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A CorroHealth Company

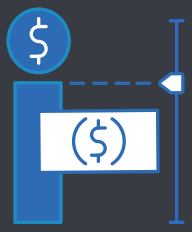
Building a Financial Safety Net

Implementing Safeguards to Achieve and Sustain Revenue Integrity

Contents

Hospitals continue to face substantial financial and operational pressures, despite COVID-19's long retreat. An historically tight labor market, rapidly rising costs, and changes in reimbursement and payer mix have left many organizations at or near the brink of financial jeopardy.[1]

Pandemic-related challenges have been made worse by revenue loss associated with the longer-term trend of shifting care sites. Procedures that traditionally were provided at in-patient facilities increasingly have moved to ambulatory surgery or urgent care settings.[2] Because these procedures typically are among hospitals' most profitable services, the reduction in volume has had a disproportionate impact on margins.



Hospitals' median operating margins fell in February 2022 by 12% from the month before to -3.45% and were down 27% year-over-year.[3] Total expenses per adjusted discharge, meanwhile, increased by 10% over the same 2021-22 period, and were up 31% from February 2020.[4]

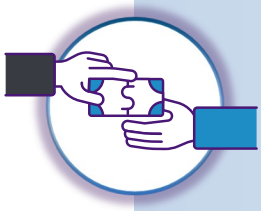
Achieving revenue integrity

To counter these adverse financial trends, it is critical for organizations to establish a financial safety net that can help them achieve and sustain revenue integrity. Simply put, revenue integrity involves implementing effective, efficient, and replicable processes and internal controls along the care continuum to prevent reoccurring issues that contribute to revenue leakage or compliance risk. These capabilities are supported by appropriate documentation and the application of sound financial practices capable of withstanding audits.[5]

Organizations that utilize both internal and qualified external resources to create a financial safety net benefit from a systematic, end-to-end approach that optimizes automation to reduce staff demands while relying on human expertise to address specific revenue cycle problems and chronic pain points.

Identifying revenue cycle pain points

Labor shortage: The Great Resignation has hit healthcare especially hard. Retirement, burnout, vaccine mandates, and competing opportunities outside of healthcare are leading many workers to leave hospital employment permanently. This exodus has removed some of hospitals' most experienced personnel while driving up costs. According to one recent study, clinical labor costs climbed 8% between 2019 and the fall of 2021, while overtime hours rose 52% over the same period.[6] While much attention has been focused on clinician departures, coding, accounts receivable, and denial management positions have not been immune to attrition.



Payer problems: Frequently changing payer guidelines and utilization issues — including medical necessity, pre-authorization, DRG downgrades, and uncertainty about experimental treatments — are continual problems for hospitals when it comes to ensuring appropriate and consistent reimbursement.

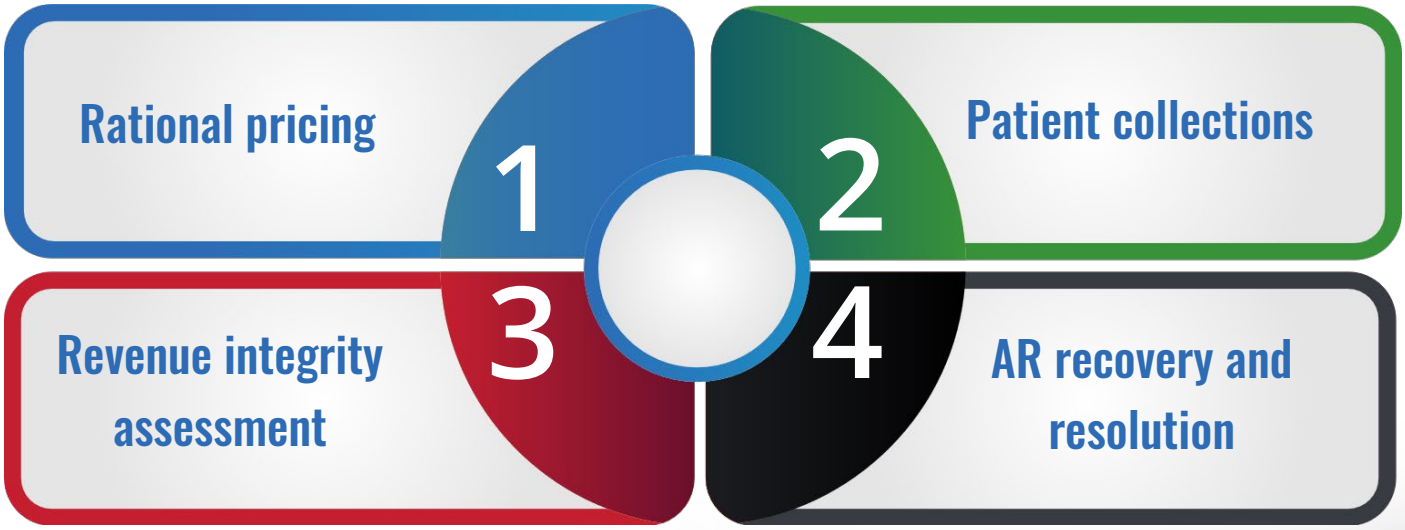
Technological challenges: A lack of effective EHR edits and frequent difficulties in dissecting and scrubbing payer EDI files to both extract and map codes can make it problematic to understand how, where, and why underpayments and denials are occurring.

Ineffective financial processes: EHR-based contract management systems that are set up incorrectly frequently generate netted amounts that are inaccurate, which can result in mounting uncollected—and unnoticed—outstanding balances.

Unsupported pricing strategies: Organizations that don't carefully assess their pricing and compare it to both competitors and market averages will find it difficult to develop a pricing strategy that is consistently optimized and competitive.

Poor communication/quality assurance: Without continual monitoring and oversight of the entire revenue cycle and clear, ongoing communications between all relevant departments, errors and omissions quickly snowball to create major lost revenue opportunities and potential compliance exposure.

4 Steps to calibrating the revenue cycle



Establishing a financial safety net to help ensure revenue integrity requires that the revenue cycle be viewed as a single process made up of component elements, each of which must be precisely calibrated to achieve optimal accuracy, efficiency, and sustainability. From the establishment of fee schedules to eligibility verification, medical documentation, coding edits, clearinghouse operations, payment posting, and denial management, every process should be carefully assessed and, if necessary, reengineered to achieve the highest level of performance.

Step 1: Rational pricing

For hospitals and health systems, a solid financial footing begins with the development of a comprehensive, market-based pricing strategy built around cost, reimbursement, and peer pricing data. This can be achieved through a systematic process of pricing review, comparison, and optimization.

1. **Current transaction data review:** Reviewing current transaction data across all revenue streams creates a comprehensive market position summary. Detailed pricing information should be documented in the following areas:
    - Room rates and observation
    - Emergency department/clinic visits
    - Diagnostic/therapeutic procedures
    - Technical anesthesia room
    - Operating room
    - Recovery/post-anesthesia care unit (PACU)
    - Pharmacy
    - Medical supplies

2. **Medicare SAF data review:** Once a hospital's pricing is quantified, current Inpatient and Outpatient Standard Analytic File (SAF) data provided by the Centers for Medicare and Medicaid Services (CMS) should be reviewed. This information, which is updated quarterly, provides access to rates charged for equivalent services by members of a designated provider peer group. Peer groups can be defined by virtually any criteria: Geographically, by facility size or type, or by those hospitals that are most consistently winning patients from a primary catchment area due to aggressive pricing.

3. **Accurate price comparisons:** From these comparisons, hospitals can see exactly how their pricing lines up with specific facilities and what averages for the entire group look like. By quantifying in percentage terms the extent to which a facility is below the average for a specific product or service, hospitals can quickly identify opportunities for increasing prices while remaining within group norms. Conversely, they can also flag any instances in which an organization is the high-priced outlier.

4. **Specific pricing targets established:** Armed with this data, qualified pricing experts can work alongside hospital financial management teams to establish specific pricing targets and timelines based on the opportunities presented. These calculations will also take into account contractual reimbursement rates to ensure the hospital is not setting the stage for excessive contractual write-offs.

    Hospitals additionally can develop effective strategies for areas or services that require pricing sensitivity. For example, a facility may want to keep prices at, near, or even below cost for some services to remain competitive with independent, free-standing entities. Similarly, areas that may consistently produce negative patient satisfaction results can receive special consideration.

5. **Transparency and defensible pricing:** Importantly, the prices developed through a rational pricing approach are defensible based on the organization's relationship to peer pricing and therefore consistent with the requirements of an effective consumer-facing transparency strategy.

Step 2: Patient collections

One of the most effective ways to stabilize the revenue cycle and reduce bad debt is to develop comprehensive methods for improving patient collections before or at the time of service. A patient payment process should provide accurate estimates through price transparency and also offer multiple payment platforms. By taking lessons from the retail industry, providers can enhance the digital patient experience to maximize collections and improve patient satisfaction.

Step 3: Revenue integrity assessment

Rational pricing and enhanced patient collections are essential for optimal margins. But without a similarly refined approach to each element of revenue cycle management, pricing and patient collections alone cannot ensure that an organization's financial foundation is sound. Embedded, often-hidden problems throughout the revenue cycle not only sabotage financial projections, but may also put the facility at significant compliance risk.

That's why a careful revenue integrity assessment is essential. Key elements include:

1. **Chargemaster review:** The hospital chargemaster should be reviewed to identify a variety of potential coding issues. These can include typographical errors, incorrect code assignments, invalid, out-of-date codes, or missing codes. Because chargemaster codes are accessed by clinicians throughout the hospital when claims are assembled, undetected errors are often replicated across many claims. The result can either be a significant amount of money left on the table due to under-coding, or an increased compliance risk because of over-coding.
2. **Onsite audits:** In addition to a documented chargemaster review, department-specific onsite audits are also integral to effective revenue integrity assessments. External experts meet with leaders from each revenue-generating department to review the department chargemaster and answer coding and charging questions.

   By accessing utilization data and recent claims, opportunities for increased reimbursement, improved charge accuracy, more effective compliance, and denial reductions can be identified. Additionally, external experts can flag questionable charge practices based on industry norms. The department audit findings should be documented in a written report that includes specific recommendations for each department. This process helps codify internal quality assurance processes.
3. **Claims edits review:** Critical to claims submission success are appropriate edits, or automated rules, that can flag deficient claims. A careful review of existing edits can help secure the final line of defense before claims go out the door. Failure to develop a robust and flexible editing system can create a domino effect of costly problems, including increasing denials and rising error rates, non-compliance penalties, and fraud and litigation expense.[7]
4. **Retrospective claims analysis:** A critical element of revenue integrity assessments involves a retrospective claims analysis. A qualified coder should carefully examine multiple claims for coding accuracy, including HCPCS, modifiers and ICD-10 codes, by comparing the claim to its supporting documentation. Reviews should include both outpatient and inpatient claims and the results should be documented on a line-by-line basis.
5. **Data editor software application:** The final component in a comprehensive revenue integrity assessment should incorporate the use of proprietary software to conduct automated claim audits. This can identify critical but often-missed charge capture problems, such as observation cases billed without evaluation and management (E&M) codes or chemotherapy administration charges that don't include chemotherapy drugs on the same claim.

Step 4: AR recovery and resolution

Once the revenue integrity assessment process is complete, scalable accounts receivable resolution and recovery solutions can be deployed in partnership with a qualified third party to systematically address problem claims across the AR spectrum. Specific expertise should be deployed for claims involving government and commercial payers, as well as worker's compensation and personal injury claims.

Through intelligent automation and process engineering, virtually every problem claim can be resolved, regardless of size or age. That means hospitals are able to realize collections from claims that otherwise would have been written off. Using a robust denial management process can not only gain increased revenue but also highlight changes needed to prevent problems from reoccurring.

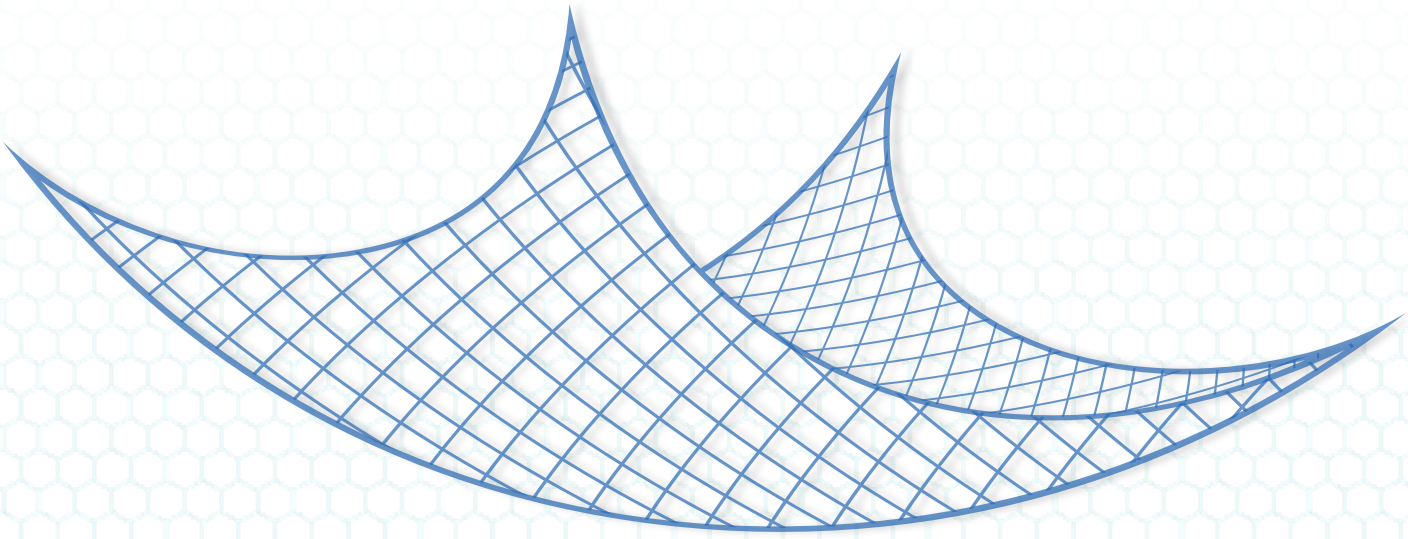
Key functions and capabilities performed by qualified vendors in the AR recovery and resolution area include:

- **Primary AR recovery and resolution:** Both small- and high-balance aging claims that are identified as problematic by staff are referred to specialized teams to help ensure quicker cash conversion and a reduction of bad debt reserves.

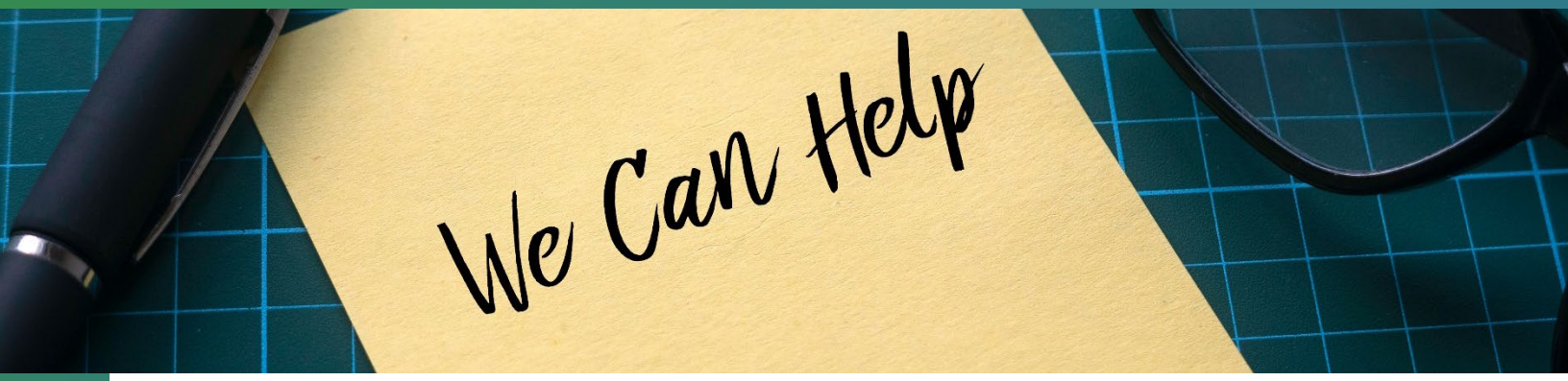
- **Pre write-off AR recovery and resolution:** Pre write-off (also known as secondary) insurance AR recovery capabilities can help hospitals collect highly-aged claims and minimize write-offs.

- **Zero-balance recoveries:** Specialized, forensic audits of written-off or zero balance claims provide an opportunity to ensure all available dollars are collected from payers. This process involves comparing payments received to anticipated revenue based on episode-of-care specifics, coding best-practices and payer-provider contractual terms. Any underpaid claims identified are resubmitted, per the payer's terms, for reimbursement. Recovered underpayments from zero-balance reviews can total 1% of write-off net placements, an amount that may be significant for large hospitals and health systems that typically write off tens of millions of dollars annually.

- **Legacy system conversions:** Transitioning to a new system can slow down the claims process and create problems for hospital personnel who must work between two billing platforms. Qualified vendors can provide interim solutions to help accelerate pre-conversion cash and assist with post-conversion AR resolution.



Concerned about improving the quality of your AR processes?



ParaRev can help

While the pandemic may be receding, organizations will continue to face rising costs and downward pricing pressure in the years ahead. Faced with the ongoing shortage of skilled workers and the struggle to maintain employee skill sets, it's important to have all the tools needed to facilitate accurate payer reimbursement and optimal cash flow.

CorroHealth, a leader in healthcare revenue cycle management, will work side-by-side with you as a virtual extension of your hospital central billing office. We help you improve operating margins and collect more of your revenue through a seamless and collaborative partnership with your internal team.

As part of this process, we take intelligent automation to the next level by automating decision-making and notation requirements, using root-cause analytics to decrease denials and optimizing pricing and transparency. Our comprehensive management solution, in fact, automates over 12,000 payer/provider variables with processes to address and resolve every AR situation automatically.

These capabilities allow us to efficiently resolve small- and high-balance aging claims and problematic insurance, and to quickly identify and correct the root causes for denied, delayed, and underpaid insurance claims. That means additional revenue for your bottom line.

Let us help your organization overcome staffing shortages, stay on top of accounts receivable inventory, identify where and how to maximize revenue and, if not yet completed, implement a price transparency program. Contact us today to learn how you can build a financial cycle safety net to help ensure revenue integrity.

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[1] David Weldon, Trends That Will Add to Financial Distress at Many Hospitals in 2022, HealthLeaders, Jan. 5, 2022
[2] Ibid
[3] Report: Hospital and health system margins off to a bad start in 2022, American Hospital Association, March 29, 2022
[4] National Hospital Flash Report, Kaufman Hall, March 2022
[5] Definition of Revenue Integrity, National Association of Healthcare Revenue Integrity
[6] PINC AI Data Shows Hospitals Paying $24B More for Labor Amid COVID-19 Pandemic, Premier, Oct. 6, 2021
[7] *Six Best Practices for Claims Editing*, Optum Insight, 2012