IN THE SUPREME COURT OF THE STATE OF NEVADA

Electronically Filed
Feb 16 2016 01:12 p.m.
Tracie K. Lindeman
Clerk of Supreme Court

LACY THOMAS,

Petitioner,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR CLARK COUNTY; THE HONORABLE MICHAEL VILLANI, DISTRICT JUDGE, DEPT. 17

Respondents,

and

THE STATE OF NEVADA

Real Party In Interest

CASE NO: 69074

RESPONDENT'S AMENDED APPENDIX
Vol. 2

FRANNY FORSMAN, ESQ.
Law Office of Franny Forsman PLLC
Nevada Bar #000014
P.O. Box 43401
Las Vegas, Nevada 89116
(702) 501-8728

DANIEL J. ALBREGTS, ESQ.
Daniel J. Albregts, LTD.
Nevada Bar #004435
601 S. Tenth Street, Ste. 202
Las Vegas, Nevada 89101
(702) 474-4004

Counsel for Appellant

STEVEN B. WOLFSON
Clark County District Attorney
Nevada Bar # 001565
Regional Justice Center
200 Lewis Avenue
Post Office Box 552212
Las Vegas, Nevada 89155-2212
(702) 671-2500
State of Nevada

ADAM PAUL LAXALT
Nevada Attorney General
Nevada Bar #012426
100 North Carson Street
Carson City, Nevada 89701-4717
(775) 684-1265

Counsel for Respondent

INDEX

CERTIFICATE OF SERVICE

I hereby certify and affirm that this document was filed electronically with the Nevada Supreme Court on February 16, 2016. Electronic Service of the foregoing document shall be made in accordance with the Master Service List as follows:

ADAM PAUL LAXALT
Nevada Attorney General

FRANNY FORSMAN, ESQ.
DANIEL J. ALBREGTS, ESQ.
Counsels for Appellant

OFELIA L. MONJE
Deputy District Attorney

I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage pre-paid, addressed to:

JUDGE MICHAEL VILLANI
Eighth Judicial District Court, Dept. 17
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89101

BY */s/ E. Davis*
Employee, District Attorney's Office

OLM//ed

ACS ACTION ITEMS

-Steering Committee Meetings

-One Step Meeting Minutes

MEETING

Accomplishments List
University Medical Center – Southern Nevada
Las Vegas, NV

Business Office Accomplishments

- Brought the follow up process in-house and eliminated 3rd party (saved expense of HFRI approximately $275,000 per month)
- Created Vital Works follow-up department
- Brought Medicaid billing and follow up back in-house from outside vendor, (Accordis - savings approximately $250,000 per month
- Set up early out self pay process (PASC)
- Initiated sale of bad debt accounts, netted hospital $5M in additional cash
- Initiated process for hospital filing to Section 1011, bringing in approximately $350,000 incremental cash per quarter.
- Improved electronic billing
    - Valid rate increased from 12% to 79%
    - Increased number of claims being billed monthly
- Increase of cash collections in Customer Service Department from approximately $6,000 per month to $250,000 per month
- Developed reconciliation department to monitor and appear managed care underpayments and denials
- Initiated monthly department meetings for communication
- Created productivity standards in each unit of Business Office
- Initiated process for working all zero pay denials resulting in $2M incremental cash monthly
- Created process for billing second insurance for MedSeries 4 accounts
- Initiated billing of 2nd insurance after Medicare through the DDE
- Changed policy on billing of MVA patients that have other insurance resulting in $1M incremental cash monthly
- Developed the "Billing Error Reduction Team" (BERT) increased clean claims submission from 12% accuracy to 79% accuracy.
- Reduced aged accounts for Anthem BCBS and Sierra, working on total AR clean up
- Developed work list in descending balance order for more effective follow up
- Trained staff on effective and efficient follow up practices
    - How to ask relevant questions to carriers that will get claims processed
    - Improved staff understanding of contracts
    - Showed staff how to multi-task while on hold with insurance carriers
- Develop tracking system for promise to pays from patients and Payers

- Set employees daily goals for KPI
- Develop rewards for staff performance
    - Provided appreciation gifts when team goals are meet or exceeded
- Develop communication with various payer regarding outstanding and pending claims
    - Developed spreadsheet
    - Liaison at JOC meetings
- Develop report of claims that are under paid (mcd)

CDM/Charge Capture Accomplishments

- **Cardiology:** AICD implant procedure charges with incorrect HCPCS codes were identified and corrected. Initiated rebilling of all calendar year of 2005 Medicare accounts that were in error and already billed. This effort resulted in an additional $6,382.32 received by UMC from Medicare. In addition, tracking until the end of year 2005 netted an additional $82,970.20 in Medicare reimbursement. At the beginning of 2006, the device was no longer being used.
- **Cardiac Cath Lab**: Erroneous coding identified when both a left and right heart cath was performed in the Cath Lab. Worked with the department manager and HIM to rectify and identify which accounts should be reviewed and rebilled.
- **Cardiac Cath Lab**: Worked with the department manager to add missing charges to their charge master, update their charge tickets and assist with the pricing of procedures and equipment.
- **Chest Pain Center:** It was discovered that no revenue was being generated in this area from July 2005 to February 2006. Projection of lost revenue was done, process changes were implemented and charging was resumed effective March 7, 2006. Expected additional revenue and reimbursement has been tracked since March 7. The average revenue per month has been approximately $295,000 and the average additional reimbursement has been approximately $45,000 per month.
- **Lab:** A test previously sent out is now being done in-house since February 2006. The average revenue per month is $4,300 with average reimbursement per month of approximately $1,200.
- **Trauma**: Reimbursement review completed for high dollar supply items where missed charges were identified. New charge tickets were implemented along with a new charging process. Previously charge tickets were getting lost which resulted in missed charges and lost revenue.
- **Trauma**: Implemented a new Level III trauma consultation charge and tracking additional reimbursement on a monthly basis. The total additional revenue since tracking began in March 2006 is approximately $1,428,000 with the average additional revenue of approximately $450,000 per month.

- **2006 CPT Update Process**: One-on-one meetings held with all department managers affected by coding updates. This process was carried out prior to the January 1, 2006 deadline. A procedure was developed; a survey was created and e-mailed to all managers to identify how they perceived the process and whether all of their questions were answered.
- **Pharmacy:** 636 drug charges were reviewed, corrected and rebilling was done.
- **Pharmacy:** 637 revenue code changes were initiated and guidelines were developed. A total of 1,058 charge items were updated in the charge master.
- A review of all inpatient pharmacy charge numbers were reviewed to update the revenue codes according to the Fiscal Intermediary instruction for billing oral medication (self administered drugs) on inpatients and hospital based outpatients. Currently the take home medications from the outpatient pharmacy are being reviewed for the correct revenue code by carrier. This initiative was a means to increase the validation of claims in the billing system and accurately report drugs.
- **Pharmacy:** Instituted a process to do a 100% review of all hemophiliac drugs posted to accounts.
- **Pharmacy:** Worked with Information Systems Department with the development of a pharmacy dosage conversion program to ensure compliant billing. The go-live date was July 2006.
- **Pharmacy:** ESRD Epogen charges with revenue codes 634 and 645 identified and built along with education to billing and coding departments in June 2006 to ensure they were properly billed and paid.
- **Pharmacy:** Issues with system Editor identified with take-home drug credit and the dispense dates outside of admit and discharge dates for self-pay patients. Information Systems Department and the Business Office to review for possible changes to the claim editor (SSI) to allow bills to go out the door without stopping as a charge correction in coding.
- **Pharmacy:** Reviewed miscellaneous CDM items to track "like" items and possibly build several more miscellaneous CDM's by revenue code. This will expedite the billing process. Incremental cash will also be tracked.
- **Pharmacy:** Charges posted by Anesthesia and OP Ambulatory to wrong accounts. Performing Physician education.
- **Transplant**: New visit charges were created, a new charge ticket was created, a new documentation form was created and post-transplant billing is being implemented with a start date of July 1, 2006. Revenue and additional net reimbursement will be tracked after July 1.

- **Burn Care**: Reviewed all supply charges, corrections were made and the charge ticket was updated. The issue of inpatient nursing services was reviewed and addressed. The burn care is in the process of updating their charge master to accurately capture the ancillary services rendered to inpatients in the burn care clinic. This should improve the validation of claims. Charge tickets are being updated. The outpatient charge tickets are completed.
- **Surgery**: Inpatient only procedures identified in the ambulatory surgery charge master. An estimate was done on possible lost revenue.
- **Surgery**: Revenue code corrections were made to 3 spine devices. These procedures were tracked during the last three months of 2005. At the beginning of 2006, these devices were rarely being used. However, during the period of tracking additional net revenue of approximately $72,000 was realized.
- **Surgery**: Reviewed all items with a 278 revenue code: graft jackets, neurostimulators and spine devices. Corrections were made as appropriate. Review and corrections are in progress for the remainder of the O.R. CDM (4,000+ items). Estimated time of completion, April 28, 2006. Completed review of all implantable plates and screws (975) line items. Deleted and consolidated items no longer in use. As a result, reduced miscellaneous charge usage for implantables by 75%.
- **Surgery:** Reviewed 17 charge tickets in OR and reduced down to 2 charge tickets for manual charge capture.
- **Surgery:** Reviewed all 2005 accounts captured on a 14,000+-page report provided to ascertain the accurate capture of chargeable supply items. It was discovered that approximately $267,000 in supply charges were being missed per month due to a reconciliation process that required the use of temporary account numbers and a manual process to merge charges from temporary accounts to "live" accounts whereby charges were being missed. An ADT interface was implemented whereby "live" accounts were made available for capturing charges thus eliminating the manual charging intervention. Also, on February 1st, 2006, we implemented a daily reconciliation process to audit all O.R. records for accuracy and completion of charge capture of supply items used in each surgical procedure. Official policies and procedures have been developed and documented. For the months of February and March, a total of 1,145 supply items were recovered, totaling $505,092.94 in additional charges and incremental cash in the amount of approximately $101,018.59. As of May month-end, total supply revenue recovered for 2006 YTD is $638,414.00 and additional incremental cash of approximately $127,683.00 (Reimbursement based on 20% of charges).

- **Surgery:** A total of 103 charge codes were found to be mismatched to the incorrect Revenue code. A report was run for the month of February and following correction, $80,342.17 in charges were eligible for rebilling, resulting in additional cash for February in the amount of $30,864.44. This report will continue to be run monthly and incremental cash will be reported as it occurs.
- **Surgery:** A total of 386 chargeable supply items in the Pyxis system were found not to be mapped to CDM charge items in Med Series 4. Those items are now being attached to the appropriate CDM numbers and will be uploaded in Pyxis by Cardinal Health. Estimated due date for this is April 28, 2006. At that time, the total additional charge amounts and incremental cash opportunity will be quantified. In the interim all items identified are being captured and charged manually through the Daily Reconciliation Process.
- **Surgery:** Complete policies and procedures were established for the Daily Reconciliation Process.
- **Surgery:** Training was completed for the newly assigned Surgery Charge master Coordinator.
- **Surgery:** Established two (2) new specialized "Miscellaneous" CDM codes (Revenue Codes 274 Orthotics & Prosthetics and 278 Implantable DME). These will be used on an as-needed-basis for billing one-time use implantable supply items but will continue to flow through the billing process without human intervention thereby eliminating billing delays. Corresponding policies and procedures for usage of these codes were also established.
- **Surgery Implants**: Chaired the intradepartmental project team to establish official policies and procedures for the internal workflow and placement of internal controls for the ordering and receiving of implantable supply items. Seven (7) departments participated. The procedures also included price negotiation and the selection of approved Vendors at UMC by Materials Management, the assignment of a dedicated Implant and Tissue Coordinator, as well as a dedicated CDM analyst as it relates to tissue and implant supply items. This process has addressed the high incidence of Miscellaneous CDM code usage by the surgery department. These special codes are now used only on a limited basis and the Surgery Dept. Director must approve their usage.
- **Surgery**: Developed a Q Drive Spreadsheet especially for use by the Surgery Dept. for documenting and managing revisions and new additions to the O.R. CDM. It will further be used internally for communicating said CDM changes to all O.R. staff members. This spreadsheet will also be used as a model for all other internal departments and will be presented and instructed thru the CDM Committee.
- **Special Procedures**: CDM reviewed and device codes added. The department manager is currently reviewing each charge items to determine if the pricing is correct and if the procedures are being accurately represented. Charge tickets will be updated.

- **Profees**: An analysis was performed to identify the total expected reimbursement for billing profee services in the Quick Cares and the Lied Clinics. This projection was estimated to be $868,000 per year. The goal to begin billing profee services is by 2006 year end.
- **Wellness Center**: Reviewed and updated charge ticket, identified training issues and developing education initiatives.
- **Education**: A PowerPoint training tool was developed on filtering and exporting files in Craneware. Other training initiatives include: pricing services, charge master education, capturing charges and charge entry.
- **Policies and Procedures**: P&P's are being created in all clinical departments. In addition the CDM team is documenting processes, developing and implementing new forms. All new documents created will be downloaded onto the "Q" drive. Admin policy updated, reviewed by CDM committee and submitted for administrative approval. Delineates the responsibilities for file maintenance and updates Policy for a procedure related to the annual update of CDM was drafted and distributed to the team for review.
- **Committee Team Meetings**: Created implementation team meetings for DME and Profee billing. Participating in the Observation sub-committee and the Billing Error Reduction Team (BERT) meetings. Created new Charge Master Committee, holding monthly meetings, developing project plans for all items. Disseminating compliance updates. Teams developed to address each initiative identified on the work plan, meetings being held and procedures developed or processed refined.
- **General Charging Errors**: Review being done of all charge corrections from Patient Accounting, HIM and Patient Access. Creating new processes for eliminating the massive amount of charging errors and training being provided to charging staff.
- **Multiple Department Efforts**: Working with Patient Access, HIM, Finance, Compliance and Patient Accounting to improve processes that impact the charge master.
- **Charge Capture:** Developing processes to delineate between charge capture and coding; identifying staff labor hours associated with charge corrections.
- **Miscellaneous Charge Usage:** A report has been developed to identify the items charged for as miscellaneous charge items. This is being reviewed and discrepancies or errors are being sent to the department managers to address. A formal procedure is being developed to delineate responsibilities for corrections. The intent is to minimize the use of the MISC charge items.
- **Supplies:** Created a hospital-wide "Routine" Supply Policy.
- **Supplies:** Identified all "chargeable" supplies in the Pyxis system.
- **Radiology:** Charge correction issues identified that create credits to zero accounts and extra work in getting the bill out the door identified. This will be resolved by providing coding access to the Radiology software PACS and Radiology access to the Vitalworks software.

- **General CDM Clean up:** Review all department revenue and usage to identify charges without usage. These CDM's will be inactivated.
- **Charge Capture/Analysis:** The CDM team is in the process of performing Charge Capture Interviews with charge entry and management staff in the following hospital departments:
    - OR
    - Materials Management
    - Wellness Center
    - Radiology
    - Pharmacy
    - Special Procedures (Interventional Radiology and Cath Lab)
    - Trauma
    - Chemotherapy
    - L&D
    - Women's Center
    - Ambulance Services
- **Charge Capture/Analysis:** All charge tickets (superbills) have been reviewed with the department managers and most have been updated. We are still waiting on a few departments to turn in their corrections. In addition, our team is working on standardizing the charge tickets with the expectation they will all be housed on UMC's intranet. A policy and procedure has been written for this standardization process including the process for maintaining the charge tickets.
- **Charge Capture/Analysis:** Providing Miscellaneous CDM report for all departments.
- **Charge Capture/Analysis:** Providing Miscellaneous Surgical CDM report for Materials Management to ensure vendor appropriateness and follow-up to OR. The expectation is to increase communication and compliant device usage per UMC MM Vendor Contracting.
- **Charge Capture/Analysis:** Analyzing coding and charge entry staff hours/dollars associated with Charge Corrections.

Eligibility Accomplishments

- 24/7 coverage in emergency department
- Placed additional EFS worker at women's center
- Placed EFS in pre-surgical for up front collection, payment arrangements and financial assistance
- Increased up front cash collection (including clinics)
- Implemented bed side collection
- Increased government, state, and county application submittals
- Placed additional EFS rep for self pay collections and arrangements
- Implemented patients to stop at discharge desk to gather required information prior to departure from the hospital.
- Develop tracking report to monitor monthly performance
    - Weekly cash collect report
    - Weekly application submission report
- Develop rewards and contest for staff motivations
    - Cash collection between EFS and Customer Service

This work was accomplished prior to Bill Taylor.

Medical Records Accomplishments

- Decreased DNFB from $42M to $9M
- Combined in-patient coding with outpatient coding – this was two separate areas and managed by two different departments
- Improved Observation billing and processes to eliminate denial in payments and bad debt write-off
- Developing new policies and procedures utilizing "best practices"
- Assisted with up grading EmStat

Patient Access Accomplishments

- Created and conducted mandatory re-training program for all registration personnel throughout the hospital as a joint effort with Patient Accounting leadership.
- Labor and Delivery "resuscitation" packets and process implemented in Labor and Delivery Triage. Policy and Procedure written.
- "Override Subscriber" and "Add Subscriber process implemented in AS-400. Process defined and staff trained.
- Identified the need for and subsequently established a QA/PI program for registration to ensure compliance with federal and state regulations, and accurate data collection for the purpose of generating a clean bill. Accuracy rate goal 95%.

- A sampling of accounts was reviewed and a baseline QA score tabulated. Reports have been created to show results and progress.
- Admission Specialists staff moved into QA role to perform registration reviews, corrections, and tabulation of monthly accuracy scores. Feedback of results, errors and education provided to staff.
- Notification process defined from Labor and Delivery to Patient Access to include delivery type, APGAR's and birth weight. Process defined as to where entry of this information is to be placed in AS-400 and notification of information to payers.
- Implemented ABN software and processes integrated into the registration process for Outpatient Procedures/tests against CPT codes for Medical Necessity for Medicare accounts.
- Pre-surgical Testing Center pre-op visit and pre-registration process redesigned and implemented to include patient pre-op visit to ASU Nursing and pre-registration and financial screening of accounts prior to date of service. Outlook scheduling training and implementation of ASU Nursing staff automating Pre-op scheduling. Pre-op visit goal—100%. Pre-registration goal is 100% and to be 3 days out on the schedule.
- Implementation of pre-registration and financial screening for Radiology, Special Procedures and Cardiac Cath patients.
- Access to ORSOS scheduling system and training provided to pre-registration team in order to have access to schedules real-time and complete pre-registration and financial screening.
- Special Procedures and Cardiac Cath service areas given access to NOVIUS Scheduling to enter patient schedules. Pre-registration staff given access to view and print NOVIUS Scheduling in order to have access to schedules real-time for pre-registration and financial screening process. Oncology next area to be added to NOVIUS scheduling.
- In-hospital Pharmacy Registration process moved back to Patient Access.
- Shift bids and staff assignments completed.
- 3 Management positions added to provide 24/7 management coverage of Patient Access.
- Management training sessions conducted for Patient Access Leadership assisted by Human Resources Department.
- Implemented Pre-registration packet log to accompany pre-registration packets. Delivering and receiving staff to reconcile packets and acknowledge receipt on the log.
- Burst fax installed in ASU automating copies of physician orders to Pre-registration for pre-registration and financial screening. Eliminates the copying/pick-up/delivery of physician orders and lost orders.
- SSI integrated into the registration process for verification of payer coverage for a set list of payers to include Medicare. Other payers are verified via phone or websites.

- Transplant post-op account pre-registration process defined and implemented.
- Increased up-front cash collections for co-pays and deductibles in the ED, Peds ED, Main Admissions, ASU and Outpatient registration.
  Established an area in the ED Registration area near the lobby that is used for patient check out. Check out entails ensuring all documents are signed, billing and demographic information is accurate and determine if the patient needs to see an eligibility worker. It is also the point where any co-pay's or deductibles due at time of service are collected. Collections have risen from and average of $600 per month in the ED to an all time high of $37,000 a month. As a department, collections have exceeded $100,000 for a month.
  Areas to be added are Oncology and Labor and Delivery Registration.
- Cash drawer handling process for Main Admission and ASU Registration to include stricter handling of the cash drawers. Drawers are secured with the Cashier at day end.
- Gift shop key and Chaplaincy Office key turned over to Security for safekeeping and no longer managed by Main Admissions.
- Active participant in a multidisciplinary Revenue Management sub-committee to address numerous Observation patient processes. Chest Pain Center first area reviewed. Responsibility for entering Chest Pain Center observation charges moved from Patient Access to Chest Pain Center.
- Created reports to monitor, identify errors and provide feedback to staff and to correct Smart Choice ID Numbers and Override Address accounts.
- Detail to cash collection summary report printing to Patient Access for review and monitoring of cash collections.
- Provided Medicare/Medicaid training through Patient Financial Services for Medicare/Medicaid insurance verifier.
- C-4 completion and monitoring function moved from Admit Specialist to Managers. Admit Specialist moved into QA.
- Elimination of Medical Record Charts from Patient Access for various reviews. Responsibility for reviews moved to H.I.M..

Emergency Department Accomplishments

- Created and conducted mandatory re-training program for all registration personnel throughout the hospital as a joint effort with Patient Accounting leadership.
- A sampling of accounts was reviewed and a baseline QA score tabulated. Reports have been created to show results and progress.
- Burst fax installed in Peds ED, Trauma and Adult ED for notification of in-house Admission orders.
- Worked the DA's office to reconsider their position on the April 2003 interpretation of the EMTALA regulation.

- The earlier opinion held that patients may NOT be asked any information that may indicate their ability or inability to pay for treatment thus requiring a 2 step process allowing patients to be treated and released without obtaining payment information. The new opinion allows patients to be fully registered after triage as long as all patients are treated exactly the same by using approved scripts written to collect financial information. This has streamlined our patient flow and increased our ability to submit clean and accurate bills.

- Assisted with an initiative to redesign the ED registration and triage areas to include a "Fast Track" area thus freeing up 4 additional beds in the ED for more acute patients, speeding up the treatment process while decreasing wait times. Plan has potential to generate more income due to increased patient volume, faster turnover and ability to treat more acute patients.
- Conducted an in-house chart audit on all floors by random chart sampling to determine ED Representative compliance to the requirements of obtaining signatures on consent forms.
  Results were tabulated. This is an on going process and part of QA.
- Significantly reduced and eventually eliminated the 0045's (escapes) through close monitoring of secondary registration follow through and subsequently eliminated this class with the initiation of the new registration process the EMTALA decision allowed. Escapes (persons leaving after treatment without UMC obtaining insurance information) were in excess of 80 per day, reduced to an average of 4 to 6 per day and are now non-existent. This has enhanced revenue.
- Moved ED admissions work area for more efficient workflow creating space for cash drawer and collection desk.
- Changed work flow and staff assignments to better serve the department and patient needs by putting staff in areas where volume was highest rather than just because there was a desk that needed a body and always had a registrar there.
- Conducted coaching and mentoring session with new managers for better communication with staff, leadership and peers.
- Identified need, made recommendation and submitted proposal for inpatient discharge lounge to be located in the PACU area of hospital. Existing lounge went unused due to bad location and poor appearance. New lounge, per Dennis Dufak, Director PPC, has been huge success in freeing up beds for ED patient admissions that previously would have been held in ED 8 to 10 hours or more. Daily usage of lounge is up more than 300% from approximately 10%.

OR Accomplishments

- Developed and implemented a daily volume log that captures cases, minutes, inpatient versus outpatient, adult versus pediatrics, minutes, and volume including 21 different service lines. Volumes previously measured only by cases – not cases by service line.
- Developed a balance score card/dashboard that tracks key indicators daily, weekly, monthly to include quality, service, cost, and productivity within the OR.
- Completed an analysis on Block Time Utilization (33%).
- Business Development Plan in process to include a thorough analysis for all service lines to include # procedures in each service line, contribution margin for each service/physician, expected reimbursement according to service line, and average cost per case. This Business Plan will include integration strategies, centers of excellence, DRG assessment/opportunity, contracts/payer relationships, required changes/management roles, image, target opportunities, and action plan.
- OR- IS system vendor selection in progress – seven vendor presentations complete with all vendor presentations completed by June 29th.
- Implemented a Pre-Admission nurse in the OR.
- Case volume increase both Monday through Friday and overall. Beat year over year case volume 4 out of 5 months. Averaging 35 more cases per month year over year.
- Implemented process calls to physician offices for block release.
- Established and implemented a Pre-Surgical Testing Center to increase case volume, reimbursement, on-time starts, decrease case delays, increase patient satisfaction/experience, testing protocols by anesthesia, cancellation policies, and training/development of all staff.
- Established screening protocols.
- Eliminated OR downtime caused by the arrival of patient's on the day of surgery due to no or inappropriate prep.
- Redesigned the registration/verification, authorization, eligibility process for accuracy and effectiveness for all surgical patient's.
- Updated and cleaned up the CDM.
- Implemented and set-up a daily charge capture audit/tracker.
- Improved capacity, patient through put while decreasing physician complaints and case start up delays.

Case Management Accomplishments

1. Enhance Clinical / Utilization Management To Assist with Revenue Cycle

- Consolidation of function into a single department, workloads reallocated appropriately for optimal productivity.
- Daily communication between eligibility financial counselors, insurance verifiers, to identify Medicare reserve days, health care benefit coverage, international patients and other payer "red flags"
- Ninety eight (98%) - one hundred (100%) percent of the contracted and non- contract patients hospital stay were certified 1st, 2nd and 3rd quarter FY 2005-2006
- Ninety eight (98%) of the Medicaid patient population hospital stay certified 1st, 2nd and 3rd quarter FY 2005-2006
- Managed Care hospitalization opportunity days delivered to UMC 1st, 2nd and 3rd quarter FY 2005-2006. < 1% (1 patient hospital day per quarter) of the opportunity days issued upheld.
- Initiated Clinic gatekeeper to review appropriateness of clinic referrals and ensure financial clearance established.
- Re-assigned admitting RN to Pre-Surgical Testing Center as gatekeeper to evaluate high cost specialty cases.
- Developed denial appeals process decreasing UMC financial risk.
- Case Management Information System selected – In progress with CFO
- Initiated review process NICU level of care

II. Improve Throughput and Patient Flow

- Enhanced care facilitation process
- Established initial transitional plan all adult in patient admissions
- Face to face direct communication with physician patients plan of care, plan of the day avoiding potential clinical barriers for discharge. Increasing physician, patient satisfaction.

III. Screening Appropriateness of Admission

- Implemented a single, consistent set of admission screening criteria across all admissions conducted by the gatekeeper case managers in Admitting and the ED (utilizing interqual criteria system determining Severity of Illness / Intensity of Service).

- All patient admitted screened for appropriateness of admission as well as level of care criteria (appropriateness of bed utilization)

- Implemented process for Administrative involvement / approval for social, high risk, unsafe to discharge patients from the ED.

IV. Cost Avoidance - Reduce Avoidable Days

- 100% of the adult patient population are case managed thereby decreasing avoidable /denial days
- Established relationship with Managed care physician and case managers for care coordination, determination of the appropriate level of care, care setting alternative and seamlessly moving patients across the continuum.
- Re-designed utilization review process ensuring timely response with third party payer request.

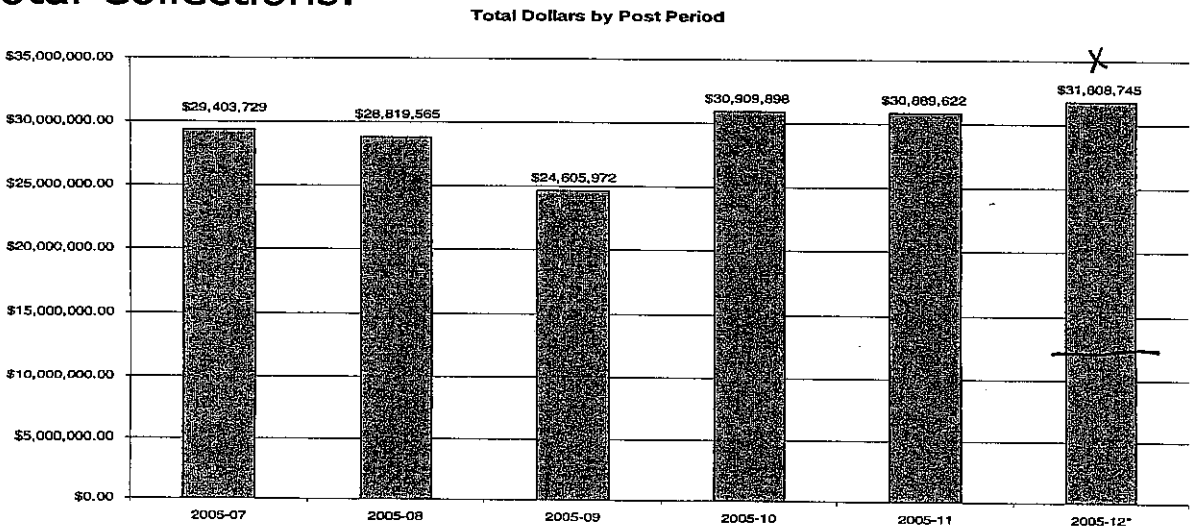
V. Concurrent DRG Worksheet

- Established Case Management Initial Assessment tool to include working DRG and projected length of stay
- Implemented process patient intent admission well specified by physician.

8813

Billing/AR

- Cash Collections
  - Up Front collections have increased approximately 200% since implementing new processes
  - Total Collections:



Closed Projects

9/20

Closed Projects

Accordis

- Work plan delivered by Accordis on 8/1 (completed)
- Established bi-weekly status meetings to continue to monitor results. (completed)

QA processes

- Develop spreadsheet for tracking of errors (completed)
- Developed QA process for identifying errors (completed)
  - Business Office reviewing rejects everyday and advising the appropriate staff in Patient Access. (completed)
  - Will work with Quick Cares to reduce error rates
  - Reviewing QA static's at morning "one stop" meetings (completed)

Closed Projects

Cash Report

- Technical resource continues on-site to develop cash posting tracking report. (completed)

Staff Training

- Set up in-service training for billing and follow up staff with various Managed Care carriers
  - Nevada Care scheduled to do on-site training. (Completed)
  - Working with PacifiCare (completed), Aetna, Blue Cross, and others to do the same (contacting provider reps)
- In-service meeting including billers and follow-up staff with Pacific Care to discuss issues. These meetings will be set up with all carriers each month. (completed)
- HFRI contract cancelled effective 9/30 and B/O staff to begin follow up. (Completed)

Closed Projects

JOC Meetings

- Developed Aged Trail Balance to send prior to JOC meetings to identify payment issues. (completed)
  - UMC staff now doing all follow-up on Commercial, Managed Care, County Agencies and Medicare
  - Most recent JOC with Nevada Care was more meaningful and less excuses.

Out of State Medicaid

- Out of State Medicaid now being sent to Great Lakes. Contract with National Access has expired but they will continue working accounts assigned prior to expiration. (completed)

Closed Projects

Secondary Billings (except Medicaid – Accordis)

- Staff began billing secondary claims (completed)
- Developed report identifying account with secondary insurance (completed)
- Assigned 1 FT FTE to concentrate on secondary billing (completed)
- Approximately $2M in collectable AR
- Also started billing secondary claims on those accounts placed with HFRI.
- Continuing to review workloads to determine maximum impact

MVA billing and follow up transferred to Patient Accounting (completed)

- Developing procedure for MVA's, information gathering, billing, follow up, liens. (completed)
- UMC staff billed out $325K week of 8/22

Closed Projects

Billing

- Since 7/20 re-billed 188 accounts or $1.4M. These are claims that were denied and now have been resubmitted with information requested. (completed)
- Developed spreadsheet for denials from 1-2005 through 6-2005 to work and re-bill.
- Re-billed 150 accounts with correct HCPCS codes for pharmacy charges. (completed)

Closed Projects

IT issues

- Meeting with IT to develop strategy for long term support for hardware and software. Temple preparing work plan. (completed)

SSI Training

- SSI personnel are on-site beginning 8/16 to train billers on their claim editor (completed)
- SSI front-end third party payer verification implementation is completed, train the trainers is completed, complete role out by 8/25. (Completed)

Closed Projects

IT issues continued

- SSI transmitting terminal is outdated and being replaced by this week, server on-site, needs to be installed (completed)
    - Swifter download
    - Payer specific edits (current terminal does not have capacity to hold these types of edits)
    - Swifter transmission
    - End result will be faster turn-around of cash

Closed Projects

Claim Denials

- Develop report to identify all denials (completed
- Procedures Developed (completed)
- Process implemented (completed)
- Tracking Report (completed)
- Developing methodology for working denials less than 6 months old. (completed)
- 2 FT FTE assigned to Denial follow up (completed)
- Denials identified since started 7/26 to date – 133 accounts for $1M
- 95 accounts appealed or reworked with requested information for $400K

Closed Projects

Collection Agency

- Reviewed existing Collection Agencies contracts (completed)
- One-on-one meetings with Collection Agencies (completed)
- Specialist were on site week of 8/8 to audit and evaluate Collection Agencies (completed)
  - Report due week of 8/22
  - Initial reaction current rate structure and volumes resulting in low productivity with these agencies
  - Working on draft proposal for early-out placements for a premium rate to handle all self pay including aged accounts.

Closed Projects

HFRI

- Specialist was on site week of 8/8 to evaluate HFRI contract and performance
  - Report due by week of 8/22
  - Initial reaction was HFRI contract should be cancelled, they are creaming accounts, and since Business Office resumed follow up finding many accounts not worked or worked insufficient. (completed – letter sent 8/18 with cancellation date of 9/31)
  - HFRI contract Cancelled (completed)

Closed Projects

Charge capture and CDM review started 7/18/05

Charge Master Policies

- Will have updated policies for submission and approval by 8/22 (Completed)
- Have appointed CDM Coordinator in Business Office (completed)
- Developed reports to project increased revenue
  - Met with MR and developed a plan with coders to identify missed charges. (completed)

Closed Projects

- Coding Backlog
  - Contract submitted for approval (completed)
    - Contract needs approval from Contracts Management (Don Haight)
    - Contracts Management with DA to see if we need to put out to bid
    - No resolution to date – process has taken 3 weeks so far
    - Vendor ready to bring in 3 coders once contract approved

Closed Projects

Misc.

- Daily "one stop" meetings continuing to review and discuss follow up strategies, participants are:
  - Patient Access
  - Patient Accounting
  - Case Management
  - Eligibility
  - Great Lakes on-site Manager
  - Medical Records

Closed Projects

Eligibility

- Recommendation for reallocation of staff by 8/26 (completed)
- Better organize/manage use of Field Reps (completed)
- Develop meaningful log for tracking Field Reps results (completed)
- Eliminated Eligibility staff from doing insurance verification when a new source is located. Supplying detail each morning of insurance information obtained by Eligibility workers to Admitting for training and verification. (completed)
- Have approved position for EFS worker at Lied Clinic – job is posted in recruitment. (Completed)

Closed Projects

- Determined workloads of current EFS staff to provide 24/7 coverage to replace the Great Lakes temporary staffing of ED and Quick Care Clinics that need EFS workers. Union gave us 30 days to develop a plan of action, due to Union 8/31. (completed)
- Working with HR to determine if we can use Per Diem employees. (completed)

Closed Projects

- Developed plan to move old accounts to Great Lakes (completed)
  - Sent 5,002 SSI/MAABD accounts for $6.2M on 8/2 (completed)
  - Sent 8,818 CHAP accounts for $21.6M aged over 120+ on 8/2 (completed)
  - Requested bi-weekly status reports (completed)
  - Brought in Great Lakes to work with Eligibility to provide 24/7 coverage in ER, and cover IP as needed (completed)
    - 24/7 coverage starting week of 8/8 (completed)
    - Working on schedules so we will have no short staff situations during lunches and breaks (completed)
    - Evaluating peaks and valleys in ER Patient loads to maximize scheduling. (completed)
- Bi-weekly meeting with Clark County Social Services (CCSS) continue to discuss elimination/correction of denied claims

Closed Projects

ED redesign

- Scheduling specialist (Dr. Greg Hobbs) for on site visit August 22 to meet/evaluate ED processes (completed)
- Increasing number of FTE's in ED during peak times to eliminate "escapes" (Great Lakes) (completed)

Closed Projects

Surgical Services Process Redesign

- Steve Gray and Ron Pimentel, Director, Surgical Services received approval from CEO to move forward with the redesign. (completed)
- Developed detailed redesign plan. (completed)
- Improving through-put by pre-admitting patients, insurance verification, case management, and pre-surgical testing.
- New design will improve surgical net revenue by $12.5M annually (conservative estimates).

2005

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

12 8/12/11

Revenue Cycle Improvement

Steering Committee Meeting

Sensitivity on CDM

August 2, 2005

Agenda

- High Impact Initiatives Updates
- Miscellaneous
- Questions/Comments

High Impact Initiatives

- Billing Methodologies
- Claim Denials
- Charge Description Master Review
- Charge Entry/Capture Processes
- Contract Management
- Surgical Services Process Redesign
- ED Process Redesign
- Coding and Charge Entry Backlogs

Billing Methodologies

- Staff Reorganization (Completed)
  - IT transferring equipment (Completed)
  - Two week Staff Training underway (completed)
- Strategy meetings with Accordis
  - Work plan delivered by Accordis on 8/1
  - Established bi-weekly status meetings
- Developing QA process for identifying errors and getting back to the admitting area for correction and training
- Technical resource on-site to develop cash posting tracking report
- Setting up in-service training for billing and follow up staff with various Managed Care carriers.
- Developed Aged Trail Balance to JOC meetings to identify payment issues.

Nevada Care

Billing Methodologies

- Patient and Financial Demographic Collection
  - Starting QA process and training of Admitting Staff
- Secondary Billings
  - Staff began billing secondary claims on 7/25
  - Developed report identifying account with secondary insurance
  - Assigned 1 FT FTE to concentrate on secondary billing
- MVA billing and follow up transferred to Patient Accounting as of 7/18
  - Free up 2 resources in Eligibility to enable better follow up on self pay.
  - Developing procedure for MVA's, information gathering, billing, follow up, liens.

Claim Denials

- Tracking Report Completed
- Procedures Developed
- Process implemented 7/20
- Developed spreadsheet to Trend Denials
- 2 FT FTE assigned to Denial follow up

Charge Description Master Review

Charge capture and CDM review started 7/18/05

- Received Charge Master file on 7/20 and reviewing Department by Department
  - Currently approximately 200 charges priced under APC reimbursement
    - Submitting recommended pricing for these items to Peter Tibone for approval – completed by 8/10
  - Meeting with Surgery, Pharmacy, ED, and Supplies
- Reviewed O/P Charge Tickets
  - Identified missing charge items
  - Update charge tickets
  - Standardize charge tickets throughout Hospital Departments

Charge Description Master Review

- Reviewed Charge Master Policies
  - Will have updated policies for submission and approval by 8/8
  - 40 departments have access to make changes to Craneware and the CDM (should only have option to view and request changes or new charges)
  - Have appointed CDM Coordinator in Business Office
- DME
  - DME licenses expired (should get license renewed)
  - Materials Management and Compliance Officer feel DME is walking out with Patient and we are not charging
  - CDM has DME charges listed, but zero price
  - Running report to capture loss in charges

Kacey approved Make Change

Charge Entry/Capture Processes

- Working with Outpatient Departments to establish Charge Entry/Capture Processes
  - Develop work flows
  - Develop best practices
  - Develop policies and procedures
- Developing reports to project increased revenue

Coding and Charge Entry Backlog

- Identified backlog in coding
  - Contract coders for ED coding
  - Contract submitted for approval
- Identified backlog in charge entry
  - Need 6 resources to eliminate charge entry by coders to allow to eliminate coding backlog
  - 3 of 6 to be filled by current vacancies, need 3 new positions
  - Working with HR

Contract Management

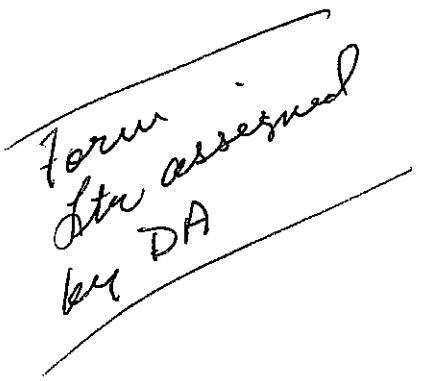
- Review existing contracts
  - In process
- Specialist to be on site next week to audit and evaluate Collection Agencies appointments set
- Completed one-on-one meetings with Collection Agencies X X
- Evaluating number of agencies needed and secondary placements.

Surgical Services Process Redesign

- Steve Gray continuing to work with Ron Pimentel, Director, Surgical Services.
- Meeting and presentation set for 8/3
- Process Redesign Patient Flow continuing

ED Process Redesign

- Reviewing self pay ED registrations daily
- Eliminate "Escapes"
  - Tracking daily
  - Developing follow up plan with policies and procedures
  - Following up on POS process in ED
- Process Redesign
  - Developing flows



Miscellaneous

- Daily Revenue Cycle meetings with direct reports to discuss issues/resolutions
- Daily "one stop" meetings to review and discuss follow up strategies, participants are:
  - Patient Access
  - Patient Accounting
  - Case Management
  - Eligibility
  - Great Lakes on-site Manager
  - Medical Records

Miscellaneous

- Track Eligibility Counselors Results
  - Evaluating work flow and developing redesign
    - Daily reviews of follow up process
    - Developing reviews of accounts over $50K
    - Better organize/manage use of Field Reps
  - Developing productive standards and tracking reports
  - Bringing in Great Lakes to work with Eligibility to provide 24/7 coverage in ER, and cover IP as needed (in training and will start this week)
  - Developing plan to move old accounts to Great Lakes
    - SSI accounts to be assigned after 300 days
    - CHAP accounts assigned after 90 days
    - Approximately 15,000 accounts to be placed, 4000 ready now.
    - Great Lakes staff will be full by 8/1

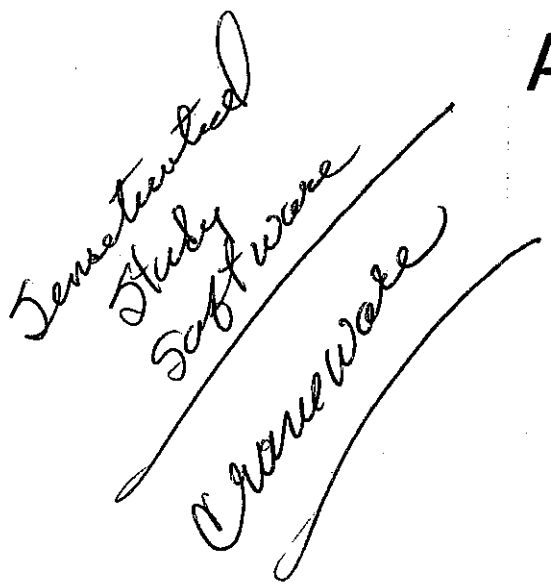
Questions/Comments

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

Revenue Cycle Improvement

Steering Committee Meeting

August 9, 2005



Agenda

- High Impact Initiatives Updates
- Miscellaneous
- Questions/Comments

High Impact Initiatives

- Billing Methodologies
- Claim Denials
- Charge Description Master Review
- Charge Entry/Capture Processes
- Coding and Charge Entry Backlogs
- Collection Agency Management
- Surgical Services Process Redesign
- ED Process Redesign
- Miscellaneous

Billing Methodologies

- Strategy meetings with Accordis
  - Work plan delivered by Accordis on 8/1 (completed)
  - Presently place through 7/30 $24,811,935, Returned $3,026,169, collected $612,861 for 2.8%. This needs to improve.
  - Established bi-weekly status meetings to continue to monitor results.
- Developing QA process for identifying errors
  - Identified resource in Business Office that will review all registrations daily.
  - Develop spreadsheet for tracking of errors
  - Develop training for registration staff
  - Evaluating Front end QA process to capture errors before the bill drops into the Business Office
- Technical resource on-site to develop cash posting tracking report

Billing Methodologies

- Setting up in-service training for billing and follow up staff with various Managed Care carriers
  - Nevada Care and PacifiCare scheduled to do on-site training.
  - Working with Aetna, Blue Cross, and others to do the same (contacting provider reps)
- Developed Aged Trail Balance to JOC meetings to identify payment issues.
  - UMC staff now doing all follow-up on Commercial, Managed Care, County Agencies and Medicare
- Out of State Medicaid not being worked due to contract issues with Great Lakes. Contract with National Access has expired. Need finalization of Great Lakes contract to protect from untimely filing issues (Stale Dates).

Billing Methodologies

- Secondary Billings
  - Staff began billing secondary claims (completed)
  - Developed report identifying account with secondary insurance (completed)
  - Assigned 1 FT FTE to concentrate on secondary billing (completed)
  - Approximately $2M in collectable AR
- MVA billing and follow up transferred to Patient Accounting (completed)
  - Free up 2 resources in Eligibility to enable better follow up on 0045 (EMTALA admits).
  - Developing procedure for MVA's, information gathering, billing, follow up, liens.

Billing Methodologies

- SSI transmitting terminal is outdated and being replaced within two weeks with a new server
  - Swifter download
  - Payer specific edits (current terminal does not have capacity to hold these types of edits)
  - Swifter transmission
  - End result will be faster turn-around of cash
- Receiving daily reports from SSI identifying accounts held in the editor
- SSI personnel are on-site beginning 8/15 to train billers on their claim editor

Billing Methodologies

- SSI front-end third party payer verification implementation is completed, train the trainers is completed, complete role out by 8/25.
  - Some SSI Issues remain
    - Medicaid Nevada not operational (this is problem from Medicaid to SSI, not with our system)
    - No access to Medicare (Mutual of Omaha intermediary contact issues between County District Attorney)
    - In progress of getting additional payers (SSI needs to get contacts with those payers)
    - Meeting schedule for 8/9 to review SSI payer list that was supposed to be included versus what we actually have available
    - SSI still working on the functionality to automatically post notes to patient accounts (SSI working with UMC IT)
    - SSI does not supply % due of co-insurance, example 80%/20%, 90%/10% for United Healthcare and Aetna. This information is available on the payers web site.

Claim Denials

- Developed report to identify all denials
- Procedures Developed (completed)
- Process implemented
- Tracking Report (completed)
- Developing methodology for working denials less than 6 months old.
- 2 FT FTE assigned to Denial follow up
- Denials since effort started 7/26 to date – 133 accounts for $1M
- 95 accounts appealed or reworked with requested information for $400K

Charge Description Master Review

Charge capture and CDM review started 7/18/05

- Received Charge Master file on 7/20 and reviewing Department by Department
  - Currently approximately 200 charges priced under APC reimbursement
    - Submitting recommended pricing for these items to Peter Tibone for approval – completed by 8/10
  - Meeting with Surgery, Pharmacy, ED, and Supplies
  - Pat off-site this week will return FT starting 8/15
- Reviewed O/P Charge Tickets
  - Identified missing charge items
  - Update charge tickets
  - Standardize charge tickets throughout Hospital Departments

Charge Description Master Review

- Reviewed Charge Master Policies
  - Will have updated policies for submission and approval by 8/12
  - 40 departments have access to make changes to Craneware and the CDM (should only have option to view and request changes or new charges)
  - Have appointed CDM Coordinator in Business Office (completed)

DME

- Running report to identify potential lost charges, will have 8/15

Charge Entry/Capture Processes

- Working with Outpatient Departments to establish Charge Entry/Capture Processes
  - Develop work flows
  - Develop best practices
  - Develop policies and procedures
- Developing reports to project increased revenue

Coding and Charge Entry Backlog

- Identified backlog in coding
  - Contract coders needed to catch up ED coding
    - FMLA absenteeism
    - Coders performing charge entry
  - Need ~~Contract Coders~~ to eliminate backlog
    - Contract submitted for approval
    - Contract needs approval from Contracts Management (Don Haight)
    - Contracts Management with DA to see if we need to put out to bid
    - Should have answer by 8/10
    - Present coding staff working overtime to catch up

Coding and Charge Entry Backlog

- Identified backlog in charge entry
  - Working overtime on charge entry (other than coders)
- Need 6 resources to eliminate charge entry by coders to allow to eliminate coding backlog
- 3 of 6 to be filled by current vacancies, need 3 new positions
- Working with HR (Meeting set for Thursday with John)

Collection Agency Management

- Reviewed existing Collection Agencies contracts (completed)
- One-on-one meetings with Collection Agencies (completed)
- Specialist to be on site week 8/8 to audit and evaluate Collection Agencies
  - Appointments set
  - Report due by 8/22

Collection Agency Management

- Recommendation of using 2 primary agencies instead of 3 (due to low rate we feel higher volumes will create more intensity) and 1 for secondary placements.
  - Will assign to Primary for 120 days at 121 they will go to secondary for follow up
- Specialist to be on site week of 8/8 to evaluate HFRI contract and performance
  - Report due by 8/22

Surgical Services Process Redesign

- Steve Gray and Ron Pimentel, Director, Surgical Services received approval from CEO to move forward with the redesign.
- Developing detailed redesign plan
- Steve Gray, Bob Jaime and Ron are developing tasks lists that will be incorporated into the final plan.
- Pre-Surgical Testing Center will be integral part to the redesign.
- Quantitative projections will be included in the design plan
- Draft Design plan scheduled for completion by 8/15
- Over site committee has been established to assist with implementation of plan. Chief Resident, CNO and 6 medical staff representatives

ED Process Redesign

- Reviewing self pay ED registrations daily (continuing)
- Eliminate "Escapes" (continuing)
  - Tracking daily
  - Adding registration staff
  - Increasing number of FTE's in ED during peak times to eliminate "escapes" (Great Lakes)
  - Developing follow up plan with policies and procedures
  - Following up on POS process in ED
- Scheduling specialist (Dr. Greg Hobbs) for on site visit in August to evaluate ED processes
- Process Redesign
  - Developing existing work flows
  - Develop future work flows incorporating best practices
  - Completion of future work flow design is targeted for 8/29 to review with ED leadership

Miscellaneous

- Daily Revenue Cycle meetings with direct reports to discuss issues/resolutions
- Daily "one stop" meetings to review and discuss follow up strategies, participants are:
  - Patient Access
  - Patient Accounting
  - Case Management
  - Eligibility
  - Great Lakes on-site Manager
  - Medical Records

Miscellaneous

- Tracking Eligibility Counselors Results
  - Evaluating work flow and developing redesign
    - Daily reviews of follow up process
    - Recommendation for reallocation by 8/25
    - Developing reviews of accounts over $50K
    - Better organize/manage use of Field Reps
    - Develop meaningful log for tracking Field Reps results
  - Developing productive standards and tracking reports
  - Set bi-weekly meeting with Clark County Social Services (CCSS) next meeting is 8/19 to discuss elimination/correction of denied claims
  - Working with Nevada State Welfare to schedule training during August
  - Eliminate Eligibility staff from doing insurance verification when a new source is located. Currently the EFS reps contact the patient and are required to gather all the necessary information and then verify coverage. This is being transitioned to the insurance verifying staff in Patient Access.

Miscellaneous

- Brought in Great Lakes to work with Eligibility to provide 24/7 coverage in ER, and cover IP as needed
  - Training completed
  - 24/7 coverage starting week of 8/8
  - Working on schedules so we will have no short staff situations during lunches and breaks
- Developed plan to move old accounts to Great Lakes
  - SSI accounts to be assigned after 300 days
  - CHAP accounts assigned after 90 days
  - Sent 5,002 SSI/MAABD accounts for $6.2M on 8/2
  - Sent 8,818 CHAP accounts for $21.6M aged over 120+ on 8/2

Miscellaneous

- Experiencing some IT issues with EFS reps, examples are back log of 13 terminals due budgetary constraints and Cactus System problems
  - Received notification from IT that request has been escalated and should have equipment within 2 weeks.
  - Cactus System interface problems, have verified county side is working properly. IT working with end users to reload application.
- Need to determine workloads and how many FTE's can be moved into 24/7 coverage to replace the Great Lakes temporary staffing of ED and evaluate the Quick Care Clinics that need EFS workers. Union gave me 30 days to develop a plan of action, due 9/3.
  - Have approved position for EFS worker at Lied Clinic – job is posted in recruitment
  - Once we determine if we can reassign staff from current EFS role to ED coverage working eligibility we are required to re-bid the jobs, which could take several additional weeks once they are identified.

Questions/Comments

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

Revenue Cycle Improvement

Steering Committee Meeting

August 21, 2005

Agenda

- High Impact Initiatives Updates
- Miscellaneous
- Questions/Comments

High Impact Initiatives

- Billing Methodologies
- Claim Denials
- Charge Description Master Review
- Charge Entry/Capture Processes
- Coding and Charge Entry Backlogs
- Collection Agency Management
- Surgical Services Process Redesign
- ED Process Redesign
- Miscellaneous

Billing Methodologies

- Strategy meetings with Accordis
  - Work plan delivered by Accordis on 8/1 (completed)
  - Presently place through 7/30 $24,811,935, Returned $3,026,169, collected $612,861 for 2.8%. This needs to improve.
  - Medicaid collections has dropped from an average of $6M per month through June 2005 to an average of approximately $2.5M for July and August. (still researching – meeting set with Accordis on 8/24)
  - Established bi-weekly status meetings to continue to monitor results. (completed)
- Developing QA process for identifying errors
  - Business Office reviewing sampling of registrations daily.
  - Develop spreadsheet for tracking of errors (completed)
  - Started discussing QA static's at morning "one stop" meetings
  - Evaluating Front end QA process to capture errors before the bill drops into the Business Office

Billing Methodologies

- Technical resource continues on-site to develop cash posting tracking report – Meeting last WK – IT, ACCTING. Close to Resolution – just verifying data
- Set up in-service training for billing and follow up staff with various Managed Care carriers
  - Nevada Care scheduled to do on-site training. (Completed)
  - Working with PacificCare, Aetna, Blue Cross, and others to do the same (contacting provider reps)
- Developed Aged Trail Balance to send prior to JOC meetings to identify payment issues.
  - UMC staff now doing all follow-up on Commercial, Managed Care, County Agencies and Medicare
  - Most recent JOC with Nevada Care was more meaningful and less excuses.
- Out of State Medicaid now being sent to Great Lakes. Contract with National Access has expired but they will continue working accounts assigned prior to expiration. (completed)

Billing Methodologies

- Secondary Billings (except Medicaid – Accordis)
  - Staff began billing secondary claims (completed)
  - Developed report identifying account with secondary insurance (completed)
  - Assigned 1 FT FTE to concentrate on secondary billing (completed)
  - Approximately $2M in collectable AR
  - Continuing to review workloads to determine maximum impact
- MVA billing and follow up transferred to Patient Accounting (completed)
  - Developing procedure for MVA's, information gathering, billing, follow up, liens. (completed)

Billing Methodologies

- SSI transmitting terminal is outdated and being replaced by week of 8/22 with a new server
  - Swifter download
  - Payer specific edits (current terminal does not have capacity to hold these types of edits)
  - Swifter transmission
  - End result will be faster turn-around of cash
- Meeting with IT to develop strategy for long term support for hardware and software. Temple preparing work plan.

Billing Methodologies

- Receiving daily reports from SSI identifying accounts held in the editor and working to get submitted. (on-going)
- SSI personnel ~~are~~ were on-site beginning 8/16 to train billers on their claim editor (completed)

Billing Methodologies

- SSI front-end third party payer verification implementation is completed, train the trainers is completed, complete role out by 8/25. √
  - Some SSI Issues remain
    - Nevada Medicaid not operational (this is problem from Medicaid to SSI, not with our system – being addressed)
    - No access to Medicare (Mutual of Omaha intermediary contact issues between County District Attorney). Staff still using Passport until resolved.
    - In process of getting additional payers (SSI needs to get contacts with those payers – need new server before completed)

Billing Methodologies

- Meeting scheduled to review SSI payer list that was supposed to be included versus what we actually have available and make corrections
- SSI still working on the functionality to automatically post notes to patient accounts (SSI working with UMC IT)
- SSI does not supply % due of co-insurance, example 80%/20%, 90%/10% for United Healthcare and Aetna. This information is available on the payers web site.

Claim Denials

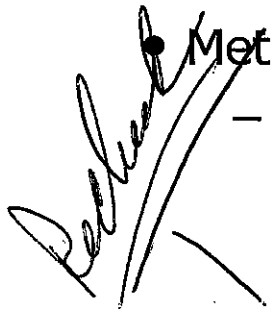
- Develop report to identify all denials (completed
- Procedures Developed (completed)
- Process implemented (completed)
- Tracking Report (completed)
- Developing methodology for working denials less than 6 months old.
- 2 FT FTE assigned to Denial follow up
- Denials identified since started 7/26 to date – 133 accounts for $1M
- 95 accounts appealed or reworked with requested information for $400K

Charge Description Master Review

Charge capture and CDM review started 7/18/05

- Received Charge Master file on 7/20 and reviewing Department by Department (Continuing)
  - Working with Ron Pimentel on OR redesign initiative around charge capture (just started)
  - Working on charges priced under APC reimbursement
    - Submitting recommended pricing for these items to Peter Tibone for approval – (completed)
    - Needs approval from Peter Tibone and CDM coordinator to input new pricing
    - * – Pulling report from IT to run sensitivity for analysis to determine dollar impact

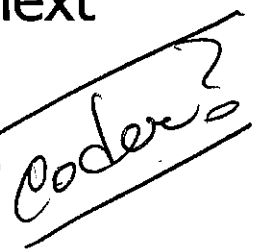
Charge Description Master Review



- Met with Surgery, Pharmacy and Supplies
  - Lost revenue issues with Pharmacy and Supplies due to Pyxis system, clean up required starting by 8/22 (implemented new Pyxis system in December and did not clean up charges prior to transferring over resulting in miss-matches and duplicates)
- Reviewed O/P Charge Tickets (on-going)
  - Identified missing charge items (on-going)
  - Update charge tickets (on-going)
  - Standardize charge tickets throughout Hospital Departments

Charge Description Master Review

- Reviewed Charge Master Policies
  - Will have updated policies for submission and approval by 8/22 (completed will present at next CDM meeting)
  - Have appointed CDM Coordinator in Business Office (completed)



DME

- Running report to identify potential lost charges, will have 8/22

Charge Entry/Capture Processes

- OR will be main focus due to re-design efforts
- Working with Outpatient Departments to establish Charge Entry/Capture Processes
  - Developing work flows (setting up meetings)
  - Develop best practices
  - Develop policies and procedures
- Developing reports to project increased revenue

Coding and Charge Entry Backlog

- Backlog in IP/ED coding
  - As of today:
    - IP coding – $33.3M – 45 days backlog
    - OP coding - $ 7.9M – 5 days backlog
    - ED coding - $16.5M – 70 days backlog
      - 230 visits per day @ average of $500 per visit = $1.2M per day
  - All out effort needed to catch up ED coding
    - FMLA absenteeism
    - Coders performing charge entry
    - ED coding getting stale dated

outcomes

Coding and Charge Entry Backlog

- Contract submitted for approval
  - Contract needs approval from Contracts Management (Don Haight)
  - Contracts Management with DA to see if we need to put out to bid
  - No resolution to date – process has taken 3 weeks so far
  - Vendor ready to bring in 3 coders once contract approved
  - Present coding staff working overtime to catch up
  - Moving Coders from Ambulatory to ED (short term fix to catch up backlog)

Coding and Charge Entry Backlog

- Need 6 permanent resources to eliminate charge entry by coders to allow to eliminate coding backlog
- All 6 positions to be filled by current vacancies, have identified vacancies and have notified HR to post (completed)
- HR to take to Lacy for approval

Collection Agency Management

- Reviewed existing Collection Agencies contracts (completed)
- One-on-one meetings with Collection Agencies (completed)
- Specialist were on site week of 8/8 to audit and evaluate Collection Agencies
  - Report due week of 8/22
  - Initial reaction current rate structure and volumes resulting in low productivity with these agencies
  - Working on draft proposal for early-out placements for a premium rate to handle all self pay including aged accounts. by 8/26

Collection Agency Management

- Specialist was on site week of 8/8 to evaluate HFRI contract and performance
  - Report due by week of 8/22
  - Initial reaction was HFRI contract should be cancelled, they are creaming accounts, and since Business Office resumed follow up finding many accounts not worked or worked insufficient. (completed – letter sent 8/18 with cancellation date of 10/1)

Surgical Services Process Redesign

- Steve Gray and Ron Pimentel, Director, Surgical Services received approval from CEO to move forward with the redesign.
- Developing detailed redesign plan
- Steve Gray, Bob Jaime and Ron are developing tasks lists that will be incorporated into the final plan.
- Pre-Surgical Testing Center will be integral part to the redesign.
- Quantitative projections will be included in the design plan
- Draft Design plan scheduled for completion by week of 8/22 Done Gray
- Over site committee has been established to assist with implementation of plan. Chief Resident, CNO and 6 medical staff representatives Meeting tomorrow

ED Process Redesign

- Reviewing self pay ED registrations daily (continuing)
- Eliminate "Escapes" (continuing)
  - Tracking daily
  - Adding registration staff
  - Increasing number of FTE's in ED during peak times to eliminate "escapes" (Great Lakes)
  - Developing follow up plan with policies and procedures
  - Following up on POS process in ED
- Scheduling specialist (Dr. Greg Hobbs) for on site visit August 22 to meet/evaluate ED processes
- Process Redesign
  - Developing existing work flows
  - Develop future work flows incorporating best practices
  - Completion of future work flow design is targeted for 8/29 to review with ED leadership

Miscellaneous

- Daily Revenue Cycle meetings with direct reports to discuss issues/resolutions
- Daily "one stop" meetings continuing to review and discuss follow up strategies, participants are:
  - Patient Access
  - Patient Accounting
  - Case Management
  - Eligibility
  - Great Lakes on-site Manager
  - Medical Records

Miscellaneous

- Have assigned Virginia to concentrate on Nursing Home placements
- Shundra will be responsible for all aspects of Eligibility (Virginia will assist)
  - Tracking Eligibility Counselors Results
    - Evaluating work flow and developing redesign
      - Daily reviews of follow up process
      - Recommendation for reallocation of staff by 8/26
      - Better organize/manage use of Field Reps
      - Develop meaningful log for tracking Field Reps results (completed)
  - Bi-weekly meeting with Clark County Social Services (CCSS) continue to discuss elimination/correction of denied claims
  - Working with Nevada State Welfare to schedule meeting to discuss denials/difficult cases and training during August. (On-going)
  - Eliminated Eligibility staff from doing insurance verification when a new source is located. Supplying detail each morning of insurance information obtained by Eligibility workers to Admitting for training and verification. (completed)

Miscellaneous

- Brought in Great Lakes to work with Eligibility to provide 24/7 coverage in ER, and cover IP as needed
  - 24/7 coverage starting week of 8/8 (completed)
  - Working on schedules so we will have no short staff situations during lunches and breaks (completed)
  - Evaluating peaks and valleys in ER Patient loads to maximize scheduling.
- Determining workloads of current EFS staff to provide 24/7 coverage to replace the Great Lakes temporary staffing of ED and Quick Care Clinics that need EFS workers. Union gave us 30 days to develop a plan of action, due to Union 9/3.
- Once we determine reassignment of staff from current EFS role to ED coverage working eligibility we are required to re-bid the jobs, which could take up to one month.
- Have approved position for EFS worker at Lied Clinic – job is posted in recruitment.

Miscellaneous

- Developed plan to move old accounts to Great Lakes
  - Sent 5,002 SSI/MAABD accounts for $6.2M on 8/2
  - Sent 8,818 CHAP accounts for $21.6M aged over 120+ on 8/2
  - Requested bi-weekly status reports ✓

Questions/Comments

2005

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

MR out of Pat access

Revenue Cycle Improvement

Steering Committee Meeting

September 13, 2005

Agenda

- High Impact Initiatives Updates
- Miscellaneous
- Questions/Comments

High Impact Initiatives

- Billing Methodologies
- Charge Description Master Review
- Charge Entry/Capture Processes
- Coding and Charge Entry Backlogs
- Collection Agency Management
- Surgical Services Process Redesign
- Patient Access Process Redesign
- Miscellaneous

Billing Methodologies

- Strategy meetings with Accordis
  - Medicaid collections has dropped from an average of $6M per month through June 2005 to an average of approximately $3.5M for July and August. They are researching and will advise by 9/15
  - Accordis sending claims to re-bill by 9/30, claiming approximately 10,000 claims that will need rebilling by 9/30. They are getting to us ASAP.

Billing Methodologies

- HFRI contract cancelled effective 9/30 and B/O staff to begin follow up. (Complete)
- Secondary Billings (except Medicaid – Accordis)
  - Approximately $2M in collectable AR
  - Also started billing secondary claims on those accounts placed with HFRI.
  - Continuing to review workloads to determine maximum impact
- In-service meeting including billers and follow-up staff with Pacific Care to discuss issues. These meetings will be set up with all carriers each month.

Henderson Police Department

223 Lead St. Henderson, NV 89015

Booking Custody Record

ENTERED LH/2091

DR NUMBER	FH NUMBER	MNI NUMBER	SUBJECT NAME	ARREST DATE	ARREST TIME
1520170	15		Meill, Anthony Gilbert	12/08/2015	2016

LOCATION OF CRIME	INTERSECTION	AT LOCATION
903 Sparrow Court Henderson Nevada 89014		☐

LOCATION OF ARREST	INTERSECTION	AT LOCATION
903 Sparrow Court Henderson Nevada 89014		☐

☒ INTERPRETOR NEEDED	☐ SUBJECT COMBATITIVE	☐ SUBJECT SUICIDAL	☒ ASK SUBJECT IF INJURED	INTAKE OFC INITIAL/P#
☑ MIRANDA GIVEN	☐ MIRANDA WAIVED	☑ MIRANDA INVOKED		

MIRANDA	DATE	TIME	GIVEN BY
	12/08/2015	2040	P. Baldino P#1997

PERSON 1	PERSON NAME (LAST, FIRST, MID., SUFFIX)	SSN	D.O.B.	AGE
	Meill, Anthony Gilbert	606-58-1546	08/12/1988	27

PERSON ADDRESS	HGT	WGT	HAIR	EYES	RACE	GENDER
903 Sparrow Court Henderson Nevada 89014	6'1"	175	Brown	Brown	White	Male

HOME PHONE	CELL PHONE	BUSINESS PHONE	OTHER PHONE	PLACE OF BIRTH
(702)202-1336				California

ALIAS	ALIAS (LASTNAME/MONIKER, FIRST, MIDDLE)

VIOLATION 1	STATUTE	CLASS	NOC CODE	COUNTS
	454.316.1	Gross Misdemeanor	51358	2

DESCRIPTION: POSS DANG DRUG W/O P-SCRPT, (1ST/2ND)

PCN NUMBER	WARRANT NUMBER

VIOLATION 2	STATUTE	CLASS	NOC CODE	COUNTS
	199.220	Gross Misdemeanor	52980	1

DESCRIPTION: DESTROY/CONCEAL EVIDENCE

PCN NUMBER	WARRANT NUMBER

P AND P: ☐ DRINKING VIOLATION ☐ CONTACT WITH CHILDREN ☐ CONTACT WITH VICTIM ☐ DRIVING VIOLATION ☐ IN GAMING ESTABLISHMENT ☐ CONTACT WITH CO-OFFENDER ☐ CONTACT WITH GANG MEMBER

ARRESTING OFFICER	P NUMBER	TRANSPORTING OFFICER	P NUMBER
Baldino, Paul	HP1997	Baldino, Paul	HP1997

Henderson Police Department

223 Lead St. Henderson, NV 89015

Booking Custody Record

DR NUMBER	FH NUMBER	MNI NUMBER	SUBJECT NAME	ARREST DATE	ARREST TIME
1620170	15		Meili, Anthony Gilbert	12/08/2015	2016

PROBABLE CAUSE REVIEW

The undersigned Magistrate has reviewed the Affidavit and Declaration of Probable Cause for the arrest of the above-named defendant without warrant for the charge(s) shown.

Finding

TIME STAMP AT BOOKING

☐ I find there is sufficient probable cause, for the purpose of continued incarceration, to believe that charged crime(s) have been committed and that said defendant has committed such crime(s). THEREFORE, IT IS ORDERED that the defendant may be held in custody until bail is posted.

BAIL: STANDARD ☐ OTHER ☐ $ _____

☐ I find there is NOT sufficient probable cause shown to allow the defendant to be held in custody. THEREFORE, IT IS ORDERED that the defendant be immediately release from custody as to the charge(s). This order is without prejudice to the City or State to proceed with the charge(s) based upon additional evidence sufficient to establish probable cause.

DPCH ☐ OR RELEASE ☐ COR RELEASE ☐ IAD RELEASE ☐

COMMENT: _____

RETURN DATE: NORMAL SCHEDULE ☐ FIRST AVAILABLE ☐ OTHER DATE _____

_____ JUSTICE COURT ☐ Date: _____ Time: _____
Signature of Magistrate MUNICIPAL COURT ☐

ARRESTING OFFICER	P NUMBER	TRANSPORTING OFFICER	P NUMBER
Baldino, Paul	HP1997	Baldino, Paul	HP1997

Henderson Police Department

223 Lead St. Henderson, NV 89015

Declaration of Arrest

DR# 1520170
FH# 15

Arrestee's Name: Meili, Anthony Gilbert
Date of Arrest: 12/08/2015
Time of Arrest: 2016

Charge	Degree	NRS\HMC
POSS DANG DRUG W/O P-SCRPT, (1ST/2ND)	Gross Misdemeanor	454.316.1
DESTROY/CONCEAL EVIDENCE	Gross Misdemeanor	199.220

THE UNDERSIGNED MAKE THE FOLLOWING DECLARATIONS SUBJECT TO THE PENALTY FOR PERJURY AND SAYS: That I, Paul Baldino am a peace officer with the Henderson PD, Clark County, Nevada, being so employed since 09/20/2012. That I learned the following facts and circumstances which led me to believe that the above named subject committed (or was committing) the above offense/offenses at the location of 903 Sparrow Court Henderson Nevada 89014, and that the offense occurred at approximately 2016 hours on 12/08/2015.

Details of Probable Cause

On 12/08/2015 at approximately 1833 hours Sergeant E. Bogdanowicz P#1408 and I, Officer P. Baldino P#1997 responded to 540 Marks Street (Walmart) located in Henderson, NV in reference to a battery.

Upon arrival Sgt. Bogdanowicz made contact with Anthony Meili (DOB 08/12/1988) who advised the following:

He was in Walmart when he noticed an old friend named "Edgar Ramirez" (Unidentified) (Unknown Clothing) and an Unknown Hispanic Male 5'10" weighing 200 pounds approached him in the Walmart by the arcade area and asked him to go into the restroom which made him "scared" because he was not sure as to what they wanted. He saw other people enter the restroom so he walked in and the above two males exited shortly after.

He still felt "scared" so he went into one of the check out lines waiting for the males to leave. As the two above described males left the Walmart he followed them to their gray unknown pickup and asked for a ride. He told them that he just got paid and wanted to go for a drink. "Edgar" and the Unknown male began striking him until he fell to the ground and then continued to strike him repeatedly until he became unconscious.

Sgt. Bogdanowicz arrived on scene and Anthony stated he wanted a ride home to speak with his father before deciding to press charges. I transported Anthony to his residence 903 Sparrow Court located in Henderson, NV. Sgt. Bogdanowicz and I contacted Anthony's father Anthony Meili (DOB 02/21/1964 SENIOR) who stated that his son Anthony was "probable selling my stolen pills" resulting in his battery.

Anthony (SENIOR) stated that he overheard Anthony (Junior) talking on his cell phone to an unknown subject stating, "I'll meet with you and sell you these pills."

I did a pat down of Anthony's person and felt a pill bottle in his front left pants pocket. I asked Anthony what the bottle was and he stated, "My Methadone" prescription. I asked Anthony for permission to remove the pill bottle from his pocket which he stated, "yes."

I removed the white bottle from Anthony's (Junior) front left pants pocket which yielded (Clonazepan 0.5MG RX#1290490 100 Pink round Tablets Prescribed by DR. James Gabroy.) The bottle contained 109 tablets of Clonazepan which Anthony (Junior) advised were his.

Sgt. Bogdanowicz spoke with Anthony (Senior) who stated that the pills were his and verified his prescription to Sgt.

Paul Baldino
Declarant's Name

Henderson Police Department

223 Lead St. Henderson, NV 89015

Declaration of Arrest Continuation Page

DR# 1520170
FH# 15

Arrestee's Name: Meill, Anthony Gilbert

Details of Probable Cause (Continued)

Bogdanowicz. Anthony (Senior) stated that Anthony (Junior) is known to steal his prescriptions on several occasions.

After further questioning Anthony stated that he does not have a prescription and the pills belong to his father. Anthony also stated that he does not have insurance, nor a prescription to obtain the medication. Anthony was trying to pass the prescription off as his own since he and his father share the same name.

Due to the fact that Anthony (Junior) was in possession of a prescription of a benzodiazepine a Schedule 4 narcotic with 109 tablets in his possession, I arrested him for Possess Dangerous Drug without prescription NRS 454.316.1

While transporting Anthony to the Henderson Jail he was moving around and repositioning his person several times during the course of the ride. Upon removing Anthony from my marked Henderson Patrol vehicle #5450, I observed one whole tablet along with several broken tablets of a white rectangular pills on the back seat of my patrol vehicle underneath where Anthony was seated. I also observed a white prescription bottle on the floor board which was labeled (Methadone HCL 10 MG RX#1290491 white rectangular tablets DR. James Gabroy.)

I read Anthony his Miranda Rights which he invoked for a lawyer.

I collected the Methadone bottle and pills left on the rear seat of my patrol vehicle. I walked Anthony into the Henderson Detention Center where he was great by Corrections Officer's. Anthony stated that he needed to use the restroom and when the Corrections Officers told him that he would not be able to use the restroom until he was searched and changed out. Anthony then stated that he was going to vomit and began gesturing that he was going to puke. Corrections staff walked him over to the trash can and I observed him lift his left hand in a closed fist over the trash can. Corrections staff told him to open his hand three times over the booking counter. Anthony eventually complied and opened his left fist releasing 104 Methodone pills onto the counter.

I counted the whole tablets that Anthony placed on the counter which equaled 104 tablets. There were also several pieces of broken tablets placed on the counter along with the whole tablets.

Due to the fact that Anthony had another prescription on his person which is also a controlled substance, I charged him with a second count of Possess Dangerous Drug without prescription NRS 454.316.1

Due to the fact that Anthony had a bottle of Methodone prescription with over 104 tablets after he has been arrested concealing them on his person, and trying to destroy the pills by either disposing them in the restroom, and with his attempt of throwing them away into the Detention Center trash can, I charged him with Destroy/Conceal Evidence NRS 199.220.

Wherefore, Declarant prays that a finding be made by a magistrate that probable cause exists to hold said person for preliminary hearing (if charges are a felony or gross misdemeanor) or for trial (if charges are a misdemeanor).

Paul Baldino

Declarant's Name

Billing Methodologies

- SSI transmitting terminal is outdated and being replaced by this week, server on-site, needs to be installed
  - Swifter download
  - Payer specific edits (current terminal does not have capacity to hold these types of edits)
  - Swifter transmission
  - End result will be faster turn-around of cash
- Receiving daily reports from SSI identifying accounts held in the editor and working to get submitted. (on-going)

Billing Methodologies

- New follow up department averaging over $1M per week in promises to pay from commercial and Managed care payers. Continuing to track results with a target of $2M per week.
- Since 7/20 re-billed 188 accounts or $1.4M. These are claims that were denied and now have been resubmitted with information requested.
- Developed spreadsheet for denials from 1-2005 through 6-2005 to work and re-bill. Will report next week on potential recovery.
- re-billed 150 accounts with correct HCPCS codes for pharmacy charges. XX

Charge Description Master Review

Charge capture and CDM Review

- Continuing review of Charge Master file Department by Department
  - Working with Ron Pimentel on OR redesign initiative around charge capture
    - Reviewing procedure charges for IP/OP
    - Review Mapping of CDM charge codes

Charge Description Master Review

- Working on charges priced under APC reimbursement
  - Submitting recommended pricing for these items to Peter Tibone for approval. Charge Master Review Committee meeting set for week of 10/1 and will be complete by then.

Charge Description Master Review

- Met with Surgery, Pharmacy and Supplies
  - Lost revenue issues with Pharmacy and Supplies due to Pyxis system. Brought in new resource, Tina Melvin to clean up and will start by 9/19 (implemented new Pyxis system in December and did not clean up charges prior to transferring over resulting in miss-matches and duplicates) Verified this was an issue.
- Pharmacy CDM review
  - Identified list of 150 accounts without HCPCS that was re-billed
  - Identified list of Pharmacy charges that do not have HCPCS codes in CDM and will re-bill where applicable.

Charge Description Master Review

DME

- Pat Huber meeting with Mike Walsh 9/14 – to discuss.

Charge Entry/Capture Processes

- OR, Burn Center, IV Therapy and Dialysis Units are the main focus.
- Developing reports to project increased revenue
  - Meeting with MR to develop a plan with coders to identify missed charges.

Charge Entry/Capture Processes

- New resource, Tina Melvin on site to begin analysis of charge capture process in each clinical area
  - Interviewing charge entry staff
  - Review processes
  - Make recommendations based on findings
  - Completed by 10/31.

Coding and Charge Entry Backlog

- Backlog in IP/ED coding
  - As of today:
    - IP coding – $33.1M
    - OP coding - $ 26.4M
    - Total Coding - $59.5M (down $2M from from 9/8)
  - All out effort needed to catch up ED coding
  - Received Contract from DA today and e-mailed changes to Vendor, HIP to fix and send three signed copies fed ex today. Will start ASAP
    - Present coding staff working overtime to catch up
    - Moving Coders from Ambulatory to ED (short term fix to catch up backlog)

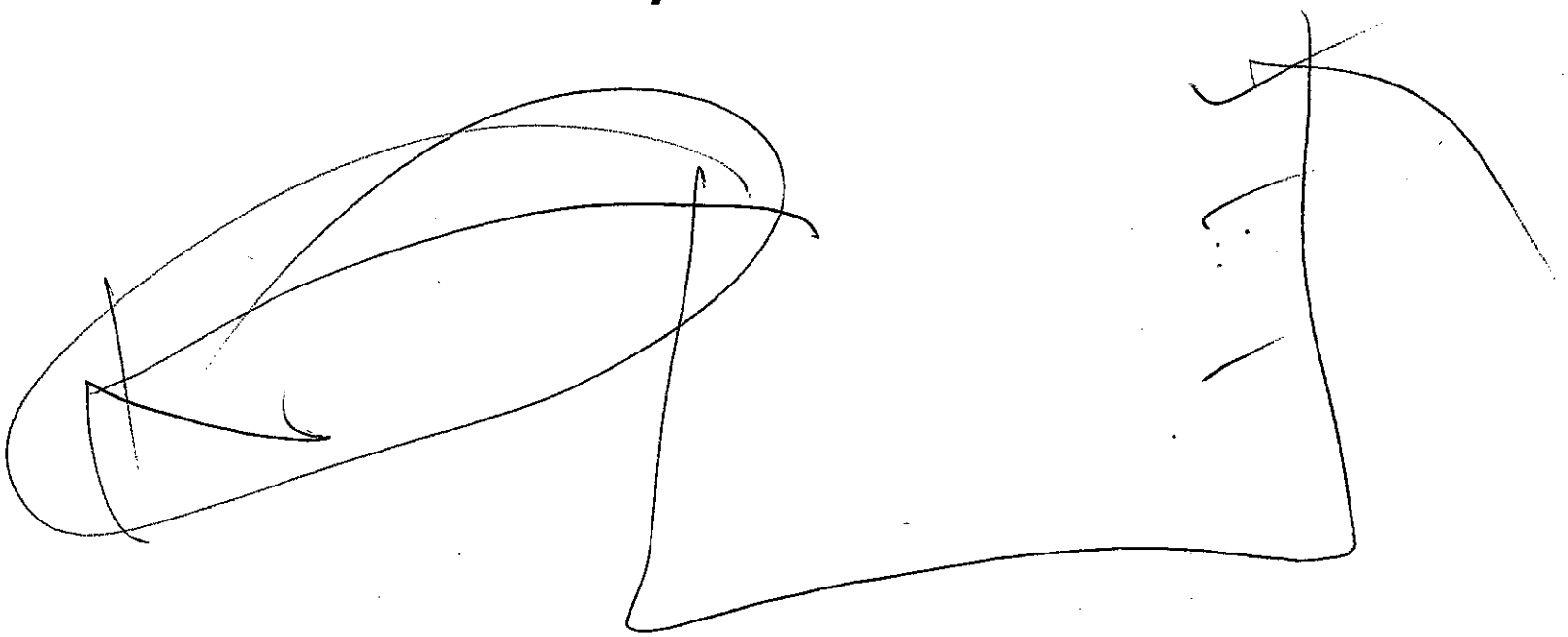
What is impact on coders?

Coding and Charge Entry Backlog

- Need 6 permanent resources to eliminate charge entry by coders to allow to eliminate coding backlog (completed)
- All 6 positions to be filled by current vacancies, have identified vacancies and have notified HR to post (completed)

Collection Agency Management

- Received proposal and reviewing, to discuss with Lacy and Bob Mills.



Surgical Services Process Redesign

- Steve Gray and Ron Pimentel, Director, Surgical Services received approval from CEO to move forward with the redesign. (completed)
- Developed detailed redesign plan.
- New design will improve surgical net revenue by $12.5M annually (conservative estimates).

Patient Access Process Redesign

IP Registration

- Evaluating reasons for duplicate registrations.
  - Medicare Pharmacy charges – not covered so opening two separate accounts
- Evaluating newborn processes (pre-registered ?)
- Meeting with staff to evaluate processes for different job functions (verifiers, Nurses, etc.)
- No ABN process in admissions – looking at solutions
- Evaluate process between Medical Records and Patient Access, too many records sitting in Patient Access
- Evaluating all process in Patient Access to optimize staffing.
- Develop front end QA process and procedures

Patient Access Process Redesign

ED Registration

- Reviewing self pay ED registrations daily (continuing)
- Eliminate "Escapes" (continuing)
  - Tracking daily
  - Adding registration staff – including 3 new management positions to provide 24/7 supervision.
  - Developing follow up plan with policies and procedures
  - Continuing on POS process in ED

25-80

20/18

Miscellaneous

- Daily Revenue Cycle meetings with direct reports to discuss issues/resolutions
- Tracking Eligibility Counselors Results
  - Evaluating work flow and developing redesign
  - Daily reviews of follow up process

Miscellaneous

- Determined workloads of current EFS staff to provide 24/7 coverage to replace the Great Lakes temporary staffing of ED and Quick Care Clinics that need EFS workers. Union gave us 30 days to develop a plan of action, due to Union 8/31. (completed)
- Working with HR to determine if we can use Per Diem employees. (completed)
- We have determined reassignment of staff from current EFS role to ED coverage working eligibility working with HR to re-bid the jobs (if necessary), which could take up to one month.

Questions/Comments

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

RA 000263

Revenue Cycle Improvement

Steering Committee Meeting

1 - Last week
MR out of Pat Access

September 20, 2005

Judy Smith
Advanced Directives

Most current
Signed & Dated
905

Document Process

Agenda

- High Impact Initiatives Updates
- Questions/Comments

High Impact Initiatives

- Billing Methodologies
- Charge Description Master Review
- Charge Entry/Capture Processes
- Coding and Charge Entry Backlogs
- Collection Agency Management
- Surgical Services Process Redesign
- ABN Processing
- Case Management Processing
- Patient Access Process Redesign
- Miscellaneous

Billing Methodologies

- Strategy meetings with Accordis
  - Medicaid collections has dropped from an average of $6M per month through June 2005 to an average of approximately $4M for July and August.
  - Accordis stated some payments have not been posted due to electronic RA problems, (this is $1.6M from July, $500K for August and $225K for Sept to date) but are still running approximately $2M behind the average UMC obtained prior to them coming on.
  - Pulling report to validate bills going out timely – no feedback from Accordis that they are receiving excessive amount of denials from First Health.
  - Accordis sent claims to re-bill by 9/30, the final batch of claims (11,000) needing rebilling by the extension of the stale date was received in the Business Office on 9/16 and will be billed by 9/23.

Medicare ALOS Produce Line

Checking Rev Volume

accordis Meeting 9/29

Billing Methodologies

- Receiving daily reports from SSI identifying accounts held in the editor and working to get submitted. (on-going). Accounts currently being held in SSI is $8.8M, approximately 2.2 days. This is down from $28M. Goal is to be no higher than $5M.
- Vital works claims held in SSI are also down to 216 claims for approximately $73K compared to 2,000 claims for approximately $678K. We started running all Vital Works claims through SSI scrubber to clean.

Billing Methodologies

- New follow up department is now full staffed and averaging over $1.5M per week in promises to pay from commercial and Managed care payers. Continuing to track results with a target of $2M per week. Will begin tracking actual collections.
- Have new FTE that will function as a Utilization/chart review nurse to ensure proper billing and charge capture, do clinical reviews for outside audits from payers, and County treatment authorizations.

Starts After JCAHO

Charge Description Master Review

Charge capture and CDM Review

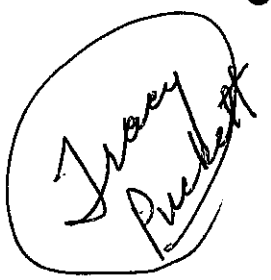
- Continuing review of Charge Master file Department by Department
  - Working on OR redesign initiative around charge capture
    - Reviewing procedure charges for IP/OP
    - Review Mapping of CDM charge codes

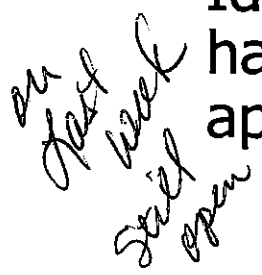
Charge Description Master Review

- Working on charges priced under APC reimbursement
  - Submitting recommended pricing for these items to Peter Tibone for approval next week when returns from vacation. Charge Master Review Committee meeting set for week of 9/20 to present new policy and procedures.

Charge Description Master Review

- Met with Surgery, Pharmacy and Supplies
  - Lost revenue issues with Pharmacy and Supplies due to Pyxis system. Brought in new resource, Tina Melvin to clean up and will start by 9/19 (implemented new Pyxis system in December and did not clean up charges prior to transferring over resulting in miss-matches and duplicates)
  - Reviewing Pharmacy CDM a few areas at a time and rebilling as necessary.
  - Identified list of Pharmacy charges that do not have HCPCS codes in CDM and will re-bill where applicable.





Charge Description Master Review

Tracey Puckett PCE Does not Charge Clark County

DME

- Pat Huber met with Mike Walsh 9/14 –to discuss if UMC should resume billing Medicare for DME. Pat to determine reimbursement from MediCaid and based on findings will determine if cost effective to bill Medicare. Mike is checking with Materials Management to determine costs.

We are currently paying for DME products, if we do not bill we will be just giving them away. Recommend we renew license and start billing ASAP.

Mike Comment: We pay why not Charge

Charge Entry/Capture Processes

- OR, Burn Center, IV Therapy and Dialysis Units are the main focus.
- One FT resource, Tina Melvin is assigned to this project.
- Developing policy and procedures for each department.
- Work with departments to ensure charge tickets are kept up to date.

Coding and Charge Entry Backlog

- Backlog in IP/ED coding
  - As of 9/19:
    - IP coding – $28.7 - last week $33.1M (9/13)
    - OP coding - $24.6 - last week $26.4M (9/13)
    - Total Coding - $53.3 - Last week $59.5M (9/13) (down $2M from from 9/8)
  - All out effort continues to catch up ED coding
    - Present IP coding staff working overtime to catch up
    - Moved Coders (overtime) from Ambulatory to ED (short term fix to catch up backlog)

Coding and Charge Entry Backlog

- All 6 positions to be filled by current vacancies, have identified vacancies and have notified HR to post. Positions have been posted and we are interviewing. Selection will take place by 9/23.
- Have signed contract with HIP to provide two coders that can do charge entry and ER coding. Should be on-site by end of week, working on schedule to be sure they are supervised.
- Revamping H&P (History and Physical) process to meet JCAHO requirements to be on the record within 24 hours of admission. This has to do with electronic signatures. Working with IT and performance improvement.

Collection Agency Management

- Received proposal and reviewing, to discuss with Lacy and Bob Mills.

Surgical Services Process Redesign

- Process scheduled to be operational by 10/15.

ABN Processing

- Currently no ABN process in place resulting in lost revenues since we cannot collect from Medicare or the patient and the portion that would fall to the patient is currently written off.
- Long term fix is to evaluate and select application software that integrates with patient access and scheduling applications.
  - Preparing RFP to SSI, Cerner, Siemens, and Health Works.
  - Working with IT

ABN Processing

- Short Term fix we have 2 options
  - Manual
    - Printing ABN from CMS web site
    - Determining coverage from fiscal intermediaries web site
  - Implement web based application (Health Works or SSI) that is not integrated with patient access.
    - User enters diagonis code or naritative
    - Application determines coverage and if ABN required.
    - Checking pricing

Case Management Processing

- The issues
  - Inconsistancy in case management practices – being conducted out of 5 different areas (Case Management, Process Improvement, Nurses in Patient Access, Social Services, and Eligibility). Impacts are reduced reimbursement due to lack of receiving addition authorization for length of stays or non-covered service.
  - High dollar patient portions that are not being monitored
  - No automated methods for monitoring patient through the continuum of care.

Case Management Processing

- The issues
  - No productivity standards
  - Unable to identify length of stay reductions and potential costs reductions. *Purchased Horizon Performance Manager for DRG and Length of Stay analysis and never implemented or not being used.
- Writing process to eliminate duplicate process between the 5 different case management areas.

Cerner Eclipsys check

Case Management Processing

- Developing processes to address High Dollar Patient monitoring
- Establishing productivity standards
- Evaluate usage of Horizon Performance Manager

Patient Access Process Redesign

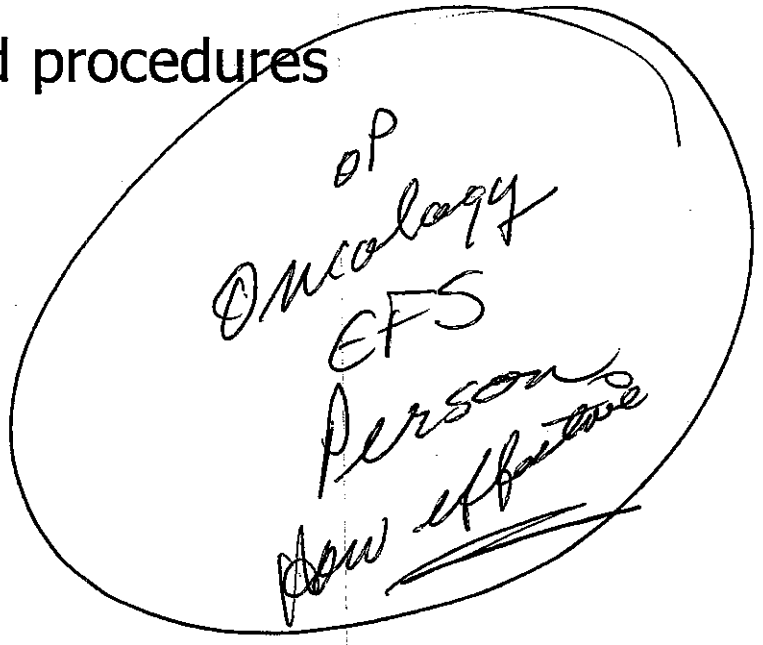
IP Registration

- Evaluating reasons for duplicate registrations.
  - Medicare Pharmacy charges – not covered so opening two separate accounts (completed)
- New resource Bob Whipple on site 9/22 to begin review of observation processes.
- Evaluating newborn processes. Meeting schedule with nursing on 9/22. Goal is to stop this process.
- Meeting with staff to evaluate processes for different job functions (verifiers, Nurses, etc.) (on-going)
- No ABN process in admissions – looking at solutions

Patient Access Process Redesign

IP Registration

- Evaluate process between Medical Records and Patient Access, too many records sitting in Patient Access (meeting with MR 9/19 to develop process to eliminate) (completed)
- Evaluating all process in Patient Access to optimize staffing.
- Develop front end QA process and procedures



Patient Access Process Redesign

ED Registration

- Reviewing self pay ED registrations daily (continuing)
- Eliminate "Escapes" (continuing)
  - Tracking daily
  - Adding registration staff – including 3 new management positions to provide 24/7 supervision.
  - Developing follow up plan with policies and procedures
  - Continuing on POS process in ED
- Lied Clinic have a group of private physicians moved and they are requesting patients registered as a patient type "P" (one time visit) Traditionally these patients have been registered as patient type "R" (recurring) and according to Geri Parks, Office Supervisor at Lied Ambulatory Care Center the reimbursement is different for these two patient types and feels we might have a compliance issue. (Currently researching)

Miscellaneous

- Tracking Eligibility Counselors Results
  - Evaluating work flow and developing redesign
  - Daily reviews of follow up process
    - We have determined that reassignment of staff from current EFS role to ED coverage working eligibility requires a re-bid of the positions. This was completed on Friday and is required to be posted for 7 days from 9/16. Once 7 days expires, we will evaluate the persons with the highest seniority to fill the positions.

Miscellaneous

- Reassigning one EFS FTE to the Lied Clinic, there is no EFS working presently and this will give them coverage 8:00 AM to 4:30 PM Monday through Friday.
- Re-evaluating work duties of EFS FTE's in ER, including one FTE spending additional time at the Women's Clinic, doing their own follow ups on verifications, etc.
- Developing a plan for the EFS workers to concentrate on getting the required information from patients and/or relatives while patient is still in-house and allowing Great Lakes to do the leg work once the patient is discharged.
- Develop a work flow plan for placement of accounts to Great Lakes or in-patient and ER, this will include time frames.

Questions/Comments

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

AGING

RA 000291

Revenue Cycle Improvement

Steering Committee Meeting

October 11, 2005

Agenda

- Total Potential Incremental Cash Forecast
- Major Production Obstacles
- High Impact Initiatives Updates
- Questions/Comments

Total Potential Incremental Cash Forecast

- Billing Improvements
  - –Denials = $600,000 per month
  - –Secondary Insurance = $40,000 per month
  - –MVA billings = $375,000 per month
  - –Early outs = $250,000 per month
  - –Accordis = $500,000 per month
  - –HFRI = $500,000 per month
  - –Reconciliation = $40,000 per month
- One time improvements
  - –DNFB = $3,200,000
  - –SSI clean up = $3,200,000

Total Potential Incremental Cash Forecast

- Process Redesign
  - Surgical Services = $300,000 per month
  - Front end collections (inpatient) = $187,000 per month
  - Front end collections (ER) = $146,000 per month
  - Reduce "escapes" from ER = $30,000 per month
  - EFS workers at Lieds and Women's Clinic = still quantifying
- Charge Capture
  - Trauma Activation charges = $105,000 per month
  - CDM clean up = still quantifying
  - ~~Charge Capture~~ = still quantifying
  - Observation = still quantifying
  - Clean up on ~~Pharmacy charges~~ – collected $81K – still quantifying
- Savings of HFRI invoice expense of $250,000 per month and postage costs for PASC of $30,000.

OP Surgery

Trauma Charge entry in Clinics

300

Not doing correctly

High Impact Initiatives

- Billing Methodologies
- Coding
- Collection Agency Management
- Surgical Services Process Redesign
- ABN Processing
- Case Management Processing
- Patient Access Process Redesign
- Charge Description Master Review
- Miscellaneous

Major Production Obstacles

- $6.3M in un-posted Medicaid cash from 7/1/2005 to 10/7/2005
- Wasted account follow up activity
- Overstating AR, could cause patient complaints.

Billing Methodologies

- Strategy meetings with Accordis
  - Medicaid collections remain down from $6M per month through June 2005 to an $3M for July through September.
  - Approximately $4M in Medicaid payments have not been posted due to electronic RA problems, or approximately $1.4M per month. Collections are still running approximately $1.6M behind the average UMC obtained prior to Accordis.
  - Pulled report and validated bills are going out timely – no feedback from Accordis that they are receiving excessive amount of denials from First Health.
  - Business Office sent out 15,000 claims that needed rebilling by the extension of the stale date (completed)

Receipt 3

Billing Methodologies

- Receiving daily reports from SSI identifying accounts held in the editor and working to get submitted. (on-going). Accounts currently being held in SSI is $12M. This is down from $28M. Goal is to be no higher than $5M. (incremental cash is $16M in additional claims dropped X .25% = $4M during October and November)
- Business Office started billing Med-Pay and Health Insurance at the same time to minimize stale date issues. In the past only Med-Pay was billed and the health insurance was not billed at all or not until Med-pay paid or denied.

Billing Methodologies

- New follow up department is now full staffed and averaging over $2.5M per week in promises to pay from commercial and Managed care payers. Also tracking actual dollars collected from promises.
- Working with Clinic Registration staff on billing issues.
- Supplied RevCare with Data load on accounts returning from HFRI to sell. RevCare to have bid by 9/30. Sent $15M and have a bid of $3M to purchase. Looking at impact on P&L

$3.5

15

Coding

- Backlog in IP/ED coding
  - As of 10/10:
    - IP coding – $23.4 - $33.1M (9/8)
    - OP coding - $24.5 - $26.4M (9/8)
    - Total Coding - $47.9 - $61.5M (9/8)
    - This converts to approximately $3M cash to UMC
    - Goal is to reduce another $12M or $2.4M additional cash by end of November.
- All out effort continues to catch up ED coding
    - Contract Coders on site
    - Present IP coding staff working overtime to catch up
    - Moved Coders (overtime) from Ambulatory to ED (short term fix to catch up backlog)

Coding

- All 6 data entry positions are filled by current vacancies. Positions have been filled and started week of 10/3. (Completed)
- Abuse of FMLA continues in this department.
- Charges are being posted starting on 10/10 directly from Emstat (emergency room nursing documentation system). This will assist with charge entry for ER and allow charge entry personnel to assist with ambulatory surgery and ER admission charges.

Collection Agency Management

- Received proposal and reviewing, to discuss with Lacy and Bob Mills.
- PASC scheduled to be on site week of 10/24. This effort should be up and running by mid November and based on their projections will result in additional cash of approximately $600,000 per month. These are early out collections through 90 days then sent to Agency for bad debt collection
- Also this will reduce postage costs since they will be sending data mailers and paying for the postage – Approximately $11,700 per month.
- Developing RFP for new collection agencies for Lacy by 10/28. Will review with Don Haight prior to getting to Lacy.

90 days
will increase

RA 000302

Surgical Services Process Redesign

- Process scheduled to be operational by 11/01
- Meeting set with Surgery Collaborative Group to discuss final preparation for live date of ~~10/24~~ next.
- This new process will improve through-put by pre-admitting patients, insurance verification, case management, and pre-surgical testing.
- New design will improve surgical net revenue (cash improvements to UMC) by $12.5M annually starting approximately Jan-2006.

ABN Processing

- Currently no ABN process in place resulting in lost revenues since we cannot collect from Medicare or the patient and the portion that would fall to the patient is currently written off.
- Premier Software is a business partner with Siemens and according to Doug we do not need to go to RFP and we can call this an upgrade. Approximately $37K.
- Waiting for Siemens/Premier proposal, anticipated by 10/14.
- Developed work/implementation plan that focuses on high dollar accounts, e.g. Surgical Services.

Case Management Processing

- Inconsistency in case management practices – being conducted out of 5 different areas (Case Management, Process Improvement, Nurses in Patient Access, Social Services, and Eligibility). Impacts are reduced reimbursement due to lack of receiving addition authorization for length of stays or non-covered service.
  - Recommendations for consolidation of duties to eliminate duplication.
  - Productivity standards being developed

Case Management Processing

- High dollar patient portions that are not being monitored
  - Developing processes to address High Dollar Patient monitoring. Accounts with balances over $40K or LOS over 5 days are being reviewed twice a week. Currently looking at a process for balances less than $40K.
- No automated methods for monitoring patient through the continuum of care.
  - Evaluate usage of Horizon Performance Manager. (according to Haydee this system is not case management concurrent review and she has other systems that are a better fit, including Midas)
  - Setting up demo currently getting dates with Midas

No case mgt
NICU
PICU
Surgical

Patient Access Process Redesign

IP Registration

- Evaluating reasons for duplicate registrations.
  - Medicare Pharmacy charges – not covered so opening two separate accounts (completed)
- New resource Bob Whipple began review of observation processes on 9/22. Have list of Medical Records he is reviewing and preparing appeals where necessary.
- Meeting with staff to evaluate processes for different job functions (verifiers, Nurses, etc.) (on-going)
- Currently they are not discharging Observation and inpatient from ED that never get to the floors. Current process (discharging from EmStat but not MS4) is tying up beds that are occupied because the patient was discharged but not in system. Process has been put in place and will monitor to be sure working.

Patient Access Process Redesign

IP Registration

- For anyone who does not have social security number that has been practiced for many years and are now bumping into real numbers. Suggest using all zeros and 1. (completed)
- Setting up ACTS database for insurance verifications start using mid-November.
- Started process to collect co-pays and deductibles due on in-house patients. Admission alerts EFS through note in system and they discuss with patients or family. (100 admission per day – assuming 50% are covered by insurance and assuming 50% of those have some deductible or co-pay due = 25 per day @ $250 = $6,250 per day X 30 days = $187,500 per month in potential additional cash)

Patient Access Process Redesign

ED Registration

- Reviewing self pay ED registrations daily (continuing)
- Eliminate "Escapes" (continuing)
  - Tracking daily averaging less than 5 per day.
  - Adding registration staff – including 3 new management positions to provide 24/7 supervision. Job posting closed 9/30 for internal candidates and are reviewing applicants. Interviews being conducted this week, decision next week and offers made.
  - Developing follow up plan with policies and procedures
  - Continuing on POS process in ED
- Lied Clinic physicians are requesting patients registered as a patient type "P" (one time visit) Traditionally these patients have been registered as patient type "R" (recurring). Medicare regulations allow either option. Looking at Medicare reimbursement to determine revenue impact.

Compliance Trudy myself

Charge Description Master Review

- Running UMC CDM through Ingenix Charge Master Analyzer software to identify trends with missing or incorrect CPT codes or incorrect revenue codes. This pretty much matches the errors identified by CraneWare. A plan is being developed to address and fix the errors identified by CraneWare and Ingenix.

Charge Description Master Review

- Working on OR redesign initiative around charge capture
  - Recommending Procedure level pricing vs. line item pricing in new OR redesign. Meeting set with Ron 10/11.
  - Approximately 5000 line items need clean up on supplies, duplications, missing items, items missing CDM numbers, etc., have currently re-billed and collected $81K. Working on projections of on-going cash potential.

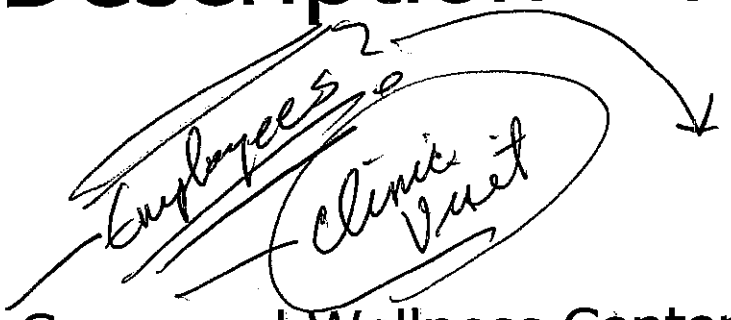
Charge Description Master Review

- Working on charges priced under APC reimbursement
  - Submitted recommended pricing for these items to Peter Tibone via e-mail, Peter has a couple questions and he and Pat will meet this week to resolve.
  - Working with Kathy Silver to determine strategy on potentially renegotiating Managed Care contracts from ASC pricing to APC pricing. Looking at high dollar/high volume procedures to determine advantages of APC pricing.

Charge Description Master Review

- Reviewing Pharmacy CDM a few areas at a time and rebilling as necessary.
- Identified list of Pharmacy charges that did not have HCPCS codes in CDM. These need to be updated in Craneware and will re-bill where applicable. Sent to IS to build conversion table to convert all drug dosages into accurate billing dosages. Working on quantifying results to determine additional cash to UMC.

Charge Description Master Review



- Quick Cares and Wellness Center are not charging Medicaid Professional Fees. Based on 2005 usage and the Medicaid fee schedule cash potential is $3.2M per year in additional cash.

Charge Description Master Review

DME

- Pat Huber met with Mike Walsh 9/14 –to discuss if UMC should resume billing Medicare for DME. Pat to determine reimbursement from MediCaid and based on findings will determine if cost effective to bill Medicare. Mike is checking with Materials Management to determine costs. Done
- Britt in IS is running report to capture all DME billed to Medicaid during the past year. Looking at large volume items and will get back with Mike.

Miscellaneous

- Electronic Posting of Remittance Advices
  - Current backlog is approximately $4M
  - SSI has successfully posted only 3 batches out of 17
  - Will be completed by 10/30.
- Evaluating EFS work flow and developing redesign
  - Daily reviews of follow up process
    - Currently have 24X7 EFS staffing in place. "Escapes" have decreased from an average of 25 per day to an average of less than 5 per day. Target cash increase as a result will be approximately $40,000 per month/$486,000 per year. (20 cases per day X 30 days = 600 cases per month if we get 30% eligible = 180 cases X $900 per case = $162,000 X 25% collection rate on gross charges.)

Miscellaneous

- Reassigning one EFS FTE to the Lied Clinic, there is no EFS working presently and this will give them coverage 8:00 AM to 4:30 PM Monday through Friday. Lied Clinic looking at seating arrangements, will be completed by 10/14.
- Re-evaluating work duties of EFS FTE's in ER, including one FTE spending additional time at the Women's Clinic, doing their own follow ups on verifications, etc. This will now give them coverage from EFS twice per week. Based on our meetings with Women's Clinic staff twice per week will be sufficient. Starting 10/4

Miscellaneous

- Oncology states no space to interview patients, currently EFS resource is "on-call" and takes patient to admitting area to complete the interview.
- Develop a work flow plan for placement of accounts to Great Lakes for in-patient and ER, this will include time frames. Will be presented during meeting on 10/5 (completed)
- Setting up discharge desk for EFS worker to begin collecting co-pays and deductibles in ER. This equates to $146,000 dollars in additional cash per month. (250 cases per day – assuming 65 cases have potential collection and average co-pay is $75 = 65 x $75 = $4875 per day X 30 days = $146,250 per month)

Questions/Comments

Collection Agency Management

- Received proposal and reviewing, to discuss with Lacy and Bob Mills.
- PASC scheduled to be on site week of 10/24. This effort should be up and running by mid November and based on their projections will result in additional cash of approximately $600,000 per month. These are early out collections through 90 days then sent to Agency for bad debt collection
- Also this will reduce postage costs since they will be sending data mailers and paying for the postage – Approximately $11,700 per month.
- Developing RFP for new collection agencies for Lacy by 10/28. Will review with Don Haight prior to getting to Lacy.

90 days
Will increase
AR

2005

UMC
UNIVERSITY MEDICAL CENTER THE SYMBOL OF EXCELLENCE

Revenue Cycle Improvement

Steering Committee Meeting

November 1, 2005

High Impact Initiatives

- Billing Methodologies
- Surgical Services Process Redesign
- ABN Processing
- Case Management Processing
- Patient Access Process Redesign
- Charge Description Master Review
- Miscellaneous

Billing Methodologies

- Strategy meetings with Accordis
  - Medicaid collections remain down from $6M per month through June 2005 to an $4.4M for July through October. This does not include approximately $3M in un-posted. This would bring the average up to $5.2. Still down about $1M per month but improving.
- Receiving daily reports from SSI identifying accounts held in the editor and working to get submitted. (on-going). Accounts currently being held in SSI is $10M. This is down from $28M.

Billing Methodologies

Dale McWilliams

- Working with IP and Clinic Registration staff on billing issues. This includes Customer Service and Customer Satisfaction
- Supplied RevCare with Data load on accounts returning from HFRI to sell. Sent $15M and have a bid of $3M to purchase. Looking at impact on P&L

Surgical Services Process Redesign

- Process scheduled to be operational by 11/01 (completed)
- This new process will improve through-put by pre-admitting patients, insurance verification, case management, and pre-surgical testing. (completed)

ABN Processing

Name the patient of WRO

- Currently no ABN process in place resulting in lost revenues since we cannot collect from Medicare or the patient and the portion that would fall to the patient is currently written off. (completed)
- Premier Software is a business partner with Siemens and according to Doug we do not need to go to RFP and we can call this an upgrade. Approximately ~~$37K~~ 68K. (completed)
- Received Siemens/Premier proposal, IT reviewing with contracts management. (Completed)
- Training begins 11/15.

Case Management Processing

- Inconsistency in case management practices – being conducted out of 5 different areas (Case Management, Process Improvement, Nurses in Patient Access, Social Services, and Eligibility). Impacts are reduced reimbursement due to lack of receiving addition authorization for length of stays or non-covered service.
    - Recommendations for consolidation of duties to eliminate duplication.
    - Productivity standards being developed

Case Management Processing

- High dollar patient portions that are not being monitored
  - Developing processes to address High Dollar Patient monitoring. Accounts with balances over $40K or LOS over 5 days are being reviewed twice a week. Currently looking at a process for balances less than $40K.
- No automated methods for monitoring patient through the continuum of care.
  - Evaluate usage of Horizon Performance Manager. (according to Haydee this system is not case management concurrent review and she has other systems that are a better fit, including Midas)
  - Setting up demo currently getting dates with Midas

Nancy Quick Care

Patient Access Process Redesign

IP Registration

- New resource Bob Whipple began review of observation processes on 9/22. Have list of Medical Records he is reviewing and preparing appeals where necessary.
- Meeting with staff to evaluate processes for different job functions (verifiers, Nurses, etc.) (on-going)
- Setting up ACTS database for insurance verifications start using mid-November.

Patient Access Process Redesign

IP Registration

- Started process to collect co-pays and deductibles due on in-house patients. Staff is excited about collections and is sharing successes with managers. Daily tracking has started.
- Started QA process between back-end and front-end. Spreadsheet with examples being shared and offenders are receiving training.
- Discuss Customer Service training for all Patient Access areas with HR. This is the first experience many customers have with UMC and needs to be done right. Developing survey for patients to fill out.