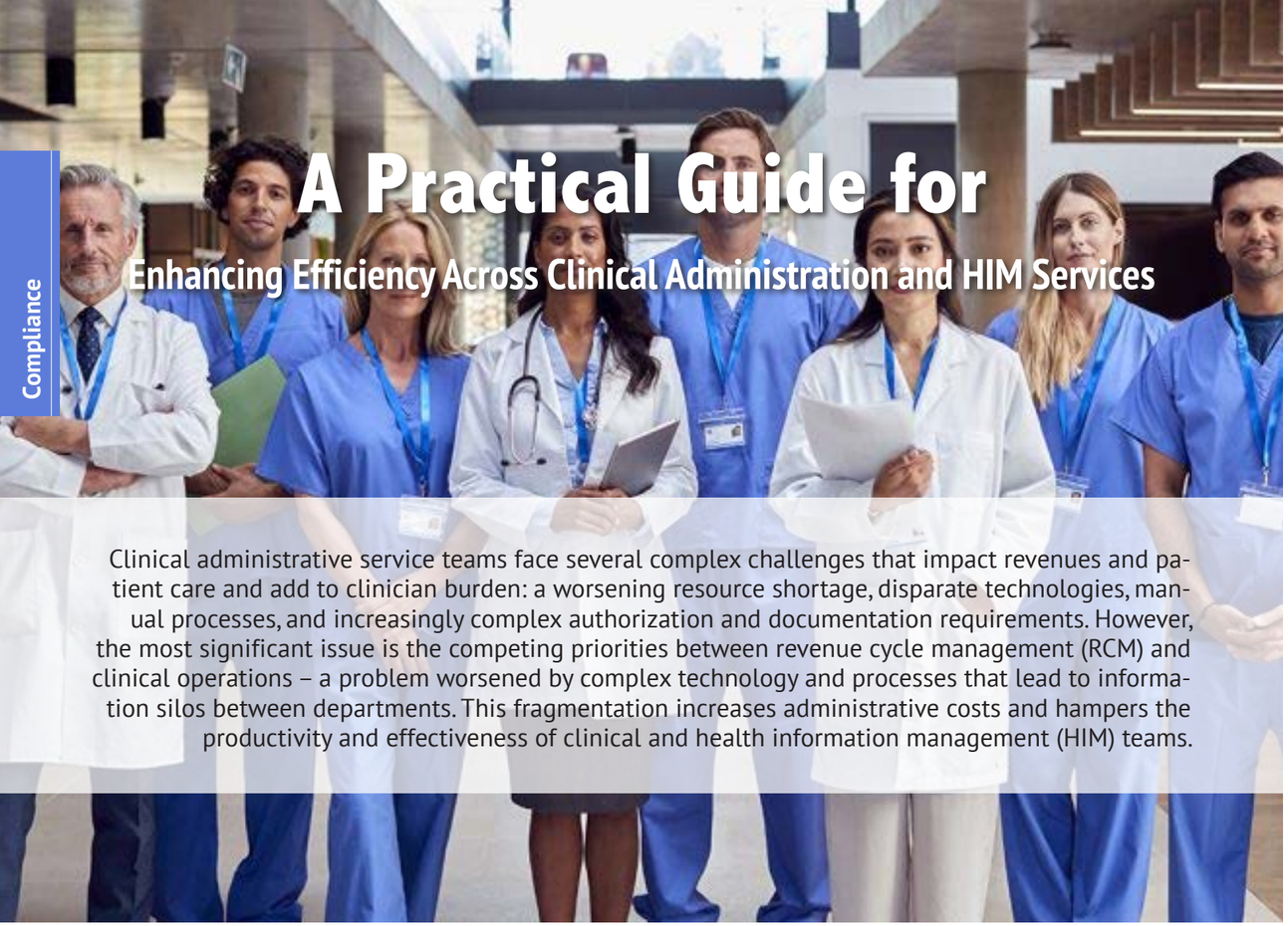

Compliance

A Practical Guide for

Enhancing Efficiency Across Clinical Administration and HIM Services

Clinical administrative service teams face several complex challenges that impact revenues and patient care and add to clinician burden: a worsening resource shortage, disparate technologies, manual processes, and increasingly complex authorization and documentation requirements. However, the most significant issue is the competing priorities between revenue cycle management (RCM) and clinical operations – a problem worsened by complex technology and processes that lead to information silos between departments. This fragmentation increases administrative costs and hampers the productivity and effectiveness of clinical and health information management (HIM) teams.

Encompassing clinical documentation utilization management (UM), prior authorizations, and clinical denials and appeals, clinical administrative services consume 15-30 percent of healthcare spending in the U.S.

Simplifying these services could reclaim billions of dollars each year and lessen or eliminate widespread impacts, including:

- Diversion of time and resources from patient care
- Delayed and lost reimbursements
- Static adoption of innovations and technologies
- Provider burnout and patient frustration

The silos created by misaligned objectives between HIM, revenue cycle, and clinical care leadership can also hamper the collaborative approach required under current team-based, patient-centered care and reimbursement models.

The Core Challenges

The disconnect between clinical and HIM can be deconstructed into several core challenges related to the specific activities that make up clinical administrative services.

Clinical Documentation Integrity

The absence of a comprehensive CDI program – or programs hampered by the ongoing shortage of experienced professionals and increasing complexity of documentation and coding – contributes to insufficient, inaccurate, or incomplete documentation. The result is 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 payor audits, fines, and clawbacks. Moreover, organizations lacking proper CDI software are missing important centralized collaboration and tools to reduce manual processes.

Utilization Management

Many UM departments struggle under the weight of staffing shortages, resource limitations, and outdated processes and technology that make staying on top of growing case volumes and increasingly complex requirements a significant challenge. Adding to the burden is inadequate data integration, which impacts the staff's ability to perform key tasks. When the effectiveness of UM teams is inhibited, workloads increase and turnaround times are delayed, impacting care access, quality, and outcomes and increasing costs.

Clinical Prior Authorizations

Prior authorization is a hotly debated, time-consuming, and expensive manual process that physicians responding to an American Medical Association (AMA) survey blame for serious adverse events and for patients abandoning treatment, not to mention being rarely evidence-based and contributing negatively to clinical outcomes. Prior authorization is also high on the list of reasons behind claims denials, due in large part to ineffective, time-consuming processes prone to human error that lack standardization between payors and providers. Frequent rule changes by payors create additional challenges, along with payor clinical guidelines and medical necessity determinations that are often not in compliance with the latest care guidelines and regulations.

Clinical Appeals

Claim denials are on the rise, leading healthcare revenue cycle and finance leaders to take a more aggressive stance on challenging denied claims. However, appeals processes are time-consuming, taking an additional 51 minutes of administrative time per claim (as reported in Denials Best Practice Playbook by Xtend Healthcare). Further, because 90 percent of denied claims are preventable (HFMA), it's a problem that is more effectively addressed prior to the denial.

Peer-to-Peer Reviews

Used primarily to review, clarify, or explain a plan of care and to align medical necessity and reimbursement criteria, most peer-to-peer reviews must be completed within 24, 48, or 72 hours of the request to avoid denial of the claim. Proper preparation can be extensive. What's more, the denying physician is rarely experienced in the specialty involved in the denial, although some states are addressing this issue legislatively.

Regulatory challenges and the increasingly complex nature of patient care-level decisions – which carry significant implications for providers – are also at play. For example, inpatient versus outpatient status for hospital services, such as surgical and complex radiological services and lab tests, impacts reimbursement rates and even whether the service is covered by Medicare.

Finally, 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.

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 must 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 and denial trends, and areas for improvement.
- Standardized processes and tools to facilitate accurate and efficient documentation.

When engaging with an outsourced service provider – which can help overcome staffing shortages and provide access to advanced technical skills, process workflows, and technology solutions – it is important to have in place strategies to guide selection and integration into the overarching workflows. This includes a comprehensive needs assessment and vendor due diligence.

By following these best practices and strategies, 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.

Resolving the Disconnect

The disconnect between RCM, HIM, and clinical services objectives – coupled with the harsh realities of staffing shortages, complex technologies, manual processes, increasingly complex care needs, and rising claim denials – puts clinical administrative service teams in an untenable situation that threatens provider organizations' financial standing and ability to provide timely, high-quality, 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. It also helps combat burdensome payor "delay and deny" tactics.

The right technology tools, a trusted outsourced service partner, and adherence to best practices let healthcare organizations realize increased efficiency, improved care outcomes, and fewer denied claims while eliminating care and reimbursement delays and reducing associated costs.

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Revenue to Realize Your Vision

At AGS Health, they help you streamline your revenue cycle through intelligent automation and global services so you're free to invest in your organization and its mission.