Reduction in Claims Denials for High-Tech Imaging (HTI) at SMDC Health System Center for Therapy in Duluth, Minnesota

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About SMDC Health System

• Serves a regional Midwest population of 460,000 at 17 locations.
• Includes four fully-owned hospitals and the Duluth Clinic, a multispecialty clinic with more than 400 physicians.
• Mission: To bring the soul and science of healing to the people we serve.
• Vision: Working together with our patients and communities, we are creating the next generation of integrated health care.
The Project Team

• Senior process expert
• Supervisor of health plans
• Office manager of radiology
• Health plans office
• Radiology schedulers
• Radiology PSA
• Trainer and process analyst
The Problem

• SMDC Health System Center for Therapy was experiencing a higher-than-usual level of claims denials from a number of insurers for high-tech imaging tests (CT and MRI).

• The claims were being denied because SMDC had not obtained prior authorization for the tests.

• This resulted in approximately $45,000 in claims denials over a six-month period (June 1–Dec 31, 2008).
Project Goal

Reduce denials of claims for high-tech imaging tests ordered by non-SMDC providers by 85 percent by March 31, 2009.
Root Cause Analysis

The process engineering team identified several first-level root causes for payment denials:

- Non-SMDC provider’s office does not have/obtain prior authorization number.
- Too many people involved in obtaining prior authorization.
- Test was scheduled without prior authorization number.
- Prior authorization is not needed for all policies within a plan, causing variation in requirements.
- Technology failures.
- Wrong facility listed on prior authorization.
- Claim denied in error.
Addressing Root Causes

• The process engineering team focused its improvement effort on a single root cause: “The non-SMDC provider does not have/obtain the prior authorization when they call to schedule the test.”

• To address this root cause, the team:
  – Used weighted cause and effect items to identify the area that would give the best outcome.
  – Silently brainstormed possible solutions, worked as a group to hone the ideas into major categories, and applied a PICK chart to the possible solutions to arrive at the best ROI with easiest implementation effort.
  – Developed new workflow and set timelines, using Who/What/When diagram for accountabilities with the implementation.

• Because the new process does not require new staff, there were no new costs incurred, and all of the gains from the new process are actual cash that was previously written off.

• Champions were assigned in each area to overcome resistance by staff who were not directly involved in the development of the new process but must follow the new workflows.
Return on Investment

• The revised workflow should virtually eliminate claims denials for no prior authorization for high-tech imaging tests at non-SMDC providers. This exceeds the initial target goal of reducing denials in this population by 85 percent.

• Based on six months of data for high-tech imaging denials for this population, denied dollars were approximately $45,000, so annualized new cash will be about $90,000.

• There were no new staff or equipment needed to implement the process improvement, so this is all cash for the organization. Getting it right the first time has also eliminated the expense of appealing denials and rebilling claims.

• There is the possibility of adding this process improvement project to another site within SMDC, which would result in further cash for the organization.
Monitoring and Evaluating Over Time

• To ensure the process is performed consistently and desired results are obtained, the control plan will monitor crucial items in the new process:
  – Referral data is complete.
  – Referral data is accurate.
  – A referral exists for every appointment for the population.
  – A prior authorization number is documented on each referral.
  – A count of the number of denials for the population is tracked.

• Data are tracked either weekly or quarterly, with countermeasures in place and individual accountability for each metric.

• Results for weekly metrics have been at goal, after a week or two of getting used to the process.
# Control Plan

## SMDC: Process Excellence Process Control Plan

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Reduce HTI Denials</th>
<th>Control Plan Owner</th>
<th>Faye Anderson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Title</td>
<td>Reduce HTI Denials</td>
<td>Control Plan Revision</td>
<td>Faye Anderson and Linda Gran</td>
</tr>
<tr>
<td>Date</td>
<td>4/27/2009</td>
<td>Process Owner</td>
<td>Faye Anderson</td>
</tr>
<tr>
<td>Project Number</td>
<td></td>
<td>Process Manager</td>
<td>Faye Anderson</td>
</tr>
</tbody>
</table>

### Process Objective
Reduce HTI Denials

### Critical Improvement Metric

<table>
<thead>
<tr>
<th>Metric</th>
<th>Acceptance Metric Limits</th>
<th>Control Method Tasks / Responsibilities</th>
<th>Measurement Frequency</th>
<th>Countermeasure Plan Defined</th>
<th>Countermeasure Accountability Signoff</th>
<th>Source of Control Metric Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral data is complete</td>
<td>100%</td>
<td>every case reviewed by Access Coordinator</td>
<td>every case</td>
<td>Case sent back to ROS to correct w CC to Linda Gran</td>
<td>Linda Gran</td>
<td>Epic referral</td>
</tr>
<tr>
<td>Referral data is accurate</td>
<td>100%</td>
<td>every case reviewed by Access Coordinator</td>
<td>every case</td>
<td>Case sent back to ROS to correct w CC to Linda Gran</td>
<td>Linda Gran</td>
<td>Epic referral</td>
</tr>
<tr>
<td>A referral exists for every appointment for HTI test ordered by non-SMDC provider</td>
<td>Yes - No 95%</td>
<td>PSA would catch if no referral exists when making an appointment in Epic</td>
<td>every case</td>
<td>PSA creates a referral if one does not already exist</td>
<td>Linda Gran and Faye Anderson</td>
<td>Epic referral</td>
</tr>
<tr>
<td>A PA # is documented on the referral</td>
<td>Yes - No 95%</td>
<td>Access Coordinator does check when final status is changed</td>
<td>every case</td>
<td>Access Coordinator gets a PA # if not already done</td>
<td>Faye Anderson</td>
<td>Epic referral</td>
</tr>
<tr>
<td>Count of # of denials for no PA #</td>
<td>5%</td>
<td>Clarity report reviewed 2 times per month and results reported to Team</td>
<td>2 times per month</td>
<td>Clarity report will be scheduled to run 2 times per month with results reported back to Team</td>
<td>Faye Anderson</td>
<td>Clarity report</td>
</tr>
</tbody>
</table>
Fishbone Diagram

Outside prov office does not give/have PA #

Failure d/t too many people involved in obtaining PA

Test was scheduled without PA #

PA not needed for all policies within a plan

Current process is to schedule test 3 days out

Tests were scheduled to provide timely/quality pt care

Denial based on wrong facility listed on PA

Ins company denied in error

Denial for no PA

Lack of knowledge re: need for PA

Wrong/ not updated ins info listed for pt

Lack of system functionality/interface between systems

IDX lacks place for PA # to show on bill

Limitations in Benefit Engine buildability

Technology failures
Contributing Factors to High-Tech Imaging Claims Denials

Contributing Factors
A - Scheduled w/o PA #
B - Provider does not have a PA #
C - Technology failures
D - Too many people involved in process
Process Flow Map of High-Tech Imaging Claims Denials

High Tech Imaging Denials

Value Scale: Blue = Value Enabling, Red = Non Value Added, and Green = Value Added

Ordering MD (Non-SMDC)
- Writes order for appropriate exam

ROS
- Apppt requested via phone
- pt name, dos, test type, ins, etc obtained
- Is PA required? Yes
- Does MD have a current PA from Ins? Yes
- Apppt scheduled 3 days out, ask that PA # be obtained and written on MD Order
- Apppt is scheduled as requested, PA # entered in IDX

PSA
- Report run, all tests scheduled previous 24 hrs
- Are all test scheduled in Epic? Yes
- Apppt scheduled in Epic, Referral Created if prompted, enter PA # in IDX
- Faxed order received
- IDX report run for all Scheduled MRI & CT tests 3, 2 & 1 days out
- All paperwork is compiled
- Did MD fax order & get PA? Yes
- Second request made for order and PA
- If not PA obtained day before scheduled test, mgr or CT Tech contacted
- Patient is informed that service will be self pay & will have to sign an ABN
- Patient usually cancels, ordering provider notified
- Orders should be faxed to SMMC but if other departments receive a fax they fax them to SMMC

Rad Mgr/CT Tech
- Call received regarding PA for scheduled MRI or CT
- Does Ins require a PA? Yes
- Pt's Medical Record reviewed
- Is information in Epic? Yes
- Call Ordering MD office to request PA
- Is PA # obtained? Yes
- If PA # not obtained prior to appt, test canceled
- Patient notified, ROS, and ordering MD
- Epic Referral created and PA information documented
- If PA # not obtained prior to appt, test canceled
- Pt notified, ROS, and ordering MD

Access Coordinator
- Call ROS to obtain test information and ordering provider
- Call ROS to obtain test information and ordering provider
- Epic Referral created and PA information documented

Question is correct servicing entity obtained for the PA
- PSA referral security is currently limited
- Christie to train PSA’s how to create a referral from Appt Desk
For More Information

• Learn more about SMDC Health System: www.smdc.org.

• More case study presentations are available from the ASQ Healthcare Division: www.asq.org/health/quality-information/library.

• Read healthcare case study articles from ASQ: www.asq.org/healthcare-use/why-quality/case-studies.html.

• To find articles, books, courses, and other resources on healthcare quality, search the ASQ Knowledge Center: www.asq.org/knowledge-center/search.