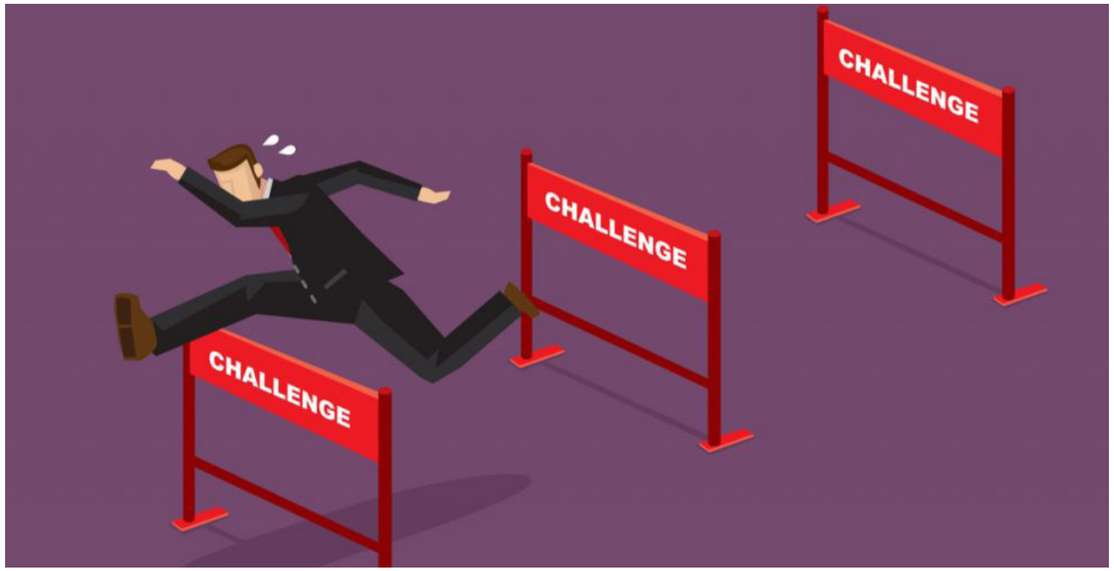
Revenue Cycle Challenges: The Financial Savior

As consumers, we all face challenging inflationary pressures in our lives, with everything presenting challenges to our budgets. Essential groceries and other items are up significantly, posing tremendous financial obstacles for all consumers. The Consumer Price Index (CPI), a closely watched gauge of inflation, recently showed that price increases continue to slow. The CPI measured 6% for the year at the end of February, down from January's 6.4%. Just the same, consumers are still faced with increasing prices, which obviously puts a damper on the economy since consumer spending accounts for nearly two thirds of the economy. So, what does this have to do with hospitals' finances and overall operations?



All hospitals and health systems are facing the same inflationary pressures as most consumers but to a larger scale and degree considering all the fixed expenses and high costs associated with operating a healthcare operation 24 hours a day, 365 days a year. All hospitals and health systems are facing nursing and physician shortages, as well as discipline shortages where hospitals and health systems have paid 258% more for contract labor during the pandemic as compared to pre-pandemic rates. Couple this with the same inflationary pressures that consumers are presently facing but to an even greater extent with high pharmacy spend, continued use of contract labor, food costs and supply increases, costs to retain current workforce with wage and benefit increase, retention bonuses, and information technology infrastructure costs, including the electronic health record—to name just a few.

A successful business must closely manage costs and grow revenue to ensure financial performance, allowing sufficient revenue to continue to invest back in the business. Labor costs account for upwards of 60% of total costs of operating a hospital. Hospitals and health systems are faced with high fixed operational costs. Growing patient and nonpatient revenue is critical to ensuring the hospital can meet its financial obligations while continuing to meet the healthcare needs of the community. The key to the revenue cycle is net patient revenue from operations, the money from operations that drops to the hospital's bottom line. Unfortunately, net patient revenue from continued hospital operations is where hospitals are facing monumental financial headwinds.

Net Patient Revenue Obstacles

Net patient revenue (NPR) is the aggregate money generated from patient services collected from payers, including private insurance, Medicaid, and Medicare. The calculation for NPR is the total patient revenues minus patient discounts. NPR does not factor in contractual adjustments, charitable donations, foundation earnings, or bad debt. Gross patient revenue is defined as the total charges at the hospital's full established rates for the provision of patient care services. Net patient revenue represents what the hospital actually collects in revenue from the payer or patient. Here is where hospitals and health systems are facing daunting hurdles, where payers are engaging in strategies to reduce their reimbursement to providers, attempting to reduce their Medical Loss Ratio—the share of total healthcare premiums spent on medical claims and efforts to improve the quality of care. The remainder is the share spent on administration costs and fees, as well as profits earned. These strategies used by the payers include, but are not limited to, issuing medical necessity and clinical validation denials, as well as DRG and level of care downgrades. If you are a medical record coder or Clinical Documentation Integrity Specialist, you are undoubtedly familiar with DRG downgrades and clinical validation denials. This is an area that accounts for a large proportion of payer denials where payers utilize sophisticated data mining and data analysis to select claims for either prepayment or post payment review, in a concerted attempt to drive down their expenditures for their members' patient care. Remember that payers have amassed a vast amount of claims data, using the claims data to devel-

op rules in conjunction with artificial intelligence and machine learning to identify "hit" cases to review and make a case for not reimbursing as coded and billed and paid under contractual arrangements.

Financial Savior?

All hospitals and health systems continue to struggle financially, dealing with decreasing reimbursement from payers, as well as experiencing lower patient volumes in the face of increasing expenses. Highly profitable surgeries are at lower volumes considering higher patient copays and deductibles in conjunction with inflationary pressures that patients face. Hospital margins continue to be negative with negative 1.0 percent in January 2023. (See Kaufman Flash Report February 2023). Couple these phenomena with payers issuing more denials that are time consuming and costly to appeal and you have a recipe for difficulty in maintaining positive operating margins. What is required to fervently address rapid fire payer denials is total transformation and cultural change throughout the organization.

Every employee involved in the revenue cycle plays a vital role in driving down often self-inflicted payer denials by embracing a mindset of "Denials Avoidance," embracing the notion that one avoidable denial is one too many. While no one role in the revenue cycle is more important than the other, let's spotlight the critical role of Coding and Clinical Documentation Integrity. Clinical Documentation Integrity Specialists' roles and responsibilities include concurrent review of medical records, identification of opportunities for physician documentation clarification, issuing of physician queries when clinically warranted, tracking of physician queries, and physician education on documentation improvement. CDI program popularity and their implementation in hospitals really took off around 2008 with the advent of the MS-DRG reimbursement system. CDI consulting companies promoted to CFOs that implementing their CDI programs were the answer to increasing reimbursement with the capture of more CCs/MCCs. This message still prevails but has been expanded to include Risk of Mortality/Severity of Illness scores and other quality measures that factor into publicly reported quality scores. One would assume that Clinical Documentation Integrity Programs would alleviate payer denials through better physician documentation. Unfortunately, this assumption is not accurate as explained further below.

As a practicing coder who is still engaged in day to-day coding, I can appreciate the duties and responsibilities of coding staff. The logic goes that with more complete and accurate physician documentation, the coder will be able to more accurately assign all clinically relevant diagnoses that impact quality data reporting, as well as achieve optimal MS-DRG assignment and reimbursement. In other words, as a result of CDI intervention, the record will speak for itself and the coder will best assign ICD-10 codes, thereby alleviating bill holds associated with retrospective queries for clarification of documentation. Excessive bill holds tie up much needed hospital revenue. So, why does this logic of CDI supporting better physician documentation, coding, and reimbursement not materialize as is evident by increasing reimbursement?

True Financial Saviors

Clinical Documentation Integrity programs can be a formidable force in alleviating unnecessary payer denials if the profession embraced the notion of denials avoidance by partnering with physicians, case management, utilization review/management, denials and appeals, and physician advisors to make significant inroads in achieving clinical documentation excellence. Today's model of CDI processes merely scratches the surface of what can be achieved in meaningful, measurable, and sustainable improvement in physician documentation, best telling and describing the patient story necessary to help the physician establish medical necessity for hospitalization. Without medical necessity, there simply is no need for CDI activities since no payment negates the efforts of CDI in capturing CCCs/MCCs. Clinical validation denials and DRG downgrades abound attributable to insufficient physician documentation that does not meet the Medicare expectation of complete and accurate physician documentation. The CDI profession must expand its breadth and depth of knowledge, skill sets, and core competencies in best practice standards and principles of documentation. This will position and equip the CDI professional with the ability to work collectively with physicians and other providers, taking the lead and serving as the change agent to really move the needle on documentation integrity. In many aspects, the term "integrity" is a misnomer in the sense present day CDI activities fail to improve the integrity of the record with secured diagnoses from the query process standing to generate more clinical validation denials. Querying for financial impact as the mainstay of CDI will continue to contribute to increasing payer denials.

Addressing Financial Challenges Head On

Hospitals and health systems will continue to experience significant financial challenges complicated by inflationary pressures. Ongoing payer denials are a definite drag on hospital finances. Rather than resorting to the perpetual inefficient process of appealing payer denials, hospitals should be ingraining in staff an attitude of denials avoidance versus denials management. A logical starting point is physician documentation quality and completeness, transforming CDI from a reactive repetitive reactionary approach to a far more efficient process of working towards achieving proactive preemptive denials avoidance physician documentation. CDI professionals are encouraged to realize and respect the medical record as a primary communication tool first and foremost, working with physicians as guides, mentors, facilitators, and resources to physicians and other providers on anything related to documentation. There is no time like the present for CDI to engage as the "Beacon of Hope" for our hospitals and health systems by doing our part to really improve the integrity of the medical record from both a patient care and high performing revenue cycle perspective.

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Glenn Krauss is a well-recognized and respected subject matter expert in the revenue cycle with a specialized emphasis and focus upon collaborating and working closely with physicians in promoting, advocating for, educating, and achieving sustainable improvement in clinical documentation that accurately reflects and reports the communication of fully informed coordinated patient care. His experiences include working with a wide variety of healthcare systems, spanning the entire spectrum and ranging from critical access hospitals, community hospitals, and Federal Qualified Healthcare Centers to large academic medical centers and fully integrated healthcare systems. He possesses 25+ years of progressive practical hands-on experience in clinical coding and documentation improvement, subscribing to the philosophy that quality of medical record documentation strongly correlates with overall quality of care achieved and the overall achievement of a high performing revenue cycle. Glenn has demonstrated the unique skill sets and core knowledge of principles and standards in best practices of clinical documentation, effectively and successfully driving physician engagement through proven strategies that create and foster a sustainable model for clinical documentation improvement. https://Core-CDI.com