Case Studies in Transaction and Code Sets Implementation and Compliance

Intermountain Healthcare

Jim Whicker, CPAM
Director of EDI
Revenue Cycle Organization
Intermountain Healthcare

Expected Major Provider Benefits

(S Lazurus - Boundary Information Group – 2000)

- Reduce staff in business office and registration
- Reduce IS support for interface engine and EDI communication
- Reduce staff that manage enrollment, referral, and eligibility phone and paper
- Collect at time of service; health plan and sponsor payments within ten days.
- Reduce bad debt
- Protection of your information resources
- Standard security/privacy policies and procedures

Intermountain Overview

- 24 Hospitals, 150 Primary Care Clinics, Urgent Care Facilities, over 800 employed physicians, home health, DME, IV Therapy, etc.
  - 4 A/R Systems – Hospitals, Medical Group, Home Care and Central Lab
- 85 percent* of claims sent via 837
  - Exceptions:
    - COB!
    - Workers Comp
    - P&C
    - Miscellaneous Payers
- 87 percent* of payments received via 835
  - Same exceptions
  - Most do EFT
  - Exclude Workers Comp, P&C, Auto, etc – over 95 percent electronic

  - *Hospital System totals

Intermountain Overview

- 99.9 percent of payers billed electronically send Eligiblity – vast majority Real Time.
- 60 percent of payers use an unsolicited 277 claim acknowledgement transaction
- 2003 - seven FTEs were reassigned who were performing pre-HIPAA EDI tools.
  - Many FTE's reduced in posting – not tracked
- A/R days are at or near the lowest in history
  - (well – until the economy tanked!)

Intermountain Overview

- Eligibility
  - Hospitals - Automated at time of registration and on demand
  - Medical Group – 4 days before appointment and on demand
- EDI Cash Posting centralized
  - 6 FTEs for 24 hosptials
  - Adding 1 now
- COB data integrated automatically into secondary claim IF payer can take COB data.

What did we gain that we didn't expect? What gains were greater than expected?

- Fewer lost transactions
  - Automation of acknowledgement process
- Cleaner claims
  - Transaction validation
- Cleaner claims
  - Quicker turnaround on adjudication – CA$H!
- Tracking of reject reasons
  - Improvement in front end data collection and edits
- More standard requirements by payers
  - Fewer rejections
- Payment database
  - Improved contract monitoring
  - Improved denial tracking, trending and data comparison
  - Contract recoveries
  - Improved "case mix" data content – quality and quantity
    - Improved identification of "who paid"
    - Denial reasons
- EFT
  - Reduction in resources for deposits, encoding of checks
  - Improved "float" on cash (limited)
- Improved point of service data available to assist in financial decisions
  - Year-to-date, lifetime, remaining, etc.
- Reduced complexity of provider enrollment, identifiers, etc.
- Linking of payer ICN/DCN
  - Automation of status queries
  - Re-direction of pending claim work
  - Cleaner "correction, void, replacement" processing
  - Improved hit percentage for status inquiries
- Payers who implemented COB correctly – process is SLICK

Disappointments?

- Acknowledgement (277CA) not mandated – 4010 OR 5010
- Poor mapping of Group and Adjustment codes in 835
- Lack of implementation of 835 Remark Codes by payers and practice management systems
- EFT – many payers will not send
- Confusion on how to create "addenda" in CCD+ ACH transactions
- Incorrect implementation of 835 correction and reversal process
- Out of Balance transactions
- Lack of "plan identification" in 271 and 835
- 277 Data quality
- 271 Data quality (great improvements for many payers)
- Excessive usage of MSG segments
- Lack of COB implementation
- Preferential treatment of paper claims/web access rather than for electronic transactions*
- No Attachments
- No national Payer ID
- Lack of communication standards or trading partner "directory"
- Lack of data validation by trading partners
- TP changes without testing
- Being TP QA department
- Companion guides – having to "customize the standard" payer by payer
- Confusion on HSA's
- Out of State Medicaid
- Payer Websites
- Institutional vs Professional claim conundrum
- Auto and Worker's Comp exclusion
- 837 "batch" generally held for day end processing while manual data entry receives immediate, real-time response
- Internal code lists
- My vision of sitting in a hammock on the beach, umbrella laden refreshment in hand monitoring claim acceptance and claim payment has not arrived.

Recommendations to Improve ROI (WEDI – NCVHS 2006)

- Reduce variability between payers and providers as much as possible.
- Develop an industry-wide standard for positive or negative acknowledgement of a claim.
- Create cross-industry support for using standard development organizations to resolve content and usage issues and to improve communication.
- Finish the roll-out of current HIPAA transactions before adding complexity.
- Take new transactions through a proof of concept process prior to adoption.
- Any national information technology standard should use the same road map.
- Resolve lingering payment issues of payment eligibility and claims status transaction.
- Adopt a national payer identification.
- Simplify set up, communication, speed of response to transactions, quality data and mapping codes.
- Clarify what constitutes an institutional versus professional claim.
- PM Systems better integrate transactions into processes

Thank You!

Jim Whicker, CPAM
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Jim.Whicker@iMail.ORG