Reimagining the Middle Revenue Cycle: A Single, Unified Platform to Overcome Today's Operational Challenges

Optum

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Navigating middle revenue cycle challenges

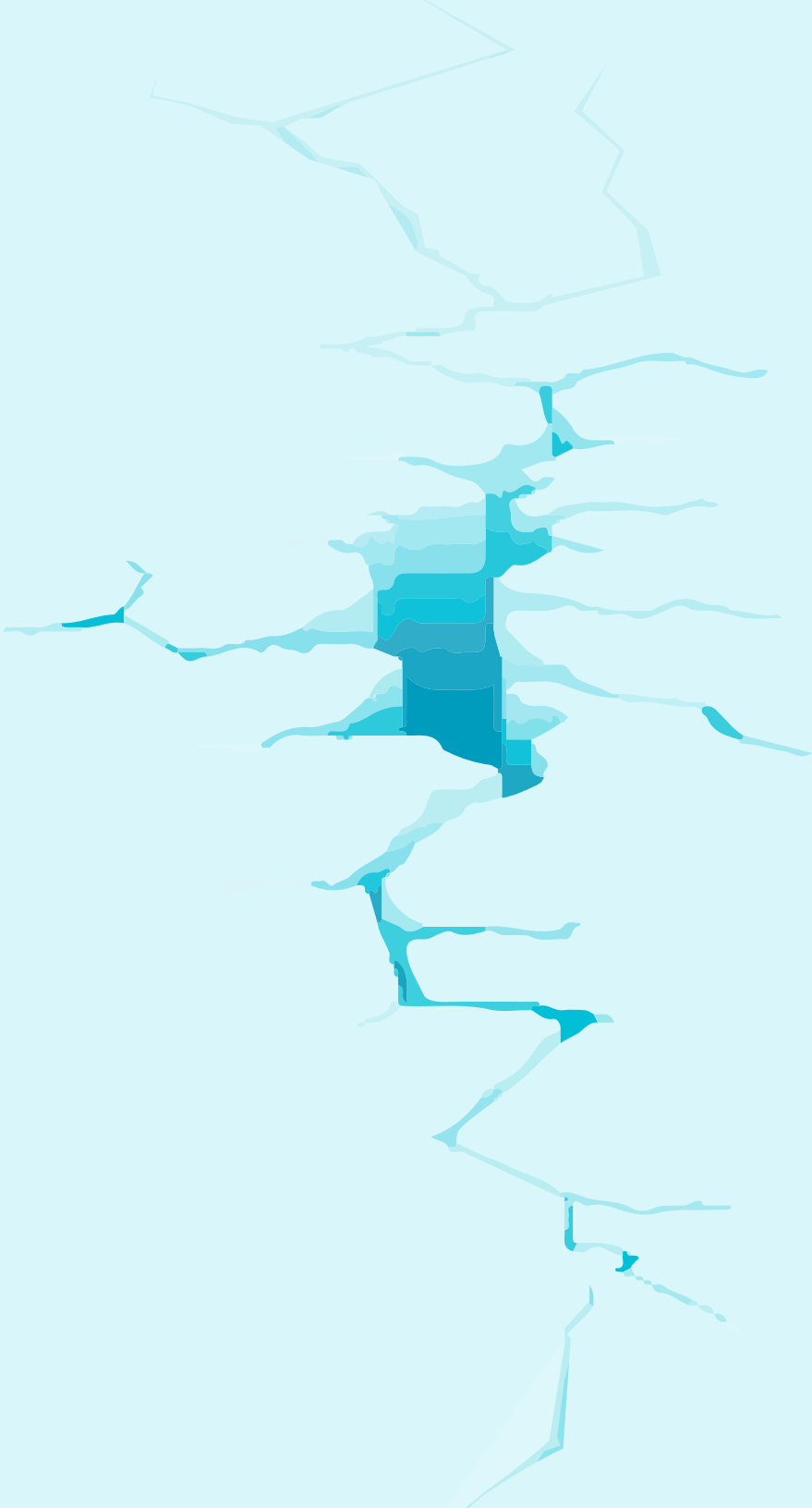
The tasks and processes that collectively make up the middle revenue cycle represent the essential lifeline linking clinical care and financial reimbursement for provider organizations. Accurate documentation, coding and charge capture are mission-critical prerequisites for strong cash flow and optimal economic performance.

Yet hospitals and health systems increasingly face significant challenges when it comes to efficiently executing middle revenue cycle tasks. Already under pressure from rising costs and evolving reimbursement models, providers must also contend with chronic staffing shortages and increasingly complex, ever-changing payer demands.

A fractured system

Aggravating these difficulties is a fragmented technological ecosystem largely consisting of disparate, single-competency solutions. The resulting duplication and lack of interoperability magnifies administrative and IT expenses, impedes communication and masks costly mistakes.

These shortcomings reflect the culmination of a decades-long, best-of-breed strategy that saw providers continually adding point solutions to address specific revenue cycle tasks. Over time, this fragmented, piecemeal approach had led to critical inefficiencies and major functional gaps.



Synergistic benefits

Eliminating today's structural deficiencies to achieve genuine interoperability can only be achieved by unifying the full spectrum of clinical and administrative middle revenue cycle tasks across a single, powerful framework. This approach eliminates the need for multiple vendors, which reduces the total cost of ownership and simplifies the complexities of revenue cycle management (RCM).

Incorporating advanced automation and artificial intelligence within a singular platform further streamlines and accelerates workflows for understaffed middle revenue cycle operations. These capabilities boost transparency to allow for dramatically improved performance monitoring, reporting and intervention. Most importantly, they enhance clinical documentation and coding to improve revenue integrity, minimize denials and help ensure appropriate reimbursement.

Essential steps no longer fall through the cracks when people, processes and technology fully align.

Key operational challenges facing the middle revenue cycle

About **40%** of all hospitals reported negative operating margins in 2024,[1] up from 25%[2] in 2019.

90% of respondents reported their organizations were experiencing revenue cycle staffing shortages.[8]

Hospitals and health systems spent **$19.7** billion in 2022 overturning denied claims.[11]

Unrelenting financial pressure

Hospitals and health systems can ill afford suboptimal revenue cycle performance in an operating environment characterized by rising costs, flat reimbursement and shrinking margins.

- About 40% of all hospitals reported negative operating margins in 2024,[1] up from 25% in 2019.[2]
- Although hospital margins overall have improved from the all-time lows set during the pandemic, not-for-profit hospitals still faced continued financial pressure throughout 2024.[3]
- The average denial rate was up to almost 12% in the first half of 2023,[4] though about 85% of denials are preventable.[5]

Chronic staffing shortages

Ongoing labor shortfalls impacting revenue cycle specialists are forcing hospitals to find new ways of doing more with less.

- A 30% shortage of qualified medical coders currently exists nationwide.[6]
- The average annual salary of medical coding and billing professionals increased 2% between 2023 and 2024 to $54,545.[7]
- In a 2022 survey of CFOs and revenue cycle VPs, 90% of respondents reported their organizations were experiencing revenue cycle staffing shortages.[8]
- A 2023 survey found that 96% of responding revenue cycle executives believed a lack of qualified workers was negatively impacting payer reimbursements and collections while 70% said staff shortages exacerbated denial rates.[9]

Increased payer friction

Payer-provider friction compounds the challenges of middle revenue cycle management. It increases administrative burden and expense and contributes to rising denials and slower reimbursement.

- 78% of hospitals and health systems say their experiences with commercial insurers are getting worse, according to an American Hospital Association survey.[10]
- Nearly 15% of all claims submitted to private payers are initially denied, including many that were preapproved during the prior authorization process.[11]
- More than half of claims denied by payers (54.3%) ultimately were overturned in 2022, but typically only after providers pursued multiple rounds of costly appeals. All told, hospitals and health systems spent $19.7 billion in 2022 overturning denied claims.[11]

Technological limitations

The proliferation of point solutions that wrap around a central electronic health record (EHR) and target specific middle revenue cycle tasks has fostered a siloed technological environment over the past several decades. These disparate applications are often unable to communicate which impedes workflows, replicates effort and contributes to documentation, coding and claims errors.

- 30% of hospitals and health systems use at least 2 revenue cycle vendors, with some using up to 4 vendors.[5]
- Newer point solutions continue to emphasize the use of artificial intelligence (AI) to execute various RCM functions. However, many stand-alone technologies rely on relatively static, single-component approaches that have shown limited accuracy and flexibility when it comes to independently deriving and assigning medical codes from clinical text for complex procedures and services.[12]
- Juggling multiple vendors increases administrative overhead while making it more difficult to identify and mitigate performance issues across the full revenue cycle.

Disparate, siloed technology impedes workflows, replicates efforts and contributes to documentation, coding and claims errors.

A strategic approach to overcoming middle revenue cycle challenges: benefits of a unified platform and intentional solution design

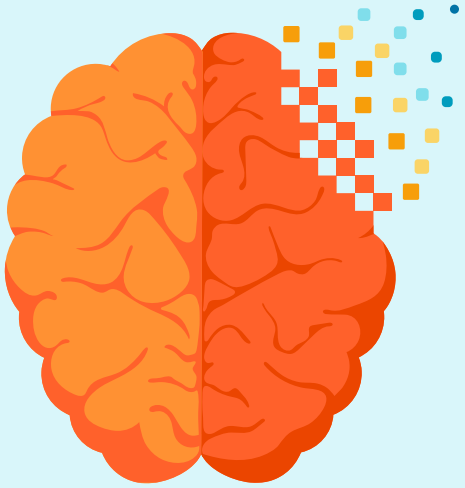
Addressing the structural and internal barriers facing middle revenue cycle operations requires a fundamentally new approach to health care technology.

Unlike existing point applications, a unified middle revenue cycle solution ensures seamless communication between the EHR, coding software and billing systems. This integration of clinical and administrative data and tasks is essential for clinical documentation integrity (CDI) and charging accuracy across facility, professional, inpatient and outpatient domains.

Combining this end-to-end approach with integrated automation and mature AI tools streamlines and accelerates workflows by helping staff more effectively manage the complexities of documentation, coding and regulatory requirements. The net result is reduced expense, cleaner claims, fewer denials and improved reimbursement.

Harnessing automation to enhance efficiency and accuracy

1. **AI-powered coding:** AI can now analyze clinical documentation to suggest accurate medical codes. This reduces the burden on human coders, minimizes errors and ensures compliance with coding standards.
2. **Automated code assignment:** AI systems automatically execute autonomous coding based on an analysis of patient records while providing partial coding assistance for more complex cases. This accelerates the coding process and frees coders to focus on other tasks.
3. **Documentation integrity review:** AI tools provide continual checks of the narrative generated by the clinical record against resulting code assignments. This capability helps identify missed documentation opportunities.
4. **Predictive analysis:** AI predicts potential coding errors and suggests when a human should make corrections before claims are submitted. This proactive approach reduces denials and improves reimbursement rates.
5. **Streamlined claims processing and denial prevention:** Using AI to prevent denials reduces manual touches, helps ensure accuracy and accelerates collections.



Harnessing AI for enhanced decision-making

1. **Data-driven insights:** AI is capable of analyzing large volumes of coding data to provide actionable insights. This knowledge can help organizations identify trends, optimize coding practices and make informed decisions about resource allocation.
2. **Real-time monitoring:** AI systems continuously monitor coding accuracy and compliance and provide real-time alerts when anomalies are identified. This enables prompt corrective action and helps maintain coding integrity.
3. **Clinical documentation integrity:** AI systems can review 100% of cases for all payers throughout the patient stay and assist in identifying gaps in documentation. Data indicating a quality event are flagged and revenue integrity reviews are conducted to ensure accurate alignment between coding and documentation.

Enhancing the coding workforce

1. **Training and support:** AI assists in training new coders by delivering real-time feedback and guidance to help build and sustain a skilled workforce.
2. **Reducing burnout:** By automating routine and repetitive coding tasks, AI reduces coder workload, improves job satisfaction and helps prevent burnout.
3. **Scheduling and workload management:** Workforce management tools optimize staff scheduling, track performance and manage workloads efficiently. This enables effective use of staff and aligns personnel with tasks that match their areas of expertise.

Strengthening cybersecurity and compliance

1. **Advanced threat detection:** AI enhances cybersecurity by detecting and responding to threats in real time to protect sensitive patient information and maintain compliance with data and privacy regulations.
2. **Automated compliance monitoring:** AI continuously monitors compliance with coding regulations and flags potential issues before they can become significant problems.

Optum Integrity One: comprehensive, end-to-end middle revenue cycle solution

The Optum Integrity One solution addresses the crucial market need for a simplified, all-in-one platform that spans the entire middle revenue cycle. Operating at the intersection of clinical, financial and administrative data, Integrity One's bidirectional information flow enables a full and accurate view of the patient encounter and seamless execution at each step in the middle revenue cycle process.

In so doing, it integrates and streamlines the many tasks needed to generate clean claims for inpatient, outpatient, physician and facility services. Speed, simplicity and transparency across the entire revenue cycle are design hallmarks of Integrity One.

By embedding automation and advanced AI capabilities, workflows are accelerated and streamlined, ensuring efficiency and compliance.

Optum Clinical Language Intelligence(TM) employs a hybrid architecture that combines statistical, knowledge-driven, and AI components. This powerful solution not only incorporates cutting-edge generative AI but also possesses a deep understanding of core clinical language.

Optum Integrity One addresses the market need for a transformational, all-in-one platform that spans the entire middle revenue cycle, while future proofing your technology investments.

Optum Integrity One transforms operations by driving timely and accurate reimbursement, revenue integrity and cost containment.

- **Automates 100% case review and code assignment for all payers:** CLI-enabled technology automates the full spectrum of clinical documentation review, case identification and code assignment throughout the episode of care.
- **Identifies gaps in documentation at the point of care:** Identifies documentation deficiencies, including potential quality events, at the point of care to enable early resolution using clinical-based AI-powered insights for all records and all payers.
- **Helps confirm complete code capture to minimize downstream denials:** CLI uses efficient and accurate code assignments to eliminate missed coding opportunities, supporting risk-adjustment methodologies and helping prevent downstream denials.
- **Supports coding accuracy with comprehensive, built-in tools:** Prevents coding errors and supports quality initiatives by identifying at-risk cases through pre-bill charge capture and rules-driven auditing.
- **Provides a truly integrated CDI and coding platform:** Facilitates interdepartmental collaboration through a single, fully integrated CDI and coding platform.
- **Automates manual CDI operations to enable program expansion:** Automates manual CDI operations for greater efficiency and accuracy, enabling CDI program expansion without requiring additional full-time employees.
- **Allows for vendor consolidation:** Reliance on a single vendor for a comprehensive complex charging, coding, and CDI solution reduces total cost of ownership and simplifies vendor management.
- **Truly autonomous coding and exception-based workflows:** Send high-confidence cases directly to billing, without need for human intervention. By utilizing logic-based rules established by the client, code pair combinations and case confidences can be seamlessly processed and billed. In addition, where exceptions arise, cases are automatically routed to coders or audit staff for review.

Reimaging the middle revenue cycle

Optum Integrity One was specifically designed to address the challenges of today's health care environment. By consolidating best-in-class functionality within a single, end-to-end platform, Integrity One improves coding and documentation accuracy, mitigates workforce constraints, effectively manages payer-rule complexities and offers previously unavailable visibility into virtually all aspects of the middle revenue cycle.

First and foremost, Integrity One's automation and AI capabilities streamline workflows and reduce human touch points while eliminating friction and overlap between clinical and administrative domains. That means fewer individuals can accomplish more with less effort and better overall results.

A single, comprehensive platform eliminates siloed functionality and resultant inefficiencies and lack of interoperability. The bidirectional flow of communications and data simplifies all aspects of middle revenue cycle management and fundamentally transforms oversight and performance monitoring. Vendor management is also greatly simplified and cost of ownership reduced.

AI functionality provides multiple layers of real-time alerts and safeguards to help maintain the integrity of clinical documentation, coding and claims. Payer opportunities for denying, delaying or disputing claims and payments are substantially reduced.

Integrity One quickly and consistently delivers clean claims that accurately reflect the specific type and level of health care service provided across inpatient, outpatient, physician and facility settings. This translates into fewer denials, accelerated cash flow and increased revenue.

Optum Integrity One marks a game-changing evolution in middle revenue cycle technological solutions. It erases long-standing inefficiencies and harnesses the power of AI to help hospitals and health systems achieve and sustain optimal revenue cycle performance, regardless of external pressures or conditions.

Learn more about what Integrity One can do for you.

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