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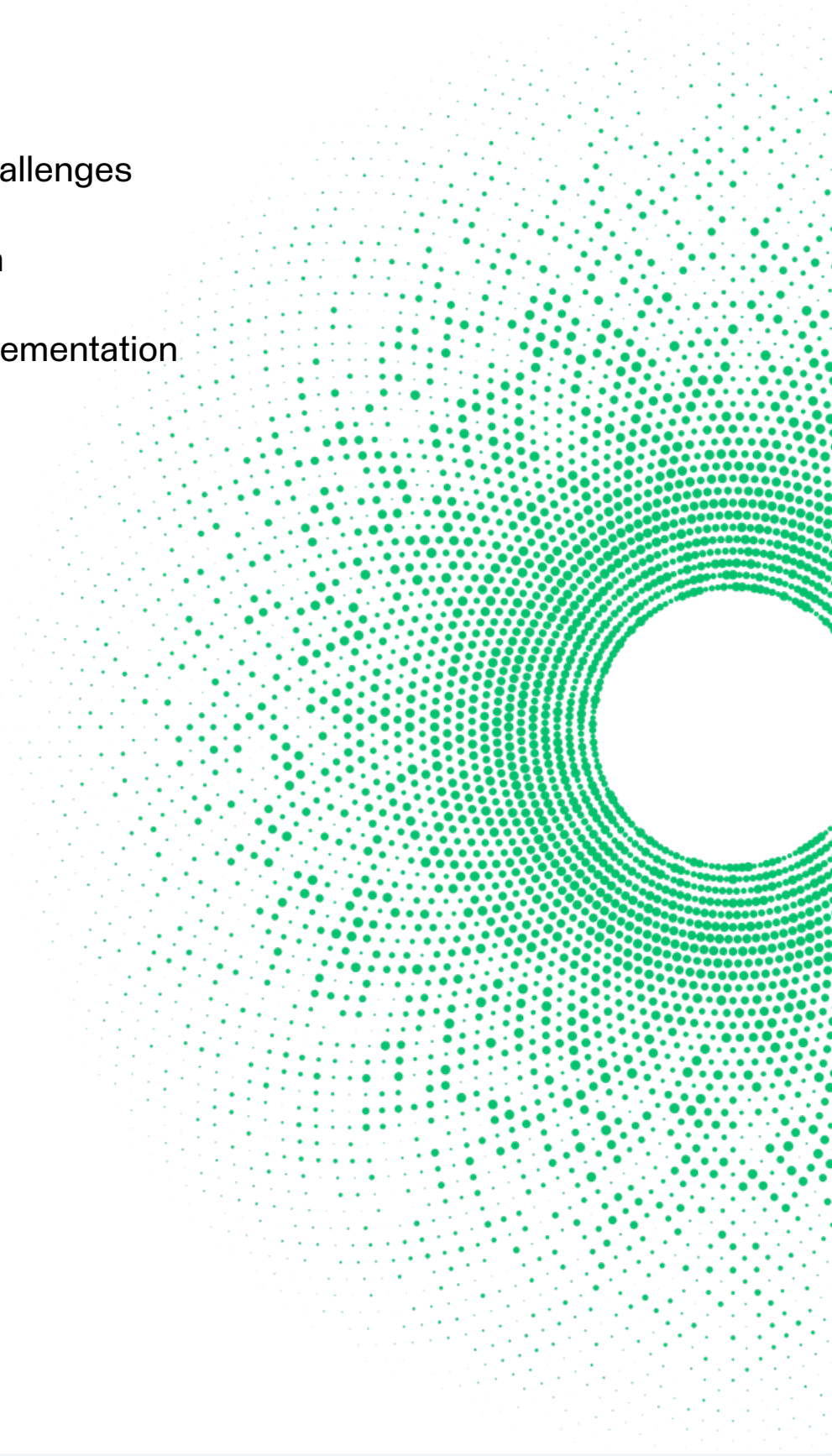
Bridging the Gap: A Practical Guide to Enhancing Efficiency Across Clinical and HIM

Contents



1.
Introduction

Clinical administrative services are saddled with numerous challenges that are impacting revenue and patient care while also adding to the burdens clinicians already bear. The root cause of these challenges is multifold: a worsening shortage of professional and financial resources, disparate technology that forces ongoing reliance on manual processes, and increasingly complex authorization and documentation requirements leading to a greater volume of denied claims.

Most significantly, however, competing priorities between revenue cycle management (RCM) and clinical operations, abetted by complex technology and processes, are creating cross-department information and communication siloes that are, in turn, increasing administrative costs and limiting the productivity and effectiveness of already overburdened clinical and health information management (HIM) teams.

Encompassing clinical documentation integrity (CDI), utilization management (UM), prior authorizations, and clinical denials and appeals, clinical administrative services consume 15-30 percent of healthcare spending in the U.S. Half of that spending is considered ineffective due to cumbersome manual processes and outdated technology, the simplification of which could help healthcare reclaim as much as $265 billion each year. [i,ii]

In addition to wasted dollars, failure to address the issues plaguing clinical administration will only exacerbate their widespread impacts, which include diversion of time and resources from patient care, delayed and lost reimbursements, static adoption of innovations and technologies, provider burnout, patient frustration, and financial strain. What's more, the silos created by misaligned objectives between HIM, revenue cycle, and clinical care leadership can hamper the collaborative approach required under current team-based, patient-centered care and reimbursement models. For example, miscommunication between HIM and clinicians is increased.

2.

A Deep Dive into the Challenges

Numerous underlying challenges are impacting clinical administrative services, including an ongoing shortage of both providers and health information professionals, which means fewer staff members shouldering increased workloads. However, of greater significance are core challenges related to the specific activities that make up clinical administrative services.

Clinical documentation integrity

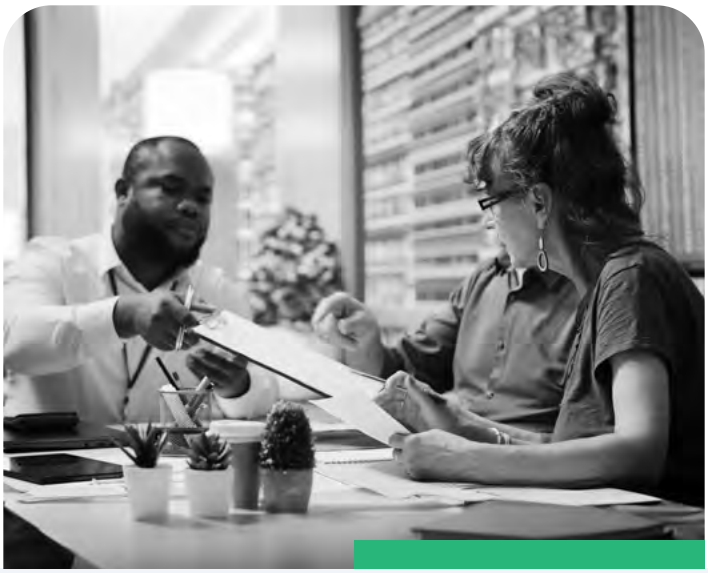
Effective CDI initiatives ensure documentation is accurate and supports specific diagnoses and codes, helping healthcare organizations avoid the financial penalties associated with over- and under-coding while enhancing revenue cycle performance. Black Book Research found that 88 percent of hospitals realized quality improvements and increases in case mix index (CMI) within six months of launching a CDI initiative, while more than 90 percent of hospitals with 150 beds or more saw CDI-related income and reimbursement increases of more than $2.1 million. Furthermore, 85 percent of hospital finance executives said CDI-generated quality and CMI improvements significantly impacted financials.[iii]

Conversely, the absence of a comprehensive CDI program, or CDI programs hampered by the ongoing shortage of experienced professionals and increasing complexity of documentation and coding, can result in insufficient, inaccurate, or incomplete documentation. This translates into improper coding, leading to rejected and denied claims, excessive claim rework, delayed reimbursement, surprise patient bills and write-offs, higher operational costs, and lower provider engagement and response rates. It also impacts compliance, exposing provider organizations to payer audits, fines, and clawbacks.

Moreover, organizations lacking proper CDI software are missing an important centralized collaboration tool for clinicians, CDI specialists, and health information professionals to support communications around physician queries and auditing. Without access to query templates, reporting, and other tools to decrease manual entry and support proper chart distribution, many teams resort to email for these communications, which is less than ideal for organization, referencing specific citations from charts, etc.

Utilization management

An important element of RCM, UM is responsible for a wide range of activities, including reviewing medical necessity, conducting utilization reviews, overseeing case management, ensuring compliance, and collaborating with clinicians to ensure patients receive the best and most appropriate care. It is a complex process critical for ensuring care appropriateness and quality, controlling costs, managing resource utilization, reducing denial rates, and improving compliance and reimbursement rates.



However, many UM departments struggle under the weight of outdated processes and technology that make staying on top of growing case volumes and increasingly complex requirements a significant challenge. Staffing shortages and resource limitations also create obstacles to effective UM, including:

01 An inability to strike the right balance between cost-saving measures and maintaining quality of care.

02 Non-compliance with an increasingly complex web of federal, state, and payer-specific regulations.

03 Increased provider resistance to UM interventions, which can lead to tensions between UM staff and providers and make it difficult to implement UM policies.

04 Difficulties coordinating UM practices across departments, including clinical staff, administrative teams, and finance representatives.

05 Delayed or denied care, which in turn negatively impacts the patient experience and satisfaction.

When the ability of UM teams to be effective is inhibited—due in part to inadequate integration of the data needed to perform tasks—workloads are increased and turnaround times are delayed, impacting care access, quality, outcomes, and costs.

Clinical prior authorizations

Ostensibly designed to support high-quality, cost-effective care, prior authorization is one of the most hotly debated, time-consuming, and expensive manual processes for provider organizations today. In 2022, more than 46 million prior authorization requests were submitted to Medicare Advantage plans alone.[iv] The American Medical Association (AMA) reports that physician practices complete 45 prior authorizations per physician per week on average, with physicians and their staff spending an average of 14 hours weekly on the process. Studies also show that the average cost for prior authorization approval ranged from $2,161 to $3,430 annually per full-time physician for primary care practices.[v]

Nearly 25 percent of physicians surveyed by the AMA said prior authorization led to a serious adverse event for a patient in their care, more than 75 percent said it could lead patients to abandon treatment, and more than one-third reported that criteria used in making authorization decisions are rarely or never evidence-based. More than nine in 10 also reported that prior authorization negatively affects clinical outcomes for their patients. Additional consequences include greater physician burnout, reduced employee productivity, and significantly higher costs across the healthcare system.[vi]

Prior authorization was ranked by 48 percent of respondents to one survey as among the top three reasons for claims denials, a problem due in large part to ineffective, time-consuming processes prone to human error. This leads to high rejection rates or information requests. The process also lacks standardization between payers and providers, while frequent rule changes by payers create additional prior authorization challenges.[vii,viii] Additionally, payer clinical guidelines and medical necessity determinations are frequently not in compliance with the latest care guidelines and regulations, leading to misalignments and time-consuming disputes.

Clinical appeals

Denied claims are a constant source of frustration for healthcare provider organizations—one that is growing rapidly, with 89 percent of health systems reporting an increase in denials over the past three years. The Centers for Medicare and Medicaid Services (CMS) further reports that 18 percent of in-network claims were denied in 2020, impacting financial stability and even patient outcomes.[ix] It's why 51 percent of healthcare revenue cycle leaders plan to take a more aggressive stance on challenging denied claims.[x]

However, appeals processes are time-consuming, taking an additional 51 minutes of administrative time per claim.[xi] Further, because 90 percent of denied claims are preventable, it's a problem that is more effectively addressed before the denial even happens.[xii]

Peer-to-peer reviews

Peer-to-peer reviews, typically between the physician in charge of a patient's care plan and a physician representing the patient's insurance company, are used to review, clarify, or explain a plan of care and to align medical necessity and reimbursement criteria. They are most often used to obtain prior authorization or appeal a previously denied claim or request. Most are required to be completed within 24, 48, or 72 hours of the request to avoid denial of the claim.

While the calls are relatively brief, typically lasting about 10 minutes, properly preparing for them can be extensive as it often involves sharing screens to review imaging studies, discussing evidence and guidelines, and determining the best, medically necessary approach. Another challenge with the peer-to-peer review processes is that the denying physician is rarely experienced in the specialty involved in the denial – an issue some states are addressing legislatively. New Jersey, for example, passed a law in 2023 that set the standard that physicians who review prior authorization requests or denial appeals have a background in the treatment being requested and the condition being treated.

Other factors

Also at play are regulatory challenges and the increasingly complex nature of patient care-level decisions, which carry significant implications for providers. A noteworthy example is inpatient versus outpatient status for hospital services such as x-rays and lab tests, which impacts reimbursement rates and even whether the service is covered by Medicare. For instance, a patient being treated in the emergency department or being held for observation is considered outpatient until a physician writes an admission order – even if the patient spends the night.[xiii]

Additionally, improper utilization of care can impact providers in multiple ways, including conflicts of interest and unnecessary use of services that increase healthcare costs due to self-referrals.[xiv] Finally, fragmented care caused by poor communications and coordination between multiple providers with a common patient can cause unnecessary testing and drive higher hospital and emergency department utilization and medical costs.[xv]

3.
A Collaborative Solution

An operational model that integrates clinical administrative services and HIM, supplements professional resources, and automates many of the problematic manual processes can alleviate many of the burdens separately plaguing the teams. This collaborative approach will also close the gap between the sides by breaking down silos and enabling a cross-functional team-based approach that increases efficiency and improves outcomes. Finally, AI-powered tools and process automation improve accuracy, reduce denials, and eliminate care and reimbursement delays while alleviating the strain on staff and resources and reducing associated costs.

Partnering with an experienced outsourced services provider eliminates the obstacles created by the shortage of experienced professionals with the requisite administrative skills needed to manage daily operational tasks and clinical expertise to facilitate effective communication with the clinical staff. They also provide access to advanced technical skills, process workflows, documentation reviews, and technology solutions with CDI and appeals processes. By augmenting the capabilities of internal RCM teams to improve the speed and accuracy of clinical documentation, authorizations, and other burdensome tasks, outsourced service providers also help provider organizations maintain compliance, achieve appropriate reimbursement, and improve patient care.

One Challenge, Two Distinct Perspectives

Clinical Perspective

- **Patient Care:** Providing high-quality, compassionate care to patients is the primary focus. This includes accurate diagnosis, effective treatment, and ensuring patient safety.
- **Clinical Outcomes:** Achieving the best possible patient health outcomes through evidence-based practices and continuous improvement.
- **Patient Experience:** Ensuring patients have a positive experience, which includes clear communication, empathy, and efficient care delivery.
- **Professional Development:** Staying updated with the latest medical knowledge and skills through continuous education and training.

Revenue Cycle Perspective

- **Financial Health:** Ensuring the financial stability of the healthcare organization by managing billing, coding, and claims processes efficiently.
- **Revenue Maximization:** Optimizing revenue capture through accurate coding, timely claims submission, and effective denial management.
- **Compliance:** Adhering to regulatory requirements and payer policies to avoid penalties and ensure smooth operations.
- **Operational Efficiency:** Streamlining RCM processes to reduce costs, increase productivity, and improve cash flow.

When properly designed and implemented, a collaborative cross-functional team-based approach to clinical administrative services will improve efficiencies for both HIM and front-line providers, including doctors, nurses, and administrative staff.

This will ultimately lead to better patient care, reduced administrative burdens, lower costs, optimized RCM, and enhanced operational efficiency—achieving the core objectives for all sides of the equation.

What to Look for in a Clinical Services Provider

The ideal outsourced partner should be able to scale rapidly to meet changing demands, including 24/7 coverage and support to alleviate backlogs and address cross-coverage needs while offering comprehensive services, including:

- CDI services tailored for both inpatient and outpatient settings.
- UM services that provide appropriate, efficient, and cost-effective care consistent with current medical standards and that utilize industry-leading criteria to ensure cases meet established guidelines and determine the appropriate length of stay.
- Clinical prior authorizations for complex medical cases, including prior and concurrent authorizations, to ensure proper reimbursement and timely care aligned to payer contracts.
- Denied claim review, including identification of root causes and development of appeals.
- Physician advisory services to optimize clinical documentation, coding accuracy, and revenue integrity.

Other key criteria when determining the ideal outsourced clinical services vendor include:

- **Clinical Expertise and Experience:** The vendor should have deep expertise and a strong track record in the specific clinical services required.
- **Quality Assurance and Performance Monitoring:** Choose a vendor with robust quality assurance processes and a clear framework for performance monitoring, including regular audits, real-time reporting, and the ability to adapt to changing requirements or regulations.
- **Scalability and Flexibility:** Ensure the vendor can scale services up or down based on needs. Flexibility in service delivery is critical, especially during peak periods or unexpected changes in demand.
- **Innovation and Continuous Improvement:** Partner with a vendor that is committed to innovation and continuous improvement and that actively seeks to optimize processes, adopt new technologies, and propose ways to enhance service delivery.
- **Financial Stability and Reputation:** A vendor with strong financial health and a positive reputation is likelier to deliver consistent and reliable services.

4.

Best Practices and Implementation Strategies

Successfully bridging the divide between clinical operations and HIM requires adherence to best practices and establishing guidelines for change management. This approach would ideally be patient-centered, emphasizing the importance of accurate documentation in improving patient care, clinical outcomes, and financial sustainability. It should also benefit from leadership support and alignment, with buy-in from both clinical and revenue cycle leadership, to ensure resources are allocated appropriately.

To foster communication and goal alignment, it is also important to establish a collaborative cross-functional team with multidisciplinary representation, including clinical staff, health information professionals, CDI specialists, and revenue cycle experts. Regular feedback loops should be established between clinical and revenue cycle teams to discuss findings, address challenges, and share best practices. This will also help foster a culture of continuous improvement, aided by regular audits, benchmarking against industry standards, and implementing feedback-driven adjustments.

Processes should be in place to keep the team current on regulatory and clinical care guideline changes and compliance requirements, as well as coding updates and medical advancements. Further, CDI initiatives should be integrated into daily clinical workflows to ensure seamless collaboration and a comprehensive understanding of documentation requirements. Finally, an effective cross-functional team should be armed with the following to ensure success:

- Education and training for clinical staff on documentation best practices, coding guidelines, and the impact on revenue cycle outcomes.
- Data-driven analytics to identify documentation gaps, coding trends, and areas for improvement.
- Standardized processes and tools, including documentation templates, clinical guidelines, and technology tools to facilitate accurate and efficient documentation.

It is also recommended that appropriate change control procedures be implemented during the transition. Change control is used as part of a larger change management plan to ensure no unnecessary modifications are made to processes to avoid disruptions and wasted time and resources.

If engaging with an outsourced vendor to fill technical and process gaps is part of the solution for HIM-clinical services challenges, it is important to have in place strategies to guide selection and integration into the overarching workflows. The first step is to conduct a comprehensive assessment to understand the organization's specific needs and to identify those clinical services that can be effectively outsourced without compromising care quality or regulatory compliance.

The needs assessment should be followed by vendor due diligence. Evaluate prospective vendors' track records, regulatory compliance, and expertise in the specific services scoped for outsourcing by reviewing case studies, testimonials and performance metrics.

Other key considerations include:

01 **Data Security and Compliance:** Establish stringent data security protocols for prospective vendors to adhere to, including HIPAA and any other relevant regulations, and confirm that prospects have robust systems in place for data protection, patient privacy, and regulatory compliance.

02 **Clear Contractual Agreements:** Contracts should clearly define the scope of services, performance metrics, timelines, and accountability measures, and include specific service level agreements (SLAs), penalties for non-compliance, and processes for conflict resolution.

03 **Training and Knowledge Transfer:** To minimize disruptions and ensure seamless integration of outsourced services, establish a structured training and knowledge transfer program focused on the organization's unique workflows, culture, and clinical standards.

04 **Communication and Collaboration Framework:** To foster transparency and collaboration, establish a robust communication plan that includes regular updates, progress reports, and checkpoints and involves key stakeholders from both the vendor and healthcare organizations.

By following these best practices and strategies, hospitals and other healthcare provider organizations can effectively bridge the gap between revenue cycle management and clinical teams while enhancing the overall efficiency and quality of clinical administrative services like CDI programs.

5.
Conclusion

The disconnect between RCM and clinical services objectives — and the harsh realities of staffing shortages, complex technologies, manual processes, increasingly complex care needs, and rising claim denials — have put clinical administrative service teams in an untenable situation that threatens provider organizations' financial standing and ability to provide high-quality, timely care.

Aligning priorities and integrating support services and technology into a collaborative, cross-functional team unburdened by information and communication silos and competing objectives bypasses these challenges and enables establishment of a highly effective approach to clinical administrative services.

With the right technology tools, a trusted outsourced service partner, and adherence to best practices, healthcare organizations will realize increased efficiency, improved care outcomes, and fewer claim denials while eliminating care and reimbursement delays and reducing associated costs.

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At AGS Health, we use technology and expertise to yield the revenue to realize your vision. Our combination of AI-enhanced technology, innovative data-driven services, and specialized support helps to maximize the performance of your revenue cycle, enabling you to focus on the most important part of your business: caring for patients.

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