

Success Profile:

Alta Bates Summit Medical Center



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Berkeley and Oakland, California
Affiliation: Sutter Health
Beds: 1,050
Annual Visits: 400,000
Net Revenue: \$875 million

The Situation:

Inadequate claims and denial tracking coupled with manual workflow resulted in poor identification and recovery rates, unnecessary credit balances, and a “wall of correspondence.” Most denials were outsourced, with monthly recovery around \$50k.

The Solution:

CareMedic’s Denial Management system to track claims, automate workflow and improve recovery rates.

The Result:

- \$3.9 million additional revenue recovered in first nine months
- 30-day underpayment backlog eliminated
- Credit balances reduced
- Productivity increased, and outsourcing reduced

The Benefits:

- Ability to identify denials and implement process improvements to increase recovery
- Ability to track and monitor claim status and potential issues
- Robust reporting options to identify and remedy causes of denials
- Expense reductions
- Net cash increase

Organization recovers \$3.9 million in first nine months with CareMedic’s denial management system

With multiple sites in San Francisco’s East Bay region, award-winning Alta Bates Summit Medical Center (ABSMC) serves more than 26 communities in Northern California, and is the area’s largest not-for-profit medical center. The organization’s two acute care hospitals provide 1,050 licensed beds, and report net revenue of \$875 million a year. An affiliate of Sutter Health, the enterprise houses its Patient Financial Services (PFS) office at its Summit campus in Oakland.

In 2002, like many healthcare organizations, ABSMC’s PFS department was confidently forging ahead using its homegrown denial management system—in an Access® database. However, most of the identified denials were handled through outsourcing agreements, and the office was unable to track its claims effectively or to determine its recovery rates.

Lack of Information

When George DerBedrosian joined the organization as Administrative Director of Patient Financial Services, he estimated that his department recovered approximately \$50,000 of its denied claims every month. At that time, PFS faced a number of challenges, including what they later discovered were monthly gross denials of \$200,000–500,000, which were not effectively tracked or captured using the existing homegrown system. Meanwhile, the department’s staff faced a relentless “wall of paper” in daily correspondence without an efficient method of routing and processing the vital information it contained.

“We were doing a fair job,” says DerBedrosian, “but we know we were not capturing all of the denials that were out

there; we weren’t capturing all that would come through on our electronic and paper remittance advices. The system was only as good as the data feed, and frankly, that left a lot to be desired....”

PFS Manager Jeanie Piscitelli was frustrated, as well. “We did not have a tracking mechanism in place to capture bad debt and send the data back to the ancillary departments because it was more of a manual process... there were a lot of discrepancies there....” In fact, their system had little credibility with other departments, and Piscitelli found little support for what evidence she could glean regarding denials—not to mention credit balances. The combination of incomplete data and manual processes finally reached a point where a solution was critical.

Building a Solution

DerBedrosian knew he needed a system with the solid capability to capture and track denials. He knew that there were denials. He knew the money was not being recovered, but without a well-organized, reliable tool to track and measure claims resolution, it was difficult to convince everyone there was a problem. To compound the confusion, most of the denials ABSMC could identify were processed by an outsourcing company that didn’t provide the feedback and interaction required for internal control.

“George came in,” Piscitelli explains, and “he knew from looking at the figures what we needed to do, and that’s when he started looking for a system. And because he’d had the experience, he knew our homegrown system wasn’t doing what we needed. We knew we were missing items, but we didn’t know the significant value of that, until we actually got in and started the full

Success Profile



George DerBedrosian and Jeanie Piscitelli conquered revenue challenges with CareMedic's Denial Management System.

implementation. You really do not know what you're missing until you start to work it and implement it."

DerBedrosian was impressed with CareMedic's solution (formerly Third Millennium's *i.suite*® Revenue Cycle Management System). "We knew we were dealing with a lot of issues," he explains. "I was working very closely

"The CFO also likes the fact that this is a direct hit to the bottom line of the medical center. These denials represent dollars we haven't collected in the past, and the \$3.9 million we've seen during the first nine months validates our decision to use CareMedic."

—George DerBedrosian

with the Sutter folks, looked at a couple of other vendors, and CareMedic just rose to the top because they have a very robust product. A lot of the competition frankly had what was almost more of a contract management system."

The organization even looked to its HIS vendor for a denial management solution, but DerBedrosian determined it wasn't as robust as the CareMedic system. "The other solution doesn't give the same reporting capabilities," he notes. "It wasn't quite as user friendly as CareMedic's product, and that played into our decision-making process." For DerBedrosian, CareMedic's denial management system was "the only significant show in town in terms of a full, robust denial management system." The fact that it accepts data feeds from the organization's primary accounts receivable system was icing on the cake."

CareMedic began implementing the application in April 2005, and Piscitelli slowly began tearing down the "wall of paper" that haunted the department every day. Using its standardized denial codes, CareMedic provided a way to efficiently

route claims and correspondence—electronically—to and from work lists, eliminating a significant amount of manual intervention and stacks of paper.

Buried Treasure Found

After just five months, DerBedrosian had impressive news for his CFO. Although still in start-up mode, the department had already recovered \$1.6 million in denied claims, and identified significantly more. By the end of 2005, the increased revenue recovery reached close to \$4 million.

"Senior management in the organization was looking for approximately \$3.5 to \$4 million [a year] from this product, and we've exceeded that already on an annualized basis. We're on track to recover \$6 million this year [2006] in revenue that would have been lost," reports DerBedrosian.

Operationally, the new system gave the PFS department an effective way to manage underpayments, and Piscitelli saw immediate results. She decided to manage contractual payments through the denial system and write rules that would automate much of the related manual processes. "We went from more than a 30-day backlog to no backlog at all," she remarks. The system's tracking and routing capability, coupled with robust reporting tools, has also made it much easier for the PFS department to work with other departments in identifying—and substantiating—the sources of denials.

Looking to the future, DerBedrosian and Piscitelli will continue expanding their use of the capabilities of CareMedic's solution, while developing benchmarks and improving denial recoveries. "We would like to explore using the document imaging component, so that we may continue to fine tune and improve our operations, which ultimately supports the Medical Center's ability to provide the best quality patient care," he explains. "After all, that's ultimately why we're here." ♦

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