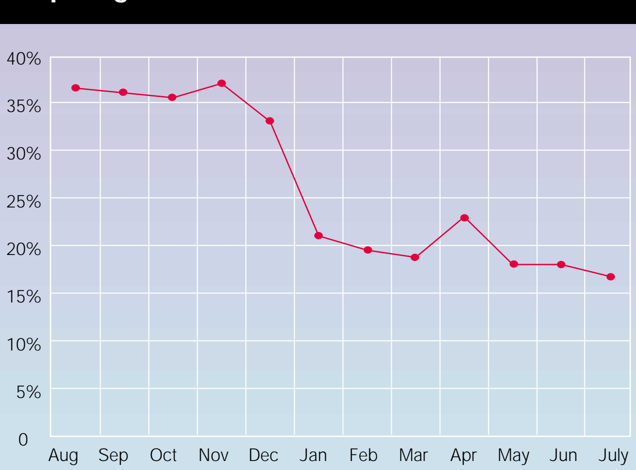

Figure 2. Percent of Bill "Scrubber" Accounts Requiring Intervention FY00–01

Long-Term Changes

The task force had a number of recommendations to improve reimbursement and claim processing, including:

- hiring a resource manager to conduct clinical reviews of the claims that were rejected by payers for lack of medical necessity
- adding new medical necessity criteria and coding requirements to the bill scrubber as soon as they became available
- identifying patient assistance programs at pharmaceutical companies to cover the cost of drugs for indigent patients or those who did not have insurance
- sending monthly reports of key indicators to administrative leadership, the governing board, and health care team members.

The task force has been in operation since May 2000, and within the first six months captured $270,000 in additional revenue. Each month, revenue capture expands. The current tracking and intervention systems have generated thousands of dollars of additional income and potential losses have been avoided (See Figure 1). More clean claims are produced and the number requiring rework has declined.

Gross days in accounts receivable has dropped from a high of 118 in FY99 to 78 in FY01.

Administrative account adjustments fell sharply from 2.49 percent in FY 00 to 1.79 percent in FY 01, reflecting accounts with charge adjustments that are not predetermined by contract.

Finally, the percentage of bill scrubber accounts requiring intervention dropped from 37 percent in August 2000 to 16 percent in July 2001 (See Figure 2).

By implementing the system changes recommended by the task force, administration has clearly helped control financial losses and dramatically improved the bottom line.

Lessons Learned

The James Cancer Hospital has learned a great deal from its experience.

First, internal resources to identify problems and find solutions were available within the organization; they just needed to be tapped. At the same time, we found that internal systems and associated inadequacies were far more obstructive than any external forces. Changing the system required being objective and honest about these obstructions. Although the staff was committed to

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providing good oncology care for the patients, people who were too close to the process did not see its problems or the opportunities for change.

Second, we learned the value of communication. Members of the task force realized that it was critical to share the important messages that emerged from task force meetings with other parts of the organization. Information was communicated via e-mail between quarterly meetings, and stories were shared via regular updates throughout the organization.

Third, the organization began to acknowledge the importance of registration, insurance benefit coordination, pre-certification, medical records, and claims management because they became more visible during the task force's exploration of reimbursement and revenue capture. As these areas were brought more fully into the organization's culture, their focus changed from pure finance to finance plus patient care, which is where they have remained. Now all our functional areas share the goal of providing good oncology services to those in need.

Fourth, the "blame-free" approach was essential. When problems were discovered, the people or departments were not blamed, but were engaged in the process of finding ways to improve performance. Education and counseling were provided, if necessary, and success was applauded. During meetings, statements that could have been perceived as accusatory were actively redirected into more constructive channels, and producing blame-free expectations became one of the ground rules for the task force.

Fifth, administrative endorsement was critical. Administration sent a clear message that the work of the task force was high priority and essential to the organization's financial health. Managers were asked to provide staff time for tasks associated with the initiative; they gave it. In fact, managers shifted their priorities and reassigned work to allow their staff members to perform tasks associated with the initiative. (These requests were made thoughtfully, so no one department would be overburdened.) Although the task force was empowered to conduct evaluations, redesign processes, and request resources, it kept administrative leadership informed of progress and the resources it had requested.

Finally, public recognition of success sends a powerful message. The Oncology Roundtable asked The James to provide information about this revenue capture initiative. Members of the task force were interviewed, and The James' efforts were written up and published as a "Best Practice." This type of recognition motivates and rewards participants. The James' board also applauded the initiative and thanked everyone involved.

The cancer center continues to monitor its charge capture processes and measure outcomes on a regular basis. Thousands of dollars of lost revenue are converted to reimbursement every month, bill scrubber rejections continue to decline, and cash receipts are up. Hard work by the multidisciplinary task force has succeeded in significantly enhancing revenue capture.

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