



# 2 0 0 3 MISSOURI TEAM QUALITY AWARD RECIPIENT

## MGP REIMBURSEMENT VALIDATION PASTE<sup>PLUS</sup> TEAM at Heartland Health in St. Joseph



### PROFILE

Heartland Health is a sole community provider hospital for a 21-county region in northwest Missouri, northeast Kansas and southeast Nebraska. With more than 2,600 employees, its vision is to be the best and safest place in America to receive healthcare and live a healthy and productive life. Heartland's mission is to improve the health of individuals and communities in the Heartland Health region and provide the right care, at the right time, in the right place, at the right cost with outcomes second to none.

### OPPORTUNITY FOR IMPROVEMENT

While physician offices strive to provide quality care, they are faced with increasing expenses and decreasing reimbursements. Heartland's Performance Improvement Oversight Team identified the Revenue Cycle as a performance improvement initiative (PII) that would enhance collections from insurance providers and improve processes. Once the PII was targeted, a pre-assessment team was selected to plan the process improvement. This team confirmed that Heartland's multi-specialty physician group was not properly reimbursed by Managed Care Organizations (MCO) for services rendered due to clinical edits that denied reimbursement for other services obtained during a routine office visit. After identifying the clinical edits for each MCO, where these edits apply and the proper reimbursement under its contract, the pre-assessment team identified major stakeholders to begin the process improvement.



### TEAM ACTIONS

Using PASTE<sup>PLUS</sup>, which merges the PASTE Continuous Improvement model, Heartland's innovative five-step performance improvement methodology, with Six Sigma concepts, the team divided the Medical Group Practice (MGP) revenue cycle into sub-processes. These sub-processes focused on areas with the most opportunity for improvement to allow a more manageable scope and avoid potential duplication of work. The sub-processes were categorized as (1) Contract negotiation; (2) Credentialing; (3) Negotiating rate or fee schedules loaded into the system; (4) Posting payment and identifying payment variance by Patient Financial Services (PFS); and (5) Analyzing variance by the PFS and the Contracting Department. Data was gathered and analyzed regarding MCO write-off charges, charges per current procedural terminology (CPT) codes, MCO denials, MCO clinical edits, MGP volume analysis, net collection percentages, Accounts Receivable (AR) financial classes per MCO and net revenue collections.

In addition, the team collected data manually over a six-month period to determine the amount paid at the individual CPT level by a specific MCO. Then the team compared the expected payment for the CPT per the contractual agreement against what MGP was actually paid.

### RESULTS

*Financial Achievements as of September 2003:*

Higher fee schedule collections--\$39,000  
Previously denied charges collected--\$81,000  
Total=\$120,000

Annual collections from completed negotiations--\$375,000  
Annual collections including verbal commitments--\$500,000

### FUTURE PLANS

In addition to this team's ongoing efforts to further improve the process, it plans to:

- complete the electronic fee schedule loading
- complete managed-care negotiations
- monitor net collections measurement monthly
- publish collection percentages monthly in a revenue cycle process scorecard.

### For more information, contact:

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