CAPLINE
HEALTHCARE MANAGEMENT

UNPACKING SUCCESS IN THE MID-REVENUE CYCLE:
PROVEN STRATEGIES FOR GROWTH

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There is a lot that happens between the patient's visit being over and claims management on the back end, which also affects revenue cycle management. This second phase of revenue cycle operations merges clinical information with financial data to construct the full patient encounter story and serves as groundwork for effective claims management and reimbursement. The mid-revenue cycle processes must be accurate and complete to sustain the financial health of a provider organization.

However, doing the same for a clinical encounter is challenging resulting in claim denials and delays in being reimbursed or ultimately through an unsatisfactory patient experience.

The National Association of Healthcare Revenue Cycle Management (NAHRI) states that denial rates typically range between 10% and 15%, covering the full healthcare spectrum across the United States. What this means is that for every 100 claims put in, 10-15 are not paid due to one thing or another.

Providers need to have comprehensive knowledge about the mid-revenue cycle, its importance, and how it impacts the front-half as well as back-half processes of an organization in terms of maintaining financial health apart from methods that help fine-tune these aspects for cutting scope charge leakage or leaked denials.

Understanding the Mid-Revenue Cycle: A Crucial Element

The mid-revenue cycle is part of the patient data lifecycle in revenue management between post-patient access and pre-care delivery (front-end) and the billing & reimbursement phase (back-end). The mid-revenue cycle is a group of processes and activities to properly capture patient information, document clinical services rendered, code diagnoses as well as treatment protocols for compliance with regulatory needs.

Key Components Of The Mid-Revenue Cycle

- Clinical Documentation Improvement (CDI)
- Coding and edits
- Charge Capture
- Compliance
- Revenue Integrity

Clinical Documentation Improvement (CDI):

This includes documentation integrity and quality, which must reflect patient illness severity as well as services rendered to achieve accurate coding and reimbursement.

Coding and Edits:

Coding for services performed and diagnoses received in a patient encounter can be coded to ICD-10-CM (diagnoses) and CPT (procedures) codes, which allows billing and claims processing. Claim coding edits correct previously reported codes to avoid or appeal denials.

Charge Capture:

Accurately documenting all the billable services and procedures that are provided to patients to get proper compensation for them. The method encompasses recording both professional and facility charges for the purpose of reimbursement.

Compliance:

The mid-revenue cycle must follow many regulations and guidelines (such as from CMS or other regulatory agencies). Adherence protects against penalties and guarantees comprehensive invoicing and compensation.

Revenue Integrity:

Revenue integrity is the practice of embedding revenue capture and prevention procedures into operational processes in order to prevent revenue leakage.

The mid-revenue cycle also encompasses case management. Case management is an area predominantly concerned with patient care, where clinicians plan and arrange after the point of admission to determine whether patients get proper treatment.

So, which treatments a patient gets and where they do so will determine how that revenue cycle shakes out. Payers sometimes don't pay for the treatments providers decide are best for their patients in specific competitive high-stakes care sites.

Mid-revenue cycle management seeks to pinpoint coverage, make sure that resources are not being used wastefully, and influence providers toward cost-conscious care.

Mid-Revenue Cycle Performance Metrics

Key performance indicators (KPIs) are essential for monitoring the efficiency of clinical documentation and coding accuracy in the mid-revenue cycle. These KPIs help identify issues such as claim rejections, delays, or underpayments. Here are the key KPIs broken down by area within the mid-revenue cycle.

KPIs for Clinical Documentation Improvement (CDI)

A recent survey by the Association of Clinical Documentation Integrity Specialists and 3M found the following CDI performance metrics to be the most important:

- Query response rate

New/re-review chart reviews per day

Query rate

Mastering these KPIs helps ensure the quality of clinical documentation, which in turn influences coding accuracy and reimbursement.

KPIs for Coding Performance

Tracking coding performance is critical for preventing claim denials and delays. Key coding metrics include:

- **Accuracy rate:** Percentage of correctly coded claims versus total documents.
- **Turnaround time:** Time taken from the date of service to claim submission.
- **Coder productivity:** Number of medical records coded per hour.
- **Days to final bill:** Time from the date of service until claim generation.
- **Claim denial rate:** Helps differentiate between authorization and coding-related denials, offering insights into coding accuracy.

KPIs for Charge Capture

Charge capture is a vital KPI that tracks how quickly billable services are converted into claims. This process impacts the timeliness of reimbursement. Additional KPIs include:

- **Charge capture rate:** Proportion of billable services captured versus total services provided.
- **Charge reconciliation rate:** Ensures that recorded charges match the services rendered, supporting accurate billing.

Compliance KPIs

To maintain adherence to regulatory standards, the following compliance KPIs should be monitored:

- **Coding compliance audit results:** Measure the accuracy of coding and compliance with guidelines.
- **Denial rate:** Tracks coding errors leading to claim denials.
- **Audit findings resolution time:** Time taken to resolve discrepancies identified during audits.

KPIs for Revenue Integrity

To prevent revenue leakage, key performance metrics for revenue integrity include:

- **Net collection rate:** Percentage of expected reimbursement collected after adjustments and write-offs.
- **Clean claim rate:** Percentage of claims submitted without errors or discrepancies.
- **Revenue leakage:** Measures potential revenue lost due to underbilling or coding errors, providing insights into missed revenue opportunities.

Selecting Which KPIs to Measure

Choosing the right KPIs to prioritize can be challenging. Providers should focus on KPIs that represent the largest opportunities for improvement, such as reducing denial rates or increasing charge capture. Benchmarking against peers is also important since claim denials and reimbursement trends can vary based on region or facility type.

Mastering the Mid-Cycle Maze: Unlocking Full Revenue Potential

The period between the registration of patients and submission of the claims as a part of the revenue cycle is very essential to a healthcare's financial status. Ideally, this part of the cycle should not be viewed as distinct concepts but rather as individual processes that may be detrimental to the revenue and cash flow.

Problems such as; Revenue loss, denied claims, delayed payments, and take-backs are typical scenarios. To maximize their revenues, healthcare providers must be able to discover such factors and find ways and means to address the issues.

Below are six top operational mid-cycle challenges, along with proven methodologies and best practices.

1. Coding

Failure to effectively address coding concerns can have adverse effects on a hospital's financial bottom line. A survey of healthcare leaders found that coding inaccuracies are among the top three causes of claim denials. Specifically, focus was placed on the fact that the denial level, in 2022, has reached 11% of the overall number of claims. Coding-related issues that affect revenue include:

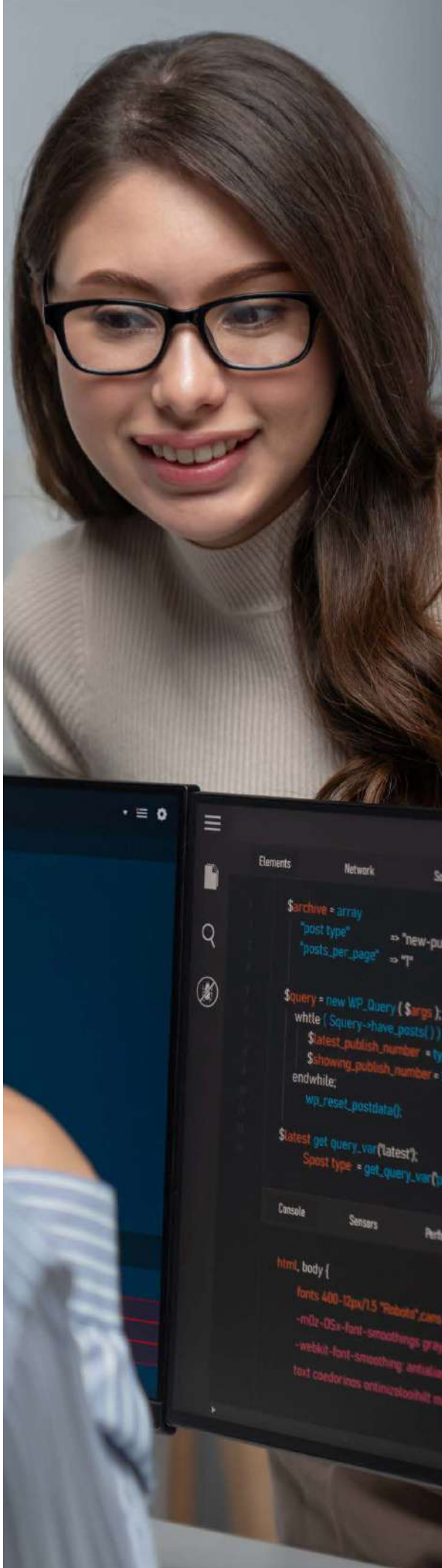
- Potential underpayments or overpayments
- Increased payer audits for certain code combinations
- Payer takebacks
- Suboptimal KPIs

- Coding backlogs
- High turnover or poor performance in coding staff
- Dissatisfied providers and patients

Incorrect coding can also be categorized under “fraud and abuse” in the set principles of the American Medical Association’s Principles of CPT® coding and attracts penalties including fines of up to hundreds of thousands of dollars among other measures that may lead to imprisonment.

Strategies to Improve Coding Accuracy:

- Implement A **Robust Quality Program** With An Accuracy Rate Of At Least 95%
- Conduct **Unbiased Coding Quality Assessments** Led By Compliance Teams
- Provide Ongoing Education And Use Coding Audit Software



- Employ **100% AHIMA/AAPC Credentialed Coders**
- Utilize **Predictive Analysis,** Including DNFC/D-NFB (Discharged Not Final Coded/Billed) Metrics

Success Story:

A large health system achieved:

- **98.5% increase in coding quality**
- **53% reduction in DNFC**
- **75% reduction in ED Late Charges**

These improvements were achieved through:

- Pre-hire online skill assessments
- Pre-production competency testing with initial quality reviews

- Monthly quality reviews with feedback
- Targeted and ad-hoc audits for root cause analysis
- Pre- and post-billing audits in key focus areas
- Detailed reporting, analysis, and feedback

With these coding quality steps in place, the system increased overall coding proficiency by over 8%, which was above the industry benchmark.

2. Medical Record Documentation

Documentation in payers has become more rigid with managers demanding more quality documents to be produced. Lack of documentation results in the denial of claims besides low satisfaction among patients. An example of a bill that a patient may be charged while they are not supposed to include an amount for a procedure they carried out due to a misunderstanding of documentation.

Strategies to Improve Documentation:

Implement a Clinical Documentation Integrity (CDI) Program:

It is utilized to perform concurrent and retrospective chart reviews of inpatient records to obtain clearer or additional information than is provided by the imprecise, part, or inconsistent written document from the provider.

Ensure Accurate Representation:

The best practices of CDI facilitate the efforts to get a more accurate representation of a patient's clinical status, which in turn produces coded information. It is for quality reporting, physician report cards, reimbursement as well as tracking of diseases.

Ongoing CDI Education:

Instruct the providers on the necessity to document the patient's care to capture the elements of the severity of illness and risk of mortality on a constant basis.

Create a Culture of Documentation Integrity:

Improve documentation accuracy and make a point to show that the work being done has a practical achievement of an observable result.

By implementing a standardized, physician-centric CDI program, a health system achieved a significant impact on Case Mix Index (CMI) capture, leading to better documentation quality and improved revenue outcomes.

3. Team Quality and Accountability

Creating an excellent revenue cycle team is tough, especially with a lack of skilled professionals. Bringing in new team members and training them can be a time-consuming process, and revenue cycle leaders often find they're too busy to dedicate that time. When inexperienced staff are involved, it can lead to more mistakes and claim denials, which just adds more pressure to teams that are already stretched thin.

Issues Related to Revenue Cycle Hiring Challenges:

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

Another issue attached to personnel is that of accountability in the formation of highly efficient collaborative teams. Cumulating backlogs, increasing deadlines, and tedious routine work may help staff to lose the big picture. This means that teams should be aware of the consequences of quality problems for the organizational financial condition.

Steps to Build a Quality Revenue Cycle Team:

- **Hire Credentialed and Certified Professionals:** Only hire credentialed and certified revenue cycle professionals and consider outsourcing for the required positions because there may be a shortage of qualified talent pool.

- **Provide Ongoing Education:** Provide staff members training such as updated information on regulatory and compliance issues affecting the university.

- **Foster a Collaborative Team Environment:** Establish team responsibility that entails the view that everyone is in it to work for the group's good.

Furthermore, performing coding audits and using other predictive analysis tools like DNFC/DNFB and account resolution opportunities helps in improving team performance and ownership.

4. High-Risk Charge Capture

Identifying and accurately charging for specific services can be tricky, sometimes more so in risky specialty areas of practice such as cardiology, nephrology, and interventional radiology among others. Such services involve string combinations that are often complicated and therefore, have higher costs of error and require a lot of resources to manage.

In a survey of revenue cycle leaders:

- **68%** said that up to **10%** of their total charges were under-coded.
- **56%** said over half of their charges were over-coded, accounting for **11%** or more of their total charges.
- Nearly **25%** reported that submitting a claim could take up to four weeks after the date of service.

Steps to Optimize High-Risk Charge Capture:

1. **Identify high-risk clinical services** that are prone to errors.
2. **Implement automation technology** that monitors processes and flags potential issues in real time.
3. **Use High-Risk Charge (HRC) capture solutions** to identify and resolve issues before they impact revenue.

Optimizing high-risk charge capture can help prevent missed or inaccurate charges, reduce charge lag times, and unlock revenue potential.

5. Cost Management

Supply costs particularly labor have been known to rise in the recent past, hence, cost control is very essential to many hospitals. Another crucial area of focus is the effective regulation of expenses associated with the use of suppliers and their services. A survey conducted among healthcare facilities revealed that roughly a quarter of the participating hospitals implement two or more RC solutions, and 5 percent of them employ over four.

For health systems, having inadequate cost control and evaluation can mean missing out on millions of dollars in unnecessary costs. It is thus important to cut spending on both labor and the vendor.

Labor Costs:

- **Geographical Analysis:** Compare the labor costs with different areas in order to pinpoint the regions with lower costs of labor.
- **Labor Consolidation:** There is an idea to cluster people in areas that are financially more advantageous.
- **Service Centralization:** Search for ways whereby services can be centralized in a bid to cut expenses further.

Vendor Spend:

- **Choose Smart Partners:** Opt for vendors that leverage intelligent mid-cycle process automation to improve productivity and reduce costs.

- **System Integration:** Ensure vendors' processes integrate seamlessly with existing systems and workflows.

According to the Centers for Medicare & Medicaid Services (CMS), "Over 2022-31, average National Health Expenditure (NHE) growth at **5.4%** is projected to outpace GDP growth at **4.6%,** raising health spending as a share of GDP from **18.3%** in 2021 to 19.6% by 2031.

6. Charge Integrity

Charge integrity means that the charges are compliant, valid, and substantiated with appropriate documentation. It is an essential component of any mid-cycle program and it involves billing of patients in order to ensure that respective healthcare systems are reimbursed. However, to be able to attain charge integrity, responses from the clinical personnel, the revenue cycle workers, billers as well as the compliance departments are imperative.

Four Key Components of Charge Integrity:

1. **Automation:** Constantly monitor all processes to identify problem areas where proactive measures may be required.

2 **Integrative Processes:** Make sure the processes in place fit the work each team does to avoid interruption or hindering the other.

3 **Ongoing Training:** Ensure there is consistent training for all the departments involved in the process of charge capture.

4 **In-depth Measurement:** Charge quality and accuracy should therefore be subjected to a detailed tracking system.

Success Story:

A large health system was experiencing poor charge-capture performance and had no way to track revenue trends in clinical departments. To handle this, they employed a solution that involved using real-time analytics to identify suspicious charges.

The solution included:

- **Daily monitoring** of charge capture at both department and charge-line levels using automated analytics.
- **Automated alerts** to revenue management stakeholders.
- **Department alerts** to capture both positive and negative fluctuations.

- **Focused remediation efforts** to reduce charging errors, rebills, and inefficiencies.

Results in the First 90 Days:

- Identified **$75M in charge errors** unsupported by clinical documentation.

- Avoided **$10.1M in late charges** through proactive identification before month-end close.

Mid-Cycle Best Practices

To maintain and enhance a hospital's mid-cycle performance, hospitals should adopt best practices in the market and set functional KPIs for team members and departments. This is expressed through the clean claims rate, initial denials that relate to coding, and charge capture timeliness in relation to days in A/R.

KPI Benchmarks:

- **Clean Claims Rate: 98%**

- **Denial Rate:**
  Industry average: 5% – 10%
  Best practice: <5%
  Ideal denial resolution: 85% within 30 days

- **Charge Capture:**
  Late charges should be ≤2% of all charges

Proven Strategies for Mid-Cycle Optimization:

1. **Skillset:** Focus on building team expertise by recruiting top talent or outsourcing partnerships.

2. **Technology:** Implement automation to streamline mid-cycle processes, reduce errors, and free up staff for other tasks.

3. **Policies and Procedures:** Establish consistent guidelines to improve quality and consistency across departments.

4. **Education:** Offer ongoing training to ensure staff maintains mid-cycle proficiency.

5. **Performance Monitoring:** Continuously track performance to identify trends and areas for improvement.

The Journey Forward

The pressure of costs, personnel shortage, and reduced revenue is becoming more and more apparent in healthcare systems. That is why enhancing mid-cycle efficiency becomes a sound initial focus. Hospitals stand to gain a great deal when they outsource their revenue cycle through the achievement of best practices, reduction of turnover time, and cutting down on expenses. This can help relieve stress in revenue cycle teams and enhance the outcomes of the hospital's revenue cycle.

How Capline Healthcare Management Streamlines the Mid-Revenue Cycle

Capline Healthcare Management is committed to helping healthcare providers maximize revenue while ensuring compliance through expert management of the mid-revenue cycle. We focus on four key areas: clinical documentation improvement (CDI), charge capture, coding accuracy, and denial management.

By enhancing these areas, we streamline operations and boost financial performance, enabling healthcare organizations to thrive. Our current list of providers consistently highlights our efficiency and effectiveness in these areas, showcasing significant improvements in their revenue cycles.

1 Mastering the Space of CDI and Documentation Accuracy

Our lineup of professional and efficient teams in place to work with our clinical teams makes sure that each patient encounter is a perfect one. We optimize clinical documentation quality by leveraging advanced CDI tools and instantly giving feedback. This is employed to minimize rejected claims and certify all services that can be reimbursed properly.

In addition to clinical documentation improvement (CDI), we also perform comprehensive eligibility verification (EV) and preauthorization tasks. We make sure that each IV form is filled with all relevant CDT (Current Dental Terminology) and CPT (Current Procedural Terminology) codes, detailing benefits, accumulation, and estimated patient responsibility (EPR) at the time of the visit. This thorough process helps eliminate errors that could lead to IV-related denials, ensuring that all potential issues are addressed before submission.

By ensuring full preauthorization, we reduce the risk of service denials and help guarantee faster approvals for procedures, improving overall revenue accuracy and reducing denial rates. Our method not only increases the accuracy of reimbursement but also elevates patient care.

2 Charge Capture Optimization

We all know the impact of missed or inaccurate charges on your revenue! This is why we have designed state-of-the-art mobile charge capture solutions that enable providers to document services in real time. Routine audits are conducted to help identify and correct variances, allowing healthcare facilities to recoup missed revenue and sustain their financial consistency.

3 Maintaining Coding Accuracy

Proper reimbursement is dependent on accurate medical coding and our certified coders have you covered. Combining AI-empowered solutions likewise enhances coding precision and ensures compliance with new guideline requirements. Pre-submission coding audits effectively reduce claim errors, decrease denial rates, and speed up the reimbursement process.

4 Proactive Denial Management

A denial could mean the loss of lots of revenue, so we prefer to be proactive when managing denials. We analyze underlying drivers and trends to prevent further issues. We also focus on key actions within AR management, such as trend analysis, which enables us to receive payments on schedule, improving both the net collection ratio (NCR) and gross collection ratio (GCR).

Additionally, we fast-track delayed follow-ups by monitoring pending ageing and sending out timely information requests, ensuring that the necessary documents are provided on time. This not only reduces delays but also minimizes denials. Upon appeal, our sophisticated claims system ensures erroneous denials are rapidly corrected and resubmitted, allowing facilities to improve cash flow while reducing administrative work.

5 Advanced Technology Integration

We embed state-of-the-art technologies like AI, natural language processing (NLP), and end-to-end revenue cycle management (RCM) platforms to enhance mid-revenue cycle functions. These deliver real-time

visibility into revenue operations, unify workflows, and drive scale for healthcare organizations at an efficient cost.

6 Outsourcing Confidence

For those who find mid-revenue cycle management overwhelming, we offer assured outsourcing solutions. Our experienced team processes the entire cycle with surgical precision, from CDI to denial management. We provide a suite of scalable solutions that are customized to each client's needs for greater accuracy and compliance without compromise.

Measuring Success — We Measure Our Success Through Key Performance Indicators:

- **Reduction in denial rates -** Our error-free coding and proactive denial management bring the overall claim rejection rate down significantly.
- **Lower days in AR -** By simplifying coding and documentation, claims are processed and paid faster.
- **Improvement in revenue capture -** We provide a robust charge capture process that prevents revenue leakage, ensuring no billable service goes undocumented.
- **Audit success rates -** Our thorough coding audits reduce compliance penalties and ensure all appropriate codes and documentation standards are met.

Trusted by Providers: Hear from Our Satisfied Clients

1. Toothwise Dental

Absolutely Amazing! Nothing but positive things to say about this company. They are very thorough, friendly and very professional. We use to be helped by Micheal Bay who was also very helpful, but now we are working with Daniel, who is super great in helping us with our credentialing needs. He's helped you in obtaining the fee schedules for the insurance that the office is credentialed with. Most definitely would recommend to any office needing any type of help with credentialing services. If possible ask for Daniel he will help you and keep you up to date with your credentialing process. Highly recommend working with him for any related to credentialing services.

2. Sher Dental

Amazing! Nothing but positive things to say about this company. They are very thorough, friendly and very professional. Daniel is the best! He has helped us through the credentialing process since the very beginning and made it very easy to accomplish everything with his help and knowledge. Most definitely would recommend to any office needing any type of help with credentialing services.

3. Aesthetic Dental

Thank you for all your hard work! We couldn't have made our office run the way it does without you! Special thank you to Puneet for all the help!

4. Jonathan Gorman

Fantastic service at reasonable and fair prices! These guys go above and beyond and have made all aspects of billing and claims management much easier! Highly recommend!!!!

Wrapping Up

The mid-revenue cycle is an essential part that determines the financial aspects of healthcare organizations. We, at Capline Healthcare Management, are a team of professionals having profound knowledge in the field of CDI services, charge capture, coding, and denial management that assists healthcare providers to achieve greater efficiency in their organization's revenue cycle.

Through the use of high-end technologies and; through the implementation of; best practices we are able to minimize lost revenues and guarantee sound financial development. In mid-revenue cycle optimization, you can count on us because of our dedication to excellence and customer-centered service.

It helps us to realize that the healthcare revenue cycle includes a variety of steps and our products are designed to improve its performance and remain loyal to the main objective of healthcare organizations which is patient care. By relying on Capline, healthcare providers can leave revenue management to us and focus on what they do best – enhancing patient outcomes. Through our past experience and full-service capabilities, we can guarantee that our clients get what they want – financial success and resiliency in the progressive world of healthcare.

Connect with our experts to discuss more about your mid-revenue cycle. We're here to assist you.

Contact Info

888-444-6041 thinkgrowth@caplineservices.com

3838 N Sam Houston Pkwy E, Ste 290, Houston, TX 77032