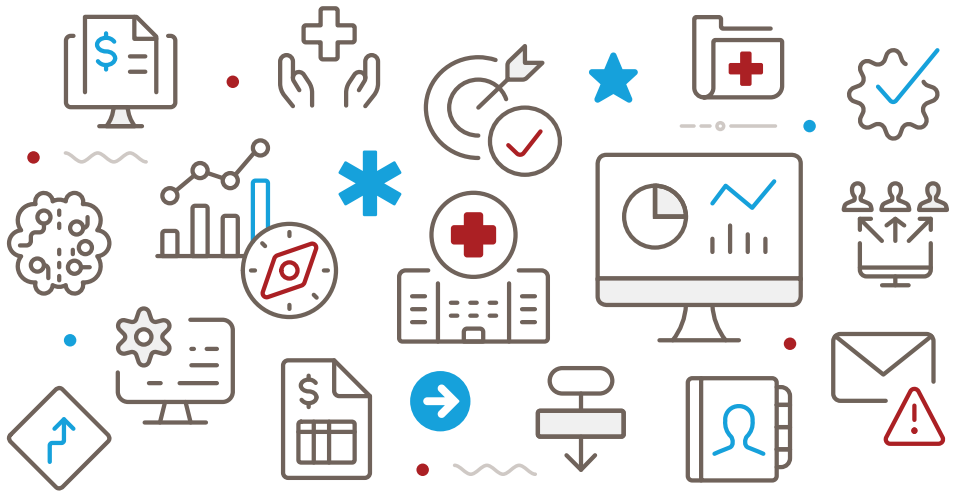
Navigating the Mid-Cycle Maze to Unlock Revenue Potential

Top six mid-cycle challenges in revenue cycle operations

CONIFER HEALTH SOLUTIONS®

The processes that encompass the middle part of the revenue cycle—that period between patient registration and claims submission—are vital to a hospital's financial health. Organizations need to approach these processes as critical operations. Managing this component as disparate processes can have negative financial implications for revenue and cash flow, leading to issues such as revenue leakage, denials, delayed reimbursements, and payer takebacks.



To improve mid-cycle operations and optimize revenue, organizations must identify key challenges and implement strategies to overcome them. The following are six top operational mid-cycle challenges, and proven methodologies and best practices that can help.

1 Coding

Unaddressed coding issues can be a key driver in impact to hospital profitability. A recent survey of healthcare leaders found that coding inaccuracies were among the top three causes of denied claims.[1] In 2022, 11% of all claims were denied.[2] In addition to denials, there are other coding opportunities that also impact hospital revenue. These include the following:

- Potential for underpayments or overpayments
- Increased payer audits for certain code combinations
- Payer recoupments
- Suboptimal KPIs
- Coding backlogs
- Poor performance or high turnover in coding staff
- Dissatisfied providers and patients

Because incorrect coding falls under the "fraud and abuse" category of the American Medical Association's Principles of CPT® Coding, penalties can run into hundreds of thousands of dollars, and include incarceration.[3]

Healthcare systems can improve coding accuracy through a multi-pronged approach:

- Robust Quality Program with better than industry standard minimum accuracy of 95%
- Unbiased Coding Quality Assessments and reviews led by compliance and quality teams
- Provide ongoing education
- Use a coding audit software solution
- 100% AHIMA and/or AAPC Credentialed, experienced team members
- Predictive Analysis, including DNFC/DNFB and account resolution opportunities

Success Story

A large health system has experienced an increase in coding quality to over industry standard at 98.5%, 53% reduction in DNFC, 75% reduction in ED Late Charges, and performance excellence in overall inventory management.

98.5%
increase in coding quality

53%
reduction in DNFC

75%
reduction in ED Late Charges

Coding quality initiatives implemented included the following:

- Pre-hire online skills assessment for candidates
- Pre-production competency testing through initial and transitional quality reviews
- Monthly quality reviews with feedback and educational alignment
- Targeted and ad-hoc audits for root cause analysis and defect avoidance
- Pre- and post-billing audits in key focus areas
- Detailed reporting, analysis, and feedback

> By implementing a coding quality and compliance program, the health system achieved more than eight percent improvement in coding quality, exceeding the industry standard.

2 Medical Record Documentation

Payer documentation requirements have become increasingly complex and stringent, making quality documentation more critical than ever. Poor documentation can lead not only to denied claims but can also negatively impact patient satisfaction. Imagine a patient receiving a bill for a procedure that should have been covered due to inaccurate documentation.

To improve documentation quality, health systems should:

- Implement a Clinical Documentation Integrity (CDI) program, including technology to perform concurrent and as appropriate, retrospective chart reviews on inpatient health records designed to clarify imprecise, incomplete, conflicting, or nonspecific provider documentation.
- Successful Clinical Documentation Integrity (CDI) programs facilitate the accurate representation of a patient's clinical status that translates into coded data. Coded data is then translated into quality reporting, physician report cards, reimbursement, and disease tracking and trending.
- Provide ongoing Clinical Documentation Integrity (CDI) education to providers on how to accurately and thoroughly document the care they provide as well as address any gaps to ensure precise capture of severity of illness and risk of morality.
- Create a culture of documentation integrity and excellence, including measurable outcomes and KPIs.

Success Story

A large multi-hospital health system has experienced substantial improvements in CMI and CDI staff productivity with Conifer's Clinical Documentation Integrity program. This was achieved through enhanced and improved CDI-Provider collaboration, communication, and quality of documentation.

7%
improvement in Medicare Case Mix Index (CMI) capture

10%
improvement in commercial payer CMI capture

24%
improvement in CDI staff productivity

> By implementing a standardized, physician-centric CDI program, the health system experienced significant CMI capture impact.

3 Team Quality and Accountability

Experienced revenue cycle professionals are in short supply, making it challenging for health systems to develop a top-performing team. Onboarding and training new, inexperienced team members take time that revenue cycle leaders may not have. And inexperienced staff can cause an increase in errors and denials, leading to even more work for already stressed staff.

Issues Related to Revenue Cycle Hiring Challenges[4]

- Increased days in A/R
- Increased denials
- Decreased productivity
- Poor team morale
- Missed revenue cycle opportunities

Besides staffing, another challenge to building a highly functioning revenue cycle team is in the area of accountability. Growing backlogs, tight deadlines, and time-consuming manual processes are often the norm for busy revenue cycle teams. Staff can easily get so bogged down in everyday tasks that they lose sight of the bigger picture. Teams need to understand their role in creating a healthy revenue cycle, which includes understanding how the quality of their work impacts the bottom line.

Health systems can develop a quality team through the following three steps:

- Using only credentialed and certified revenue cycle professionals, which could require outsourcing if qualified candidates are in short supply
- Providing continuing education, including ongoing regulatory and compliance training to keep up with continually changing rules
- Creating a "we're in this together" team environment to promote accountability
- Use a coding audit software solution
- 100% AHIMA and/or AAPC Credentialed, experienced team members
- Predictive Analysis, including DNFC/DNFB and account resolution opportunities

4 High-Risk Charge Capture

When it comes to capturing accurate charges—and receiving appropriate payment—some charges are more difficult than others. Those most challenging, such as specialty services like cardiology, nephrology, and interventional radiology, often have complex code combinations that make them more prone to error and more resource-intensive to manage.

In one survey of revenue cycle leaders, 68% said that up to 10% of their total charges were under-coded, and 56% said that over half of their total charges were over-coded.[5] This accounted for 11% or more of their total charges. Yet nearly one in four reported that submitting a claim can take up to four weeks after the date of service.

Three steps health systems can take to optimize high-risk charge capture include the following:

- Identify high-risk clinical services that are more prone to error
- Implement automation technology that monitors processes and flags potential issues
- Use HRC (high-risk charge capture) solutions to identify and resolve potential problems before they impact revenue

Optimal high-risk charge capture can prevent missing and inaccurate charges, reduce charge lag times, and realize revenue potential.

5 Cost Management

With growing supply and labor costs soaring, effectively managing costs is critical to a hospital's bottom line. Managing vendor costs is also essential. Research indicates that nearly a third of hospitals use two or more revenue cycle vendors.[6] Of those, five percent use more than four. Health systems can lose millions due to preventable expenses without in-depth cost analysis and proper oversight.

Health systems should consider addressing labor and vendor spending to reduce costs and improve cost management.

Labor Costs:

- Conduct analysis by geography to identify lower labor cost potential.
- Consider consolidation of labor in more financially favorable geographical consolidations.
- Identify opportunities for like-services centralization.

Vendor Spend:

- Choose partners that leverage intelligent mid-cycle process automation technology to improve productivity and reduce costs.
- Look for a partner whose processes integrate seamlessly with the organization's existing systems and workflows.

According to the CMS, "Over 2022-31 average National Health Expenditures (NHE) growth (5.4 percent) is projected to outpace that of average GDP growth (4.6 percent) resulting in an increase in the health spending share of Gross Domestic Product (GDP) from 18.3 percent in 2021 to 19.6 percent in 2031."[7]

6 Charge Integrity

Charge integrity is the assurance that all charges are accurate, complete, and supported by documentation. It is a critical component of any mid-cycle program and helps to ensure that patients are billed correctly and that healthcare systems receive the correct reimbursement. However, it requires careful coordination between clinical staff, revenue cycle staff, billers, and the compliance department.[8]

Such coordination is most effective when it contains the following four components:

- Automation that continuously audits processes and flags potential issues for proactive intervention
- Integrative processes that fit within each team's workflows
- Ongoing training for each department involved
- In-depth measurement to track quality and accountability

Success story

A large health system was experiencing poor charge-capture performance but lacked a way to monitor clinical department-specific revenue trends. They needed a way to safeguard against errors going unnoticed until after claim submission or month-end close. The health system implemented a solution that leveraged analytics to aggregate charging data from multiple sources to detect anomalous charging in real-time.

The solution included the following:

- Daily monitoring of charge capture activity at the department and charge-line levels using automated analytics
- Automated email alerts sent to revenue management stakeholders
- Department alerts to capture both positive and negative fluctuations
- Focused remediation efforts to reduce potential charging errors, rebills, and inefficiencies

Results achieved in the first 90 days:

- Identification of $75M in charge errors that was unsupported by clinical documentation
- Avoidance of $10.1M in material late charges related to activities identified before month-end close.

Mid-Cycle Best Practices

To ensure optimal mid-cycle performance, hospitals should implement industry best practices and establish key performance indicators (KPIs) for team members and departments. There are four key metrics organizations should follow. These should include the clean claims rate and initial denials, which are good indicators of coding accuracy, and charge capture timeliness and days in A/R, both of which are good indicators of team performance and process efficiencies.

Clean Claims Benchmarks

- **Clean claims rate:** 98% [9]

Denial Rate Benchmarks

- **Industry average denial rate:** 5% – 10% [10]
- **Best practice for optimal performance:** <5% [11]
- **Ideal denial resolution rate:** 85% within 30 days [12]

Charge Capture Benchmarks

- **Late charges as a percentage of total charges:** ≤2% of all charges [13]

In addition to KPI benchmarks, there are five proven strategies hospitals can implement to help address mid-cycle challenges and help improve revenue performance.

- **SKILLSET.** Focus on elevating the collective team skillset through recruitment and retention of top talent or through outsourcing partnerships.
- **TECHNOLOGY.** Implement technology to automate mid-cycle operational processes, reduce errors, and eliminate manual processes, which can free up staff time to focus on other tasks.
- **POLICIES AND PROCEDURES**. Establish clear policies and procedures to ensure all team members are following the same guidelines, which can improve quality and consistency.
- **EDUCATION.** Implement ongoing training and educational programs to help team members achieve and maintain mid-cycle expertise.
- **PERFORMANCE MONITORING.** Continuously monitor mid-cycle performance to identify problematic trends and opportunities for improvements.

The Journey Forward

Health systems are under more financial pressure than ever before. With ongoing labor challenges, rising costs, and shrinking revenue, the focus should be on improving efficiencies, creating a culture of continuous improvement, and embracing change. The mid-cycle is a great place to start. Investing in a revenue cycle partnership for all or a portion of the mid-cycle can help. The most effective partners will leverage best practices in all areas of the mid-cycle to deliver high-quality, improving turnaround time while achieving significant savings for their clients. Revenue cycle teams benefit through reduced stress, and hospitals benefit through lower costs and improved revenue cycle performance.

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