Case Study
PIH Health

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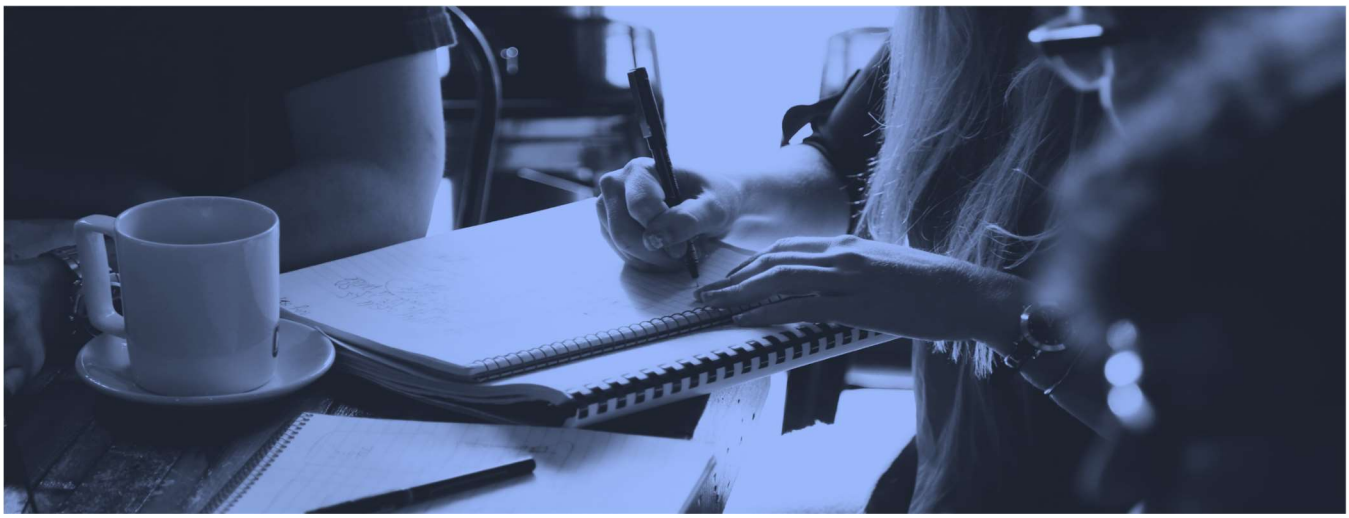
PIH HEALTH

About PIH Health

In 1959, PIH Health was founded as Presbyterian Intercommunity Hospital out of a significant community need for improved healthcare. Today, PIH Health is a nonprofit, regional healthcare network with two hospitals, numerous outpatient medical offices, a multispecialty physician group, home healthcare services and hospice care, as well as heart, cancer and emergency services. They have more than 5,100 compassionate, valued employees.

PIH Health serves more than 2.1 million residents in Los Angeles and Orange Counties and throughout the San Gabriel Valley and is committed to remaining a leader in healthcare advances - offering technology, equipment, facilities and services that benefit patients.



Interview of Sue Carlson, Executive Director of Revenue Cycle at PIH

Q: What prompted you to make a change in PIH's Revenue Cycle operations in 2010?

A: PIH

Vendor A was putting very little into further development of their Claim Management System. When I voiced concerns, vendor A tried to get us to look at a better" system they owned. If I was looking, I was going to look at all options. Quite frankly Cirius' reputation preceded them and they immediately became one of the four vendors to evaluate.

At this time, we had a 100% touch rate and had not been able to significantly reduce A/R days. We knew we had to improve our billing process.

There were many inefficiencies with vendor A:

- The system had inefficient edits; causing claims denials. We had to manually troubleshoot denials (or even identify there was one).
- We could not create our own edits and It took weeks to months to get edits added due to our internal approval process and Vendor A's internal procedures.
- Because we could not bill payers directly, there was an automatic two-day increase to A/R days.
- We had no way to do automated claims error corrections. For example, if a charge did not get updated with the correct CPT, we had to manually locate the claim and manually rebill each claim.
- We couldn't automatically bill secondary payers.
- Vendor A didn't support all payers resulting in unnecessary paper claims.
- MSP claims took 30 minutes to process.
- We used two claims systems, one for Medi-Cal and one for all others. This limited how we could use staff.
- We couldn't quantify our clean claims percentage with vendor A.
- Billers had to create two claims when risk was split between the plan and IPA on the same claim and then delete the lines for which the payer is at risk. There were no edits that alerted the biller to split the claim. This can and did delay payments, increased denials, and caused rework.

We needed better reporting capability and better workflow tools:

Vendor A had limited reporting tools which enabled review of total claims billed per biller, however, the reports were not complete, and one had to go through several tabs and reports to identify claims deleted. Vendor A did not offer reporting tools for edited claims, one could only review in claim tracking tool and only when looking at the individual claim directly. The claims acceptance reports were impossible to read so the only way we knew if a claim was accepted was to go online and query claim by claim.

- We could not identify or quantify dollars that were left on the table due to poor performing edits or provide denial by payer reports to management.
- We had an 11% Medicare rejection rate (hit T status yet had passed CA edits, but not accepted by FL)
- The Medi-Cal software vendor did not have a report to capture claims that were never printed or billed electronically.
- We couldn't measure biller productivity and accuracy.
- Our IT staff had to start at 5:00 a.m. to begin report retrieval. Due to problems on Vendor A's side, some reports were still not available until late morning. This significantly impacted our productivity.

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Summary of Benefits:

- ✓ Ability to create own edits.
- ✓ Ability to automate claim error corrections (i.e. charge not updated with correct CPT).
- ✓ Ability to automate a rebilling of a targeted group of claims.
- ✓ Capability of standardized complete and superior reporting (i.e. reports for edited claims or deleted claims).
- ✓ Work Flow tool.
- ✓ Standard edits provided timely.
- ✓ All payer management and editing system.
- ✓ Split bills between plan and IPA, edits created which prevents delays and denials.
- ✓ Ability to quantify clean claim percentage and status.
- ✓ Decrease Medicare rejection rates.
- ✓ Identify all Medicaid claims billed and accepted, paper or in electronic format.
- ✓ Decreased time to bill an MSP claim.
- ✓ Measuring tool for biller productivity and accuracy.
- ✓ Automated secondary claims billing

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Q: What were your challenges to overcome?

A: The organization had competing priorities. We were in the midst of installing an electronic health record, integrating with a medical group, etc. Getting IT Governance approval was the biggest challenge. Once installation began, we had to make installation a priority while not dropping the ball on billing and follow-up. We had a director that did an outstanding job of ensuring a successful installation.

Q: How did you determine to make the change?

A: We knew we had to make a change. We lined up Vendor A against four other vendors. We brought the selection down to two, compared them side by side, then chose Cirius.

Initial 24 Month Metrics:

A/R net days

Before Cirius implemented 71.9
At 12 months 56.3
At 24 months 45.0

Cash Collections

Before Cirius implemented ..... 29.3 M
At 12 months ..... 32.4 M
At 24 months ..... 33.1 M

Reallocated 2 staff members