

# Reducing Outpatient Coding Rejections

SHS Annual Conference

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MedStar Health

# Agenda

- Background
- Current State
- Opportunities
- Future State
- Results
- Next Steps

# Our Organization

## MedStar Health

- 9 hospitals and other businesses
- \$3.9 Billion annual revenue
- 1.2 million annual OP visits
- 26,000 associates
- 5500 affiliated MD





## Good Samaritan Hospital

- Urban community hospital
- \$450 million annual revenue
- 140,000 annual OP visits
- 2,400 associates
- 39,467 CMI Wt Adj Discharges

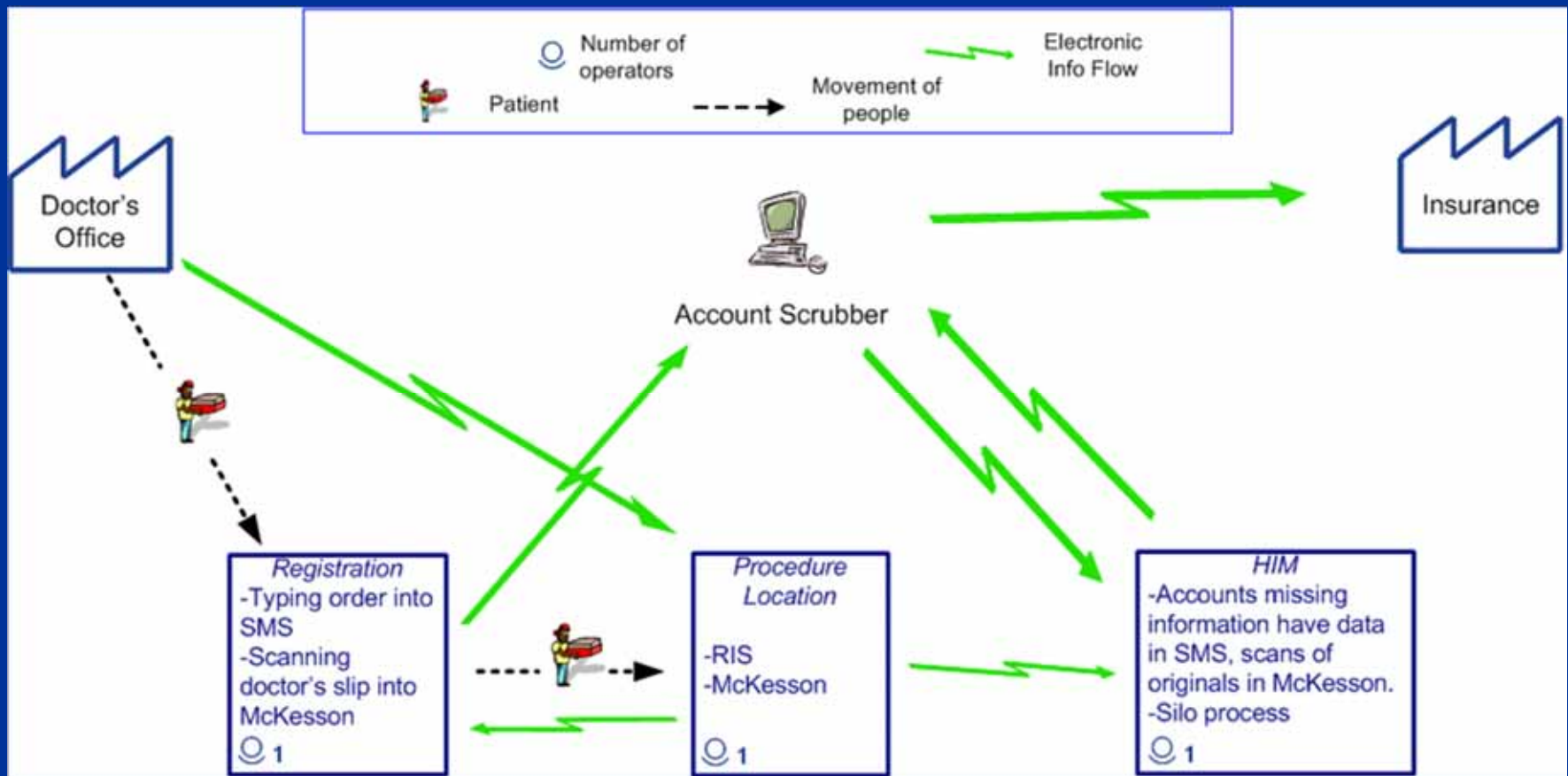
# Project Background

- Goal: Identify causes of coding rejections resulting from patients initially presenting to registration and begin corrective actions to eliminate 80% of them
- Multidisciplinary Team including Registration, Coding, Imaging, and Finance
- Scope: Patient is scheduled for an outpatient service or procedure to payment of bill. Exclude ED, Ambulatory Surgery, Observation, Wound Healing, and Sleep Study patients

# SIPOC

Suppliers	Inputs	Process	Outputs	Customer
List the suppliers of any inputs to this process	List the inputs to this process	High level process map (30,000 feet)	List the outputs of this process	Identify the customers of these process outputs.
Doctor's Office	Script for procedure or diagnosis	<div style="border: 1px solid black; border-radius: 15px; padding: 5px; text-align: center;">                     Doctor writes manual script                 </div>	Potential write-off account list	HIM/Finance
Registration Staff	Additional data fields within hospital IS used for registration	 <div style="border: 1px solid black; padding: 5px; text-align: center;">                     Registration clerk enters patient data into HIS                 </div>	Patient record	Hospital IS
Patient	Patient information	 <div style="border: 1px solid black; padding: 5px; text-align: center;">                     Patient testing is completed                 </div>	Complete Claim	Insurer
		 <div style="border: 1px solid black; padding: 5px; text-align: center;">                     HIM performs any rework needed to complete claim                 </div>		
		 <div style="border: 1px solid black; padding: 5px; text-align: center;">                     Billing sends Medicare / Private Insurance the patient bill                 </div>		

# Current State Process Map



# Current State Statistical Analysis

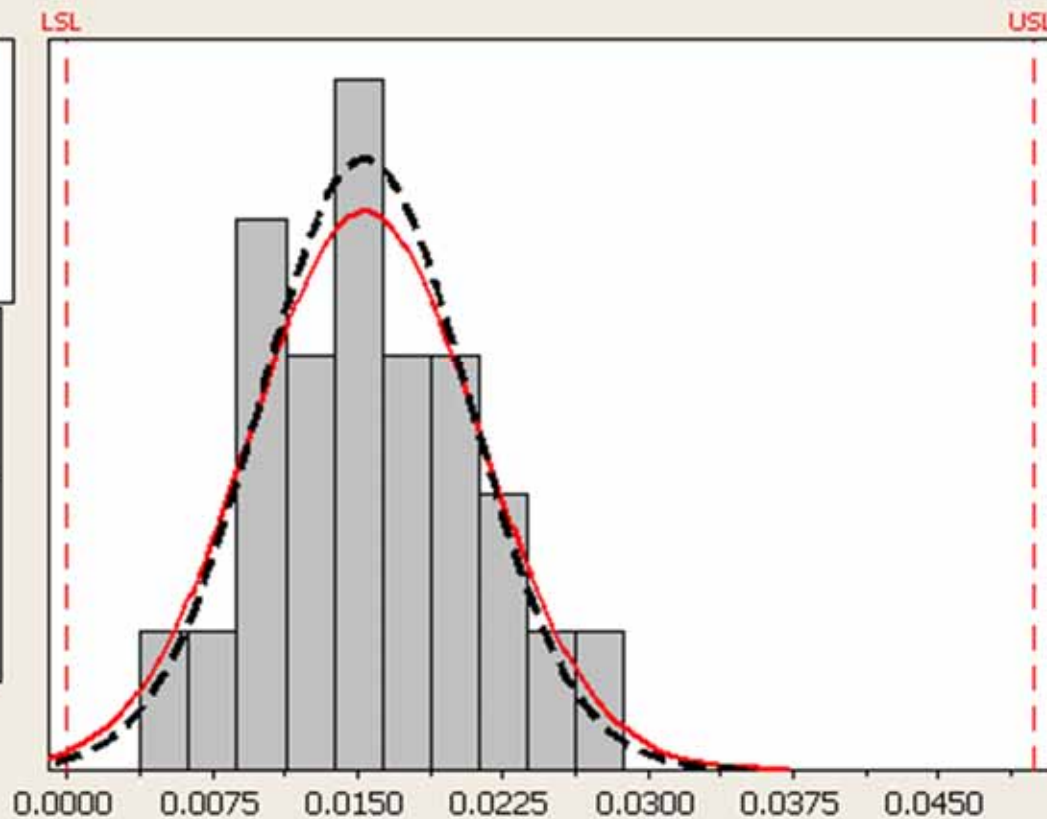
Error Rate per Week Before Implementation

Process Data	
LSL	0
Target	*
USL	0.05
Sample Mean	0.0153396
Sample N	24
StDev(Within)	0.00590929
StDev(Overall)	0.00539807

Potential (Within) Capability	
Cp	1.41
CPL	0.87
CPU	1.96
Cpk	0.87

Overall Capability	
Pp	1.54
PPL	0.95
PPU	2.14
Ppk	0.95
Cpm	*

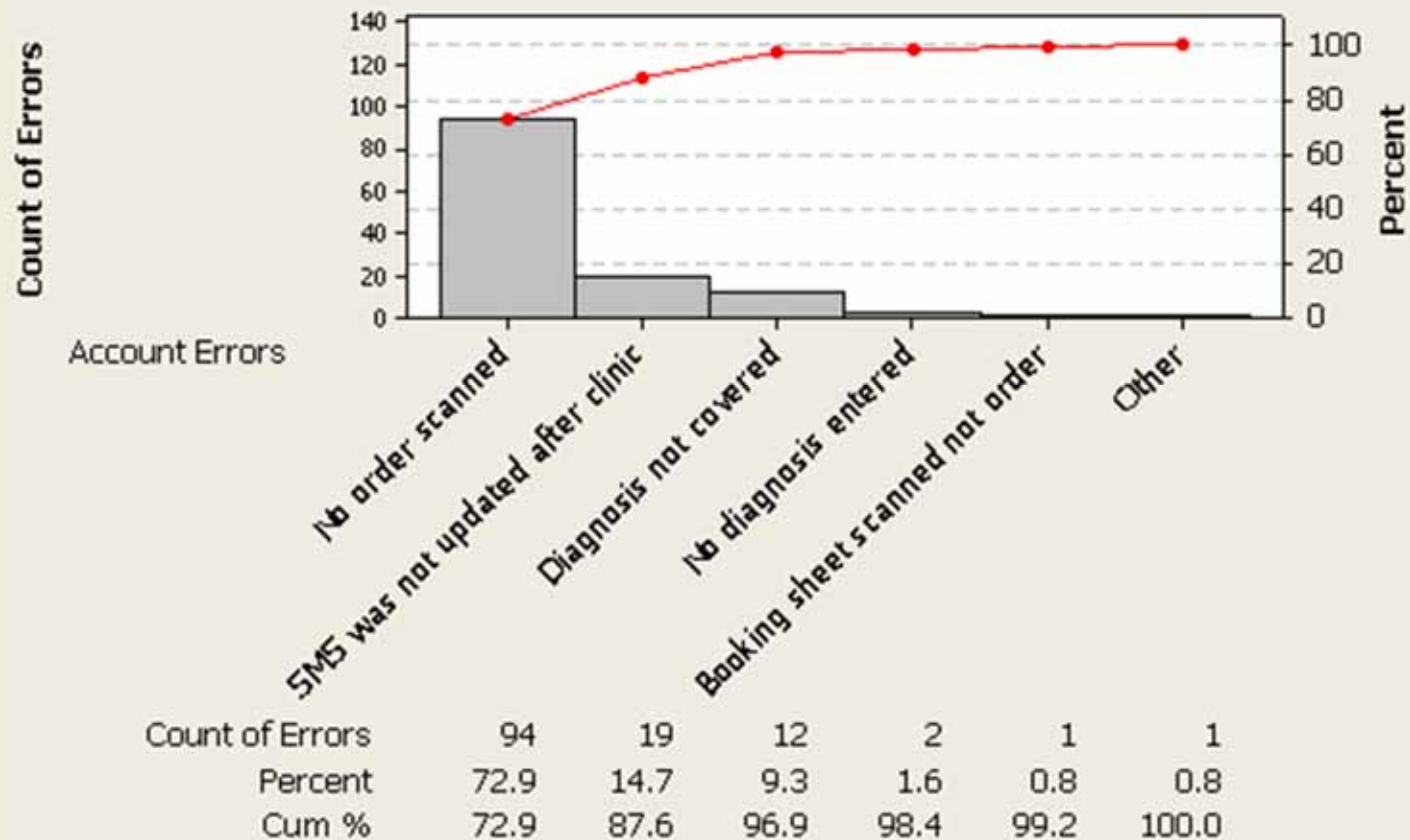
	Within
	Overall



# Patient-Level Data Study

97 Accounts in April 2011

Pareto Chart of Account Defects Leading to Denied Claims

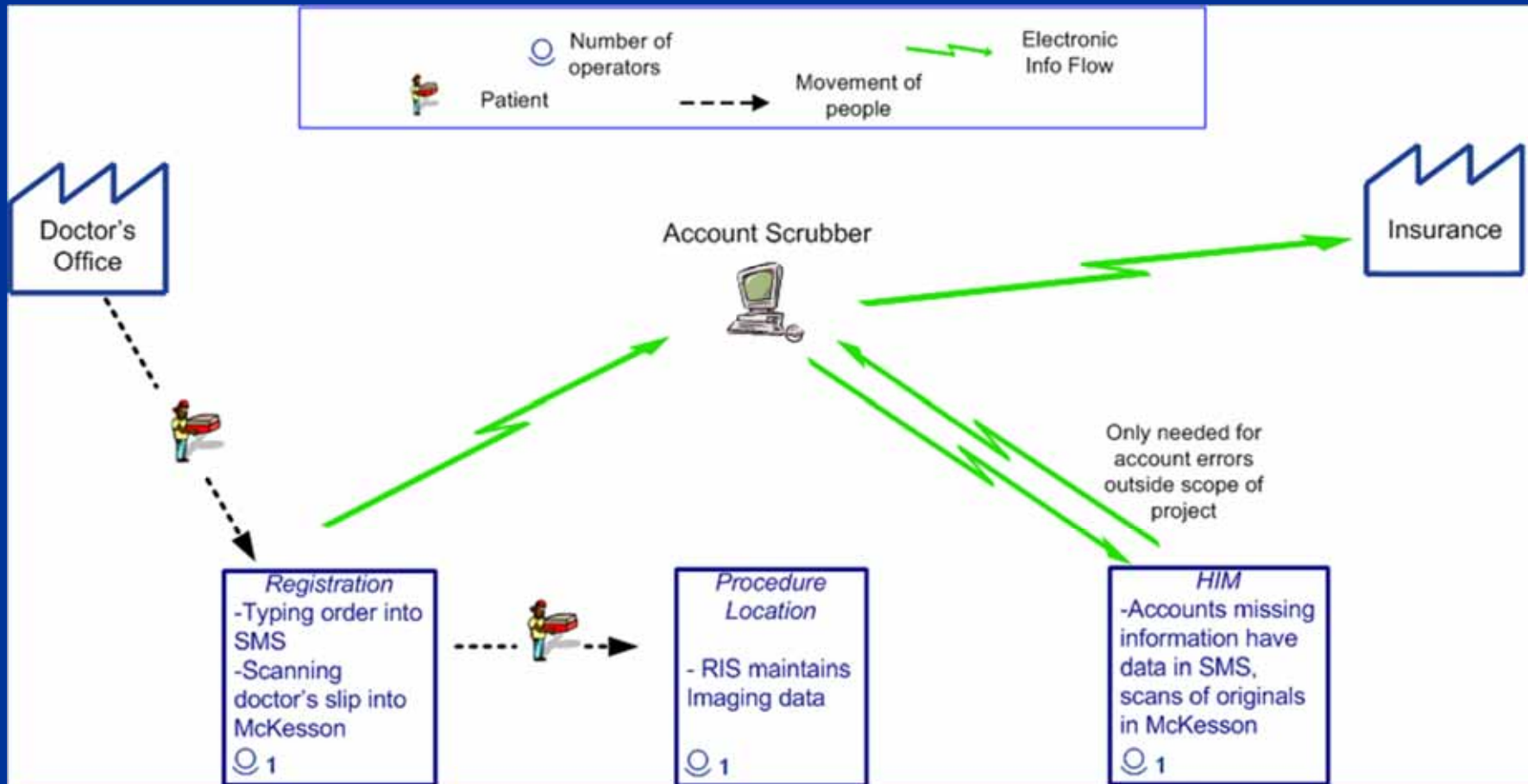


# Opportunities

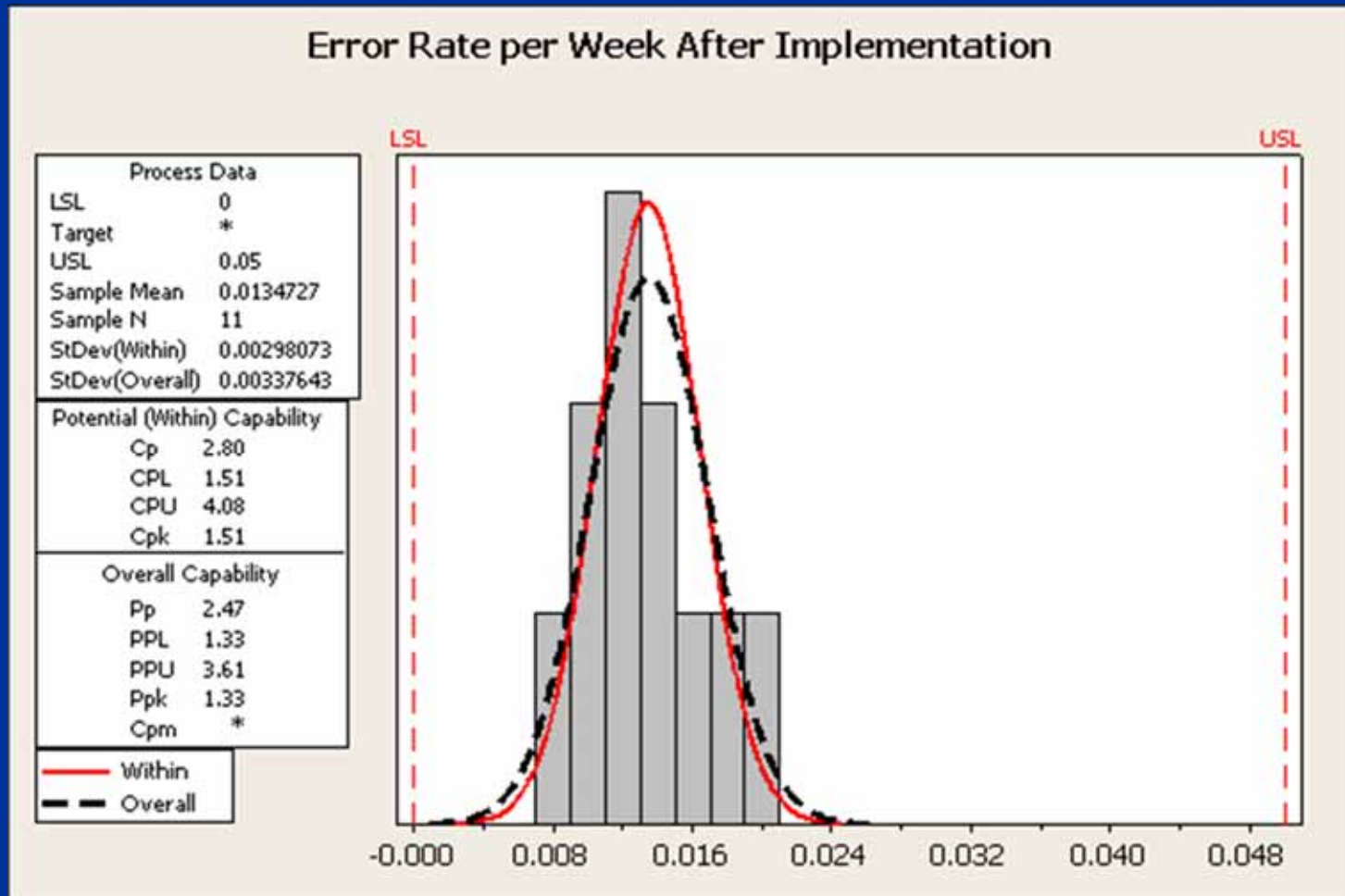
- Change policy for procedure visits: Registration clerk calls procedure location and receives fax with updated information before patient registration is complete
- Create standard work for registration staff
- Fix broken scanners at registration desk
- Create report of registration errors which runs at night and is worked the next morning
- Change policy of specialist MD office regarding updating patient diagnosis

Future Intervention: Share reimbursable diagnoses with primary care MD group

# Future State Process Map

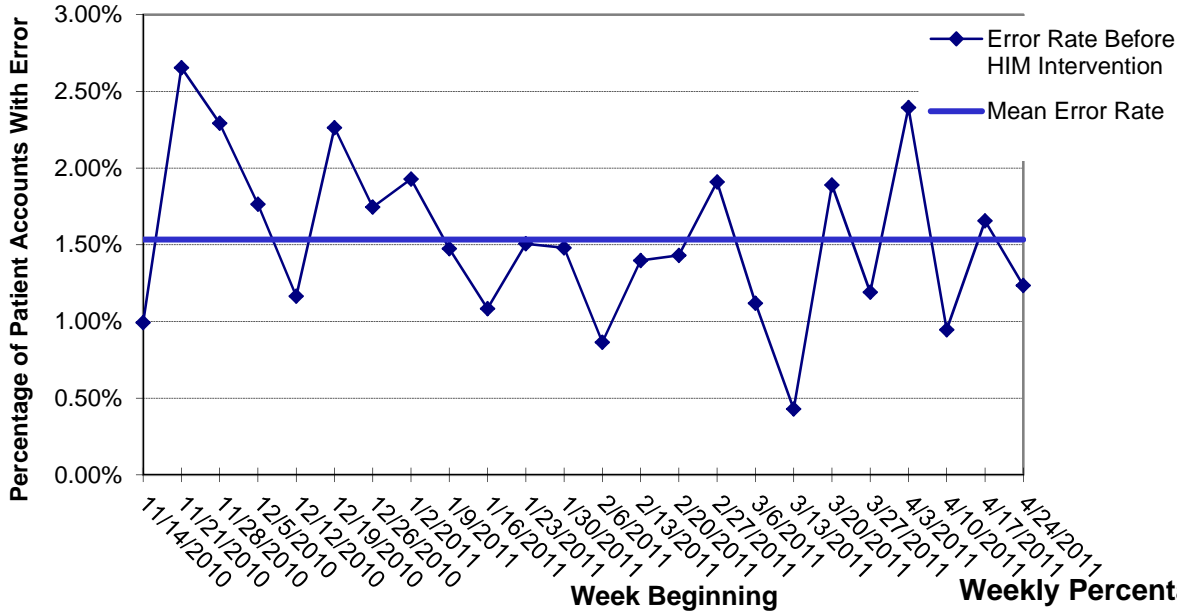


# Results – Post-Intervention Performance



# Process Statistical Analysis

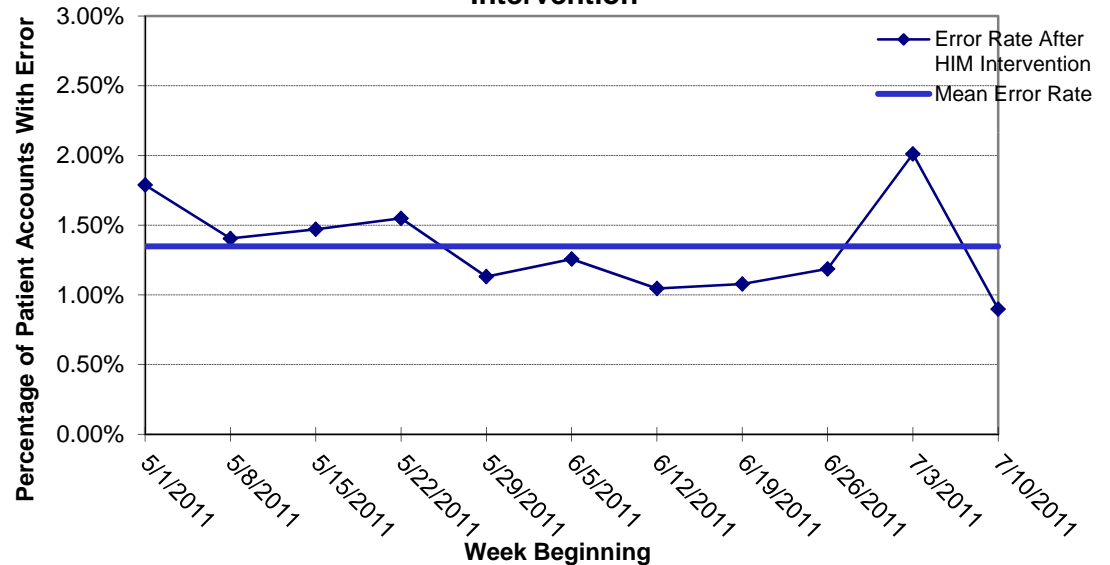
Weekly Percentage of Patient Accounts with Errors Before Intervention



Pre-Intervention  
Mean: 1.53%

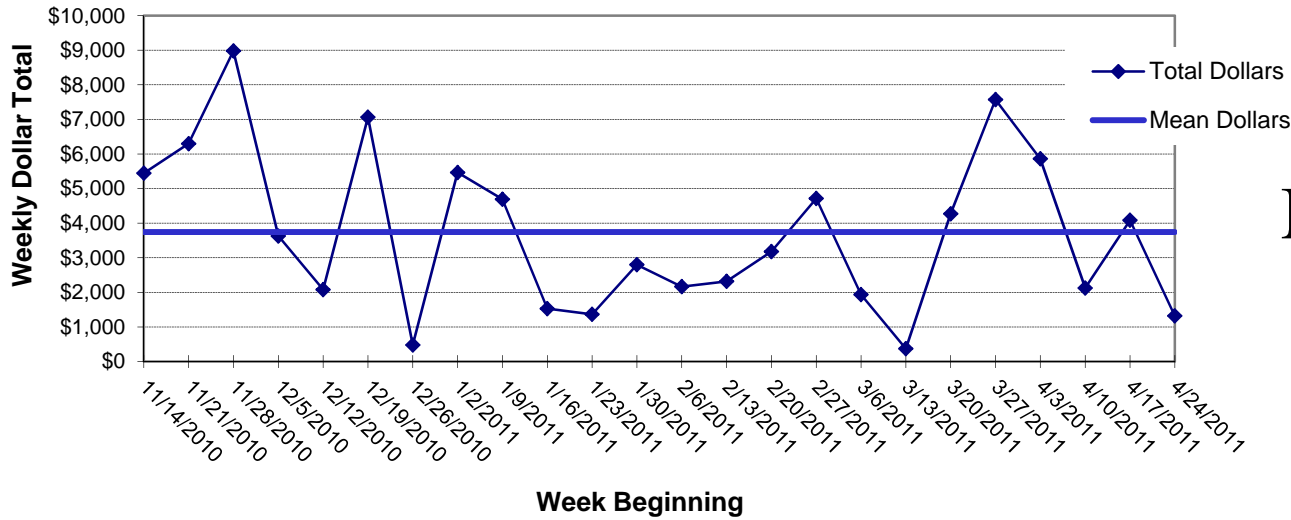
Post-Intervention  
Mean: 1.35%

Weekly Percentage of Patient Accounts with Errors After Intervention



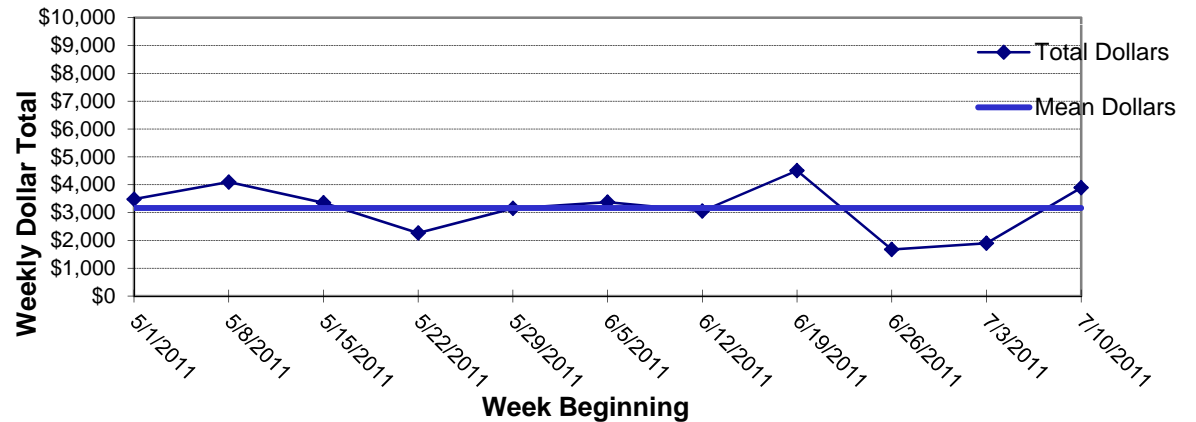
# Bottom-Line Results

**Weekly Dollars of Patient Accounts With Errors Before Intervention**



Mean: \$3740

**Weekly Dollars of Patient Accounts With Errors After Intervention**



Mean: \$3160

# Results Summary

- Annual write-off reduction of \$50,000
- Annual rework reduction of 50 cases
- Process performance  $C_p$  doubled to 2.8

## Extrapolated Results – Hospital Wide

- Annual write-off reduction of \$4.2 million
- Annual rework reduction of 230 cases

# Next Steps

- Eliminate rework at registration desk

Work with referring physician offices to ensure correct patient information is sent every time

- Broaden scope

- Include coding methodology in process

- Review other GSH outpatient areas' denials

- Expand study across MedStar Health

# Questions ?

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