Show Me the Money

10 Ways Texas Tech Physicians is Improving Its Revenue Cycle

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Executive Associate Dean, School of Medicine
Chief Executive Officer, Texas Tech Physicians
VISION
Texas Tech Physicians of Lubbock will be a top-tier medical practice nationally recognized in quality patient care, satisfaction and value.

MISSION
LUBBOCK
Texas Tech Physicians
IMPROVE THE HEALTH OF PEOPLE WE SERVE WITH A SPIRIT OF COMPASSION AND KNOWLEDGE.

OUR VALUES
ONE TEAM
KINDHEARTED
INTEGRITY
VISIONARY
BEYOND SERVICE

PATIENT SATISFACTION
QUALITY MEDICAL CARE
FINANCIAL PERFORMANCE
EMPLOYEE SATISFACTION
BUSINESS GROWTH

IT ALL STARTS WITH YOU!
The pillars of revenue cycle performance

**Speed to collect**
How long does it take to collect, as measured in AR days?

**Net Collections**
How much of your adjusted charges are you actually collecting?

**Cost to Collect**
How much do you spend as an organization collecting what you’re owed?

**Utilization**
Are you maximizing provider schedules and clinic resources?
Implemented Dashboard

• The purpose of this dashboard is to provide the different locations of Texas Tech Physicians (TTP) with clinical data for reports, record keeping, tracking, and other management duties. These reports provide a quick, comprehensive look at their performance from a daily scale to monthly.

• Focus on 3 main categories of the Invoice Transaction data that comes from Informatics: Charges, Collections, and Write-offs Missed Revenue

• We have designed a system that routinely receives these files and imports them into our application where they are displayed in easy to manage sections of the dashboard.
Implemented Dashboard

• This offers all of the locations the ability to be as granular or wide-cast as they wish to be when looking at their invoice transaction data derived from Informatics.

• Without this dashboard, they would all need to log into Informatics, run daily reports, then perform a thorough analysis of hundreds (often thousands) of records to get close to the level of accurate and readily available display that this dashboard provides.
### Charges by Provider

**ACHARJI MD, SUBASIT**

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<tr>
<th>Payor Type</th>
<th>Charges by Provider</th>
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<tbody>
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*Figures represent charges by provider over the months from February 2016 to January 2019.*
Monthly Missed Revenue

$0.48M

Missed Revenue for January 2019

- Anesthesiology
- Dermatology
- ENT
- Family Medicine
- Internal Medicine
- Neurology
- OBGYN
- Ophthalmology
- Orthopedics
- Other
- Pathology
- Pediatrics
- Psychiatry
- Surgery
- Urology

TBD

Payer Type

Feb 18, Mar 18, Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19
2 Pre-Visit Workflow

• Pre-visit Workflow
  • Why?
    • Patients are most engaged with their healthcare provider prior to and during an appointment.
    • Offices represent a low cost option for collecting patient responsibilities and obtaining critical information necessary for billing
  • What?
    • Build a workflow to track specific issues requiring resolution and seek out resolution prior to and during the appointment rather than afterwards.
    • Work on the exceptions – not on every appointment. By using what we might know about the patient – or what we already know is missing and needed – we can provide follow on the important tasks.
Pre-Visit Workflow

• Pre-visit Workflow
  • How?
    • Company specific edits are designed based upon need – here are just a few examples:
      • Insurance Coverage – also called Eligibility information
      • Minor or Invalid Guarantor Information
      • Bad Address
      • Special Needs
    • Edits designed to hit 10 days prior to scheduled appointment
      • Prior to the appointment edits can be pursued by staff to update the information on the patient’s account
      • On appointment day unresolved edits can be worked by the department during patient visit either during the check in or check out process
Pre-Visit Workflow

• Increased POS Collection
• Decreased Self-Pay A/R
  • Reduced cost for Self-Pay collections
    • Self Pay Follow up staff cost
    • Statement cost
    • Collection agency cost
• Reduced Eligibility Denial Rate
  • Reduced Self-Pay follow up that results in obtaining corrected insurance information
• Increased Reporting
  • Department specific performance data
• Increased Accountability
  • Understanding resolved versus unresolved task volume helps to hold the Practice team accountable
• Overall Value is in engaging patients to deal with known issues when they are most engaged
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Inpatient Denials

• Medicare inpatient denials are our largest source of denials by dollar amount
• Many of these Medicare denials resulted from being sent to the wrong payor (ex. Aetna Medicare patient registered as Traditional Medicare patient)
• TTP workflow to correct these claims before they are sent to the payor
Denials by location
Inpatients from a partner hospital are assigned an insurance FSC.

Texas Tech Physicians translates “hospital” FSC to TTP FSC.

Proper FSC

Group Eligibility Request Definition (GERD)

- Yes → Bill
- No → Non-manual

Non-manual:
- Business Office for manual intervention
- Clinics to handle patient specific data

Resolve → Bill
• Helps medical groups, health systems, and payers leverage patient intake to achieve their strategic objectives.

• Intake management system for over 70 million patients annually through a platform of applications, including patient registration, revenue cycle, clinical support, appointments, and patient activation.

• Use medical histories, insurance benefits, socio-economic indicators, and other demographics to gather important data and engage patients in their care.
“We can use Phreesia technology to ensure that there are guardrails in place for best practices and hold our staff accountable.”

“We can get clean and validated patient information into IDX, our system really needs a clean up.”

“We won’t have to wait for a credit card machine to be freed up for a payment, each of the pads have their own swipe, that’s lots more people making payments all at the same time, collecting more and using less resources.

“What a timesaver!...We can manage all our forms, have them signed and automatically store them ....do you realize how much time, paper, costs we could cut out?”

“We can improve the speed of the check in and increase patient satisfaction by only focusing on what’s needed to collect for that visit. No more asking a patient to sign something twice or enter in their demographics more than once.”

“We can improve employee satisfaction by taking work off the front desk and moving it to the patient. We can also take the heat off of them having to ask for money which most people innately don’t like to do”

“We can gain patient satisfaction by allowing patients to pay in the privacy of their own chair and self-select a payment plan that is comfortable for their budget.”

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**Speed Up Throughput and Improve Workflow**

**Increase Collections**

**Improve Patient Satisfaction**

**Improve Employee Satisfaction**
Patients Use These:

AT HOME OR ON THE GO
Desktop, mobile

AT LOCATION SITES
PhreesiaPad

Staff Use These:

AT LOCATION SITES
Phreesia Dashboard

AT LOCATION SITES
Texas Tech

Real-time Integration

Electronic Documentation

Patient Administration System

Texas Tech Technologies

Payers

Payment Networks

HOW DID WE OVERCOME CHALLENGES?

2018 Phreesia Confidential Information
5 PRODUCT CATEGORIES WITH MULTIPLE APPLICATIONS

Appointments
- Online appointments
- Referrals
- Appointments queue to track requests

Revenue Cycle
- Insurance verification
- POS payments
- Card on file with Payment Assurance
- Payment plans
- Online payments

Registration
- Mobile and in-office registration
- Specialty-specific workflows
- Consent management
- Registration Dashboard

Clinical Support
- Clinical screeners for 25+ specialties
- Behavioral health screeners for primary care

Patient Activation
- Patient surveys
- Service-promotion messaging
- Branded patient announcements
- Preventive-screening outreach for Medicare

Real-time integration with leading PMs and EMRs
Robust analytic tools
Reliable and Scalable Platform
Commitment to privacy and security
PATIENT SATISFACTION RATES | JANUARY 2018 – NOVEMBER 2018

19,331 surveys completed = 83% Patient Satisfaction!

81%  82%  82%  83%  83%  82%  85%  84%  83%  83%  85%

Satisfied %
There are currently seven clinical departments using 3M for coding purposes. Since 3M’s inception, 23,210 man-hours have been spent working in the program; touching 452,150 notes and approving 335,222 notes for charges. The School realized an increase in higher level of E/M services for Jan 18 to Dec 18 of 12906 notes, resulting in $4,270,423 in charges and $1,586,157 in collections. The average notes per hour worked for the twelve-month period was 14.443; the fastest coder in the system coded 58.907 notes per hour. The largest volume of notes coded was a coder in OB/GYN; coding 17,708 notes.

CodeMonitor went live on Friday, February 1. With the departments’ assistance of provider specific criteria, clinical notes will flow directly from 3M to TES, without coder assistance. This will expedite the process of sick and routine clinical visits, reducing the number of notes a coder works in 3M.
- 21% increase in inpatient coder productivity
- 15% increase in outpatient coder productivity
- 74% increase in professional fee coding productivity
- 64% increase in use of auto-suggested codes
- 4% decrease in outsourced coders no longer required
Service to post
Coding

- Volume over time
- Quality of coding compared to documentation

Encounters
- Day
  - % of encounters coded correctly
Lockbox

• Electronically posts payments that were traditionally done by paper.
• Turn all our paper payments in an 835 files for electronic posting.
  • All the paper checks and EOB we used to post manually auto posts.
  • About 80-85 percent auto posts with no human intervention.
• All of our correspondence is now digital making management of our mail much cleaner.
• Having digital copies allows us to better track work completion and assignments.
• Also provides AR great electronic resources when following up on denied claims.
• Overall Time saver / improved accuracy.
Reorganized Denial Team

• Organized our teams to work by denial type/category
• Working by denial has allowed us to better assign based off the difficulty of the work
  • This helps when bringing on someone new as we can give them easier work as they are learning and the more difficult work to the experienced person.
  • Previously new employees were assigned everything for a particular clinic for their payer group (such as Medicaid) no matter how easy or difficult the work was.
  • Has also made work quicker as employees tasks are very similar allowing them to gain efficiencies.
• We rotate the assignments on each team quarterly
  • This helps provide a little peer pressure as employees know that their work file will be handed off to the person next to them in three months
  • It also give a fresh set of eyes and we have had some employees come up with some time saving ideas as they switch workflows.
Self-Pay

**Budget plans**
- More flexible budget plans that will allow patients to pay us while juggling other bills and prevent people who want to pay from going to collections.

**Expanded discount program**
- Provide self-pay discounts at time of services and shortly after first statement.
SPARC-Supporting Provider After Recruitment Care

What is SPARC?
• SPARC is a provider onboarding program with the ultimate goal of increasing revenue by helping providers to start seeing patients quicker. This includes careful monitoring of enrollment process.

How to Achieve that Goal
• Our team created a comprehensive and interactive checklist that was vetted by Human Resources, Faculty Affairs, the EEO Office, Enrollment, Credentialing, and the Clinical Departments. The list is set-up in a way to maximize efficiency and includes contact information, plus tips and tricks to expedite the onboarding process. The list is updated monthly and departments are highly encouraged to utilize the list.
Electronic Statements

- Patients will be able to see up to date balances online.
- Patients will have the ability to make budget plans online any time of the day within the terms that we set.
- Patients can choose to get electronic and/or paper statements.
- Will be able to do credit card on file payments currently patients have to call every month to make a payment on their budget plans.
- All payments will come back in an 835 file for electronic posting.

Coming this summer
Using 2006 as base year, when we collected $42.8 million, we have grown to $78.7 million in 2018.

Net collections up 5.4% from FY17 to FY18.