Case Study

Leveraging operational data and process analytics for efficient delivery

This case study outlines how to re-design a complex, high risk, end-to-end claims appeals intake to improve outcomes. The recommended re-design included metrics around timeliness and productivity, and Standard Operating Procedures (SOPs) to achieve a more streamlined and simplified organization and sustainable, improved performance. This goal was achieved through leveraging operational data and process analytics aimed at improving the effectiveness and efficiency of the medical claims appeals lifecycle.

Background - Overview

Our rapidly growing health plan client had previously engaged us in an effort focused on claims appeals inventory management and reduction in order to mitigate accreditation compliance risk. There are strict prompt pay and timeliness regulations relative to processing claims appeals, and our client was out of compliance with these.

We discovered that our client had several different methods of appeals intake as well as multiple teams with responsibility for handling appeals. Further, there was no comprehensive approach to appeals processing and a history of inventory mismanagement and accountability gaps in part due to there being many different teams involved in the overall appeals lifecycle. The various methods of intake also created opportunities for appeals to be misrouted, misidentified, or simply lost.

We helped our client implement new performance standards and some basic metrics/reporting for appeals processing, which allowed them to better manage the appeals inventory. As a result, the outstanding appeals inventory was reduced from 50% out of turnaround time compliance to under 2%. This result dramatically reduced the compliance risk. Operations leaders continued to manage their process and inventory daily, making staffing adjustments as needed to establish a steady state that meets the newly established performance standards.

Leveraging the right measures that we identified through this effort, we were also able to re-engineer the delivery process. Link to previous case study is included below:

Case Study: Claims Operations Appeal Organization and Process Improvement

IMPETUS FOR NEW PROCESS IMPROVEMENT PROJECT

This case study focuses on insights from the previous study, here leveraged to re-design the new end-to-end process.

Through this effort, our client gained a new perspective about how much time and effort was actually being expended to work appeals. By creating operational metrics and reporting, there was transparency not just about the appeals inventory, but also the number of resources across the organization involved

and how fractured the overall effort was. Armed with data and reporting aligned with metrics that more accurately depicted current state appeals processing (how work was actually getting done, as well as the outcome), our client was able to build the business case for a new organization structure with full accountability for managing appeals.

Client retained our services (post the initial compliance risk-related project) to assist in taking the appeals processing work to the next level of organization. The net of this work involved first establishing the goals for appeals management and from there defining roles and responsibilities, processes, standard operating procedures, and interrelationships to comprise a new dedicated appeals team.

OBJECTIVE FOR NEW PROCESS IMPROVEMENT PROJECT

Design of an end-to-end claims appeals intake and handling process and a dedicated team generating results that meet or exceed established performance standards, successfully supporting our client into the future as they grow and expand their overall operations. Stated goals included:

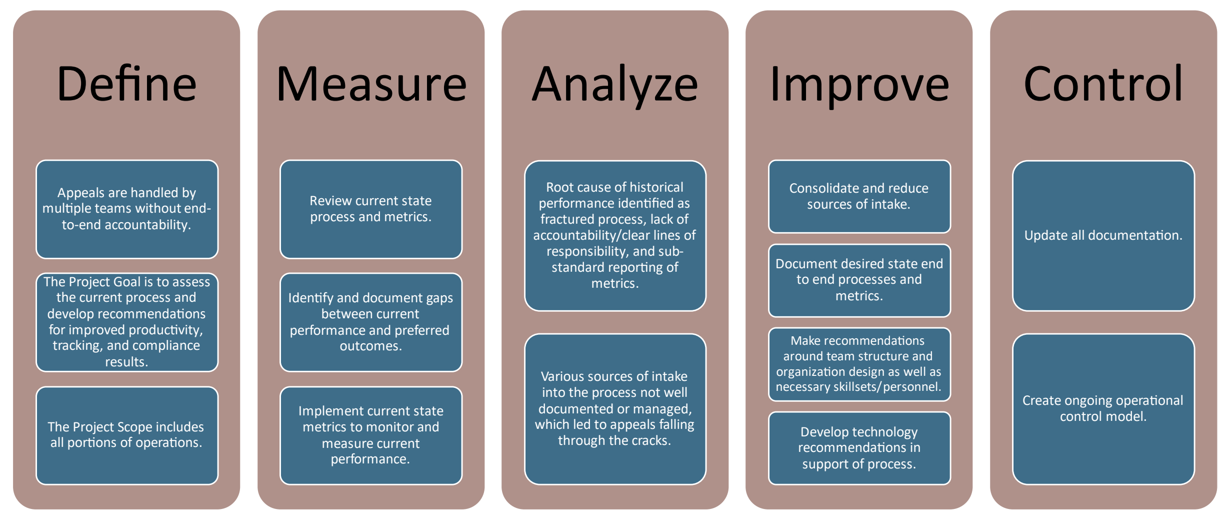
- Documenting the future state claims appeals intake and resolution process.
- Developing processes and metrics in support of the process redesign.
- Assessment of technologies in use and recommendations for future state needs.
- Identifying future state organizational structure.
- Updating all documentation and reporting.

MEDICAL CLAIMS APPEAL:

A REQUEST FOR A HEALTH INSURER TO REVIEW THEIR DECISION TO DENY A BENEFIT OR PAYMENT FOR A MEDICAL SERVICE

OVERALL APPROACH – SCOPE, MILESTONES, AND STRUCTURE

A standard process improvement methodology was put in place to serve as the overall foundation and structure for this initiative.



The previous project with our client already revealed that there were multiple teams with some level of responsibility for working medical claims appeals, which was the key driver leading to the accreditation compliance risk and overall ineffectiveness. An obvious, immediate solution might have been to simply assign resources to manage appeals, eliminating the number of handoffs and shoring up the process that way.

However, attempting to build an organization structure without first doing the due diligence to thoroughly assess and ultimately identify and document a defined process (including key performance indicators for ongoing tracking) would not have served our client well. Therefore, as a first step we proposed conducting an end-to-end organizational process review, to serve as the basis for recommendations moving forward.

The overall scope of the organizational process review included:

- Identifying all types of appeals and their current owners.
- Understanding existing processes and reporting in each area.
- Engagement with current teams to determine pros and cons of including their work in the overall scope.
- Identifying all current methods of intake for new appeals (phone calls, e-mail, standard mail, portals, work queues) and how the existing process works for each.
- Evaluating the possibility of eliminating and/or consolidating the various methods of intake.

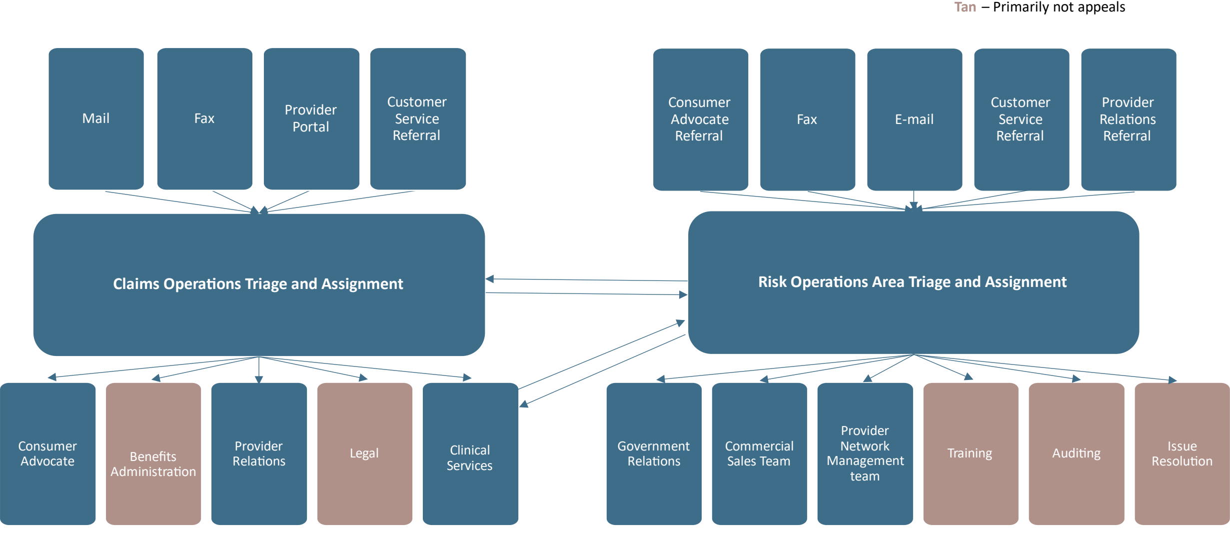
FINDINGS

Taking a closer look at the dispostion of appeals at intake, it became abundantly clear that there was a lack of any sort of documented process providing guidance to individuals within these intake areas (e.g., the mail room) in terms of what to do with the appeals received (who decides where to send appeal for resolution, how is that decision made, where it should be sent, who is responsible for what to do next).

In addition to the lack of standard operating procedures (SOPs), there was also inadequate tracking (how many appeals are being received) which of course made it impossible to "count" the volume of new appeals or know how many were being sent where, and how long they were sitting in a work queue pending resolution.

Without standard procedures or a defined process, the general approach was to send the appealed claim to the area that denied or processed it in the first place. The individuals at intake did not consider it their responsbility to follow up or take any particular action, other than to pass the appeal on to another area of the organization for resolution. Further, not only did the individuals at intake not have SOPs related to where to send the appeal, they did not have any particular training as might be expected if they were to be left to their own devices in terms of how to determine the best place to send the appeal.

DOCUMENTED PROCESS PRIOR TO IMPROVEMENT EFFORT



KEY LEARNINGS – OPERATIONAL IMPROVEMENT TOPICS

There were a number of key learnings centered around the various operational improvement topics that resulted from our end-to-end process assessment, leading to recommendations for a defined process and organizational structure in support of that process.

MANAGEMENT OF WORK QUEUES:

Within each of the areas that typically received the appealed claims from intake, there were a dozen or more individual work queues. The 3 or 4 separate and distinct teams involved each reporting up to different leaders, and entirely different divisions of client organization.

Again, as was the case with Intake, there were no documented SOPs or processes in place within the areas that appeals were being sent, and no detailed operational metrics and reporting to represent how the appeals work got done. Given the lack of process and metrics/reporting, it was not surprising to discover that individuals in these “receiving” areas did not feel any particular sense of accountability or “ownership” for working appeals, and all had other work that they were primarily responsible for. So, not only were they not measuring, no one was ultimately being held accountable for the result.

DETERMINATIONS OF BEST PRACTICE FOR APPEALS RESOLUTION

TYPES OF CLAIMS APPEALS:

- ✓ MISSING INFORMATION
- ✓ NOT FILED ON TIME
- ✓ INCORRECT PATIENT INFORMATION
- ✓ MEDICAL CODING ISSUES
- ✓ DUPLICATE BILLING
- ✓ DOCUMENTATION-MEDICAL NECESSITY
- ✓ REFERRAL OR PRIOR AUTHORIZATION REQUIRED
- ✓ SERVICE NOT COVERED BY BENEFIT PLAN

As part of our initial compliance related work with client, we were able to help with establishing some initial reporting for daily tracking and aging, across the organization. As a next step to enable a more informed set of appeals resolution recommendations, we worked with each of the intake and receiving departments to categorize the types of appeals, and thus the different work involved in appeals resolution.

This enabled us to develop a better appreciation for how determinations were currently being made at the various steps in the appeals lifecycle, and what was working well or not. From that, some best practices were identified, and that became the basis for piecing together a set of operating procedures and a supporting process flow.

It also helped with recommendations concerning the skill set and knowledge required to make the various determinations required to successfully process appeals (how to correctly categorize, steps required for resolution, what constitutes a successful outcome) as well as the most likely (appropriate) area and structure for a dedicated, accountable team to reside.

PROPOSING ORGANIZATIONAL STRUCTURE SUPPORTING THE APPEALS PROCESS:

A stated objective for this project was to make recommendations for a dedicated, centralized team with responsbility for claims appeals. Knowing more of necessary details regarding all stages of the appeals lifecycle (where are appeals coming in, where are they being sent, how determinations for resolution are being made, what skills and expertise are required to process appeals), we were able to set forth a defined process, and ultimately a dedicated organization structure (including updated roles and responsibilities) to support the process.

We ended up recommending a centralized appeals team with all the needed expertise so that the appeals would no longer need to be routed to multiple areas. We proposed that the the dedicated team be set up in the risk management department, which was separate and distinct from the areas that had been making the initial claim determinations. We determined that this team had to be independent and not influenced by these initial determinations.

The proposed organization for the centralized appeals team included: a staffing model, standard operating procedures (SOPs) for each of the phases of the appeals process, guidelines and rules dictating the corrent disposition for each type of appeal, and leadership in place with direct accountability for end-to-end appeals management.

HOW PERFORMANCE WILL BE EVALUATED (HOW AM I BEING MEASURED?):

Being held accountable requires the ability to measure and report on performance (both process and outcomes). Other than call center metrics, none of the teams formally involved had operational reporting in place to provide insights into the health of their operations. We were able to identify detailed metrics to mirror each of the steps in the overall process, with reporting designed to support process, metrics, quality and operational insights required to assess performance, and establish accountability accordingly.

Summary of Key Learnings

Operational Improvement Topic	Discovery	Recommendation
Intake	New appeals were being identified via a number of different intake pathways and routed without guidelines about how to route. Intake personnel were not necessarily qualified to make these determinations.	Have all appeals route to the same place for triage and assignment within a centralized appeals team.
Work queues	Due to decentralized approach, there were multiple work queues and teams where appeals could be routed. This precluded the ability to accurately track incoming volume.	Route all appeals to centralized appeals team – one consolidated work queue.
Best practice (process)	No end to end process in place to set the tasks in order and ensure uniformity for how appeals should be handled.	Develop a full process for for all types of appeals to ensure compliance with established policies and procedures.
Organization structure	Several teams involved with a practice of routing claims to the area where the initial appeals denial was issued.	Centralized appeals team to handle all appeals, reporting within an area of the organization separate and distinct from where initial denial determinations were made.
Metrics/reporting	No metrics in place to grade the program and ensure standards were upheld.	Create reporting to include measurements of quality and turn around time (TAT), in addition to basic operations metrics.

DISCUSSION

Overall, we found that while the client was working hard to address their compliance and quality issues with appeals, they were not performing with basic operational discipline, starting with a lack of a defined process. Without a defined process, it was difficult to contemplate how to best address an organization design to accomplish the appeals work.

From an organizational standpoint, there was no overall accountability for the appeals handling, leading to a disjointed approach and a lack of comprehensive vision into the current state. Without this knowledge, the organization did not realize they had a problem until it progressed to a point where timeliness caused accreditation and customer service issues.

In addition, and related to, the lack of overarching accountability, there were no metrics in place or a process to enforce them. Without standards, there was no mechanism in place to ensure uniformity in how appeals were handled.

Finally, there was no reporting to give insight into overall inventories, new receipts, or aging. There was nothing in place to alert anyone when backlogs began to accumulate.

BASIC BLOCKING AND TACKLING FOR IMPROVED PERFORMANCE

As is the case with much of the operational improvement work we undertake on behalf of our clients, it is the simple things (the basic blocking and tackling) that end up being the drivers of performance improvement opportunities. Often when we are approached by a client seeking help with improving operational performance, the client has already made some assumptions about how the current process works (or doesn't work, as the case may be). Many times, these assumptions are being made without the right level of tracking and measurement. Even when there is operational reporting in place, it may no longer reflect the current situation in terms of new performance expectations.

Maybe there was once a well defined process in place that worked well, but as internal and external realities come into place that change some aspect of what work needs to get done and/or new requirements for what needs to be accomplished, the existing process no longer supports the desired outcome. However, it is difficult to figure this out without the right operational metrics in place.

This is especially true for fledgling and growing organizations, but can also be true for established enterprises, as they enter new markets or encounter other external influences (like new regulations) that call for a re-evaluation for how things are getting done. This can lead to operational improvement efforts that are more like putting a bandaid on the underlying problem, without taking a step back to examine more closely how the work is getting done and where there is an improvement opportunity that best reflects the desired outcome.

In situations (like the one described in this case study) where the improvement opportunity may call for a new organizational structure, the best way to determine that is by first defining the process that will produce the best outcome. The new organizational structure should support the process, and not the other way around.