MD Clarity

A Guide For Providers

Healthcare Underpayments

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Late last year, a three-judge arbitration panel in Florida determined that UnitedHealthcare paid ER clinician group TeamHealth clinicians just 30 percent of what they estimated would be fair compensation for care provided. The judges awarded TeamHealth $10.8 million in this most recent payment, bringing its total recovery from UnitedHealthcare to nearly $500 million. TeamHealth has also won underpayments cases against Centene and Molina.

TeamHealth President & CEO Leif Murphy, called Molina's reimbursement practices "abusive," stating that, "like many insurance companies across the United States...[it] refused to negotiate fair reimbursement with emergency medicine physicians, coercively underpaid physicians, and exposed its members to its underpaid balances."

Murphy voices the experience of many providers struggling to win fair payments from payers. Here, you'll uncover every source of underpayments and the steps you can take to minimize them.

How Bad Is The Underpayment Situation For Providers?

It's significant. One study published in Becker's Hospital Review found providers lose one to three percent of their net revenue annually due to underpayments from commercial payers. Other studies put that figure as high as 11 percent.

With healthcare insurance companies' error rates at 19.3 percent (according to the AMA), clearly, a good portion of underpayments begin in payers' offices. And it's not just private payers who are shaving payments. In 2020, an American Hospital Association analysis showed Medicare and Medicaid underpaid U.S. hospitals by 100.4 billion.

Payers aren't the only sources of provider underpayments. Errors made in providers' revenue cycle offices trigger them as well.

Also at the heart of diminished provider revenue are the issues plaguing the American healthcare system as a whole. Competing interests of providers, payers, and patients have birthed a fractured, broken, and inefficient healthcare delivery and payment system. This guide touches on healthcare leaders' vision of how to rectify all aspects, no matter their source.

Payment Variance

You may have heard the catch-all term "payment variance." Payment variance is the difference between the

expected payment and the actual payment. Both providers and payers make errors that result in payment variances. Because payer underpayments sap provider revenue and overpayments put providers at risk for legal action, you must address payment variances. Failing to rectify overpayments leaves you exposed to Civil Monetary Penalties Law liability, False Claims Act liability, and exclusion from federal healthcare programs. Still, many groups and practices are not current on their variances.

The Impact Of Underpayments

Given that net revenue per physician full-time equivalent (FTE) recently hit $695,088, a physician group with 20 providers that brings in $14 million in annual net revenue could be missing out on $140,000 to $420,000 in the annual income they've earned. A group with 100 physicians earning $70 million per year gets shorted $700,000 to $2.1 million. That money could go to additional staff, a down payment on a new PET/CT scanner, or any number of practice improvements.

More importantly, to achieve common group goals of attracting capital, new talent, or even a buyer, the group must show the most robust EBITDA possible. When private equity or other buyers compare figures among several groups, showing robust revenue integrity and a healthy underpayments recovery protocol is a competitive advantage.

Healthcare Industry Challenges Fueling Underpayments

To reduce underpayments and increase revenue, first understand how the existing healthcare system creates conditions that enable them.

Plan complexity

Any provider group receives payment from dozens of different insurance payers, and each of those offers multiple plan types (Bronze, Silver, Gold), multiplying benefit variations. Add the yearly restriction updates payers make, and back office staff can miss a code, a charge, or a contract update. Consider, too, that the AMA updates ICD and CPT codes yearly (225 new codes, 75 deletions, and 93 revised codes just this year) and it's easy to see how handling patient billing lacks precision. No practice, hospital, or group escapes these errors.

Given this level of complexity, it's no wonder that the majority of all claims submitted to payers contain errors. In truth, grasping the fine details of an individual patient's current benefits is often beyond the capability of even experienced billing staff.

Staffing shortage

Most likely, you are experiencing the healthcare shortage firsthand. The COVID pandemic along with demographic factors have thinned out the ranks of those willing to work in healthcare, including in administrative roles. According to a study cited by Becker's Hospital Review, 63% of providers are grappling with revenue-cycle staffing shortages. When staff are limited, only the most pressing and lucrative tasks get accomplished. If underpayments won't typically return the revenue denial appeals or A/R collections cover, they drop to the bottom of the list.

High volume

A shrinking administrative team means that those who remain are overburdened with an insurmountable volume of claims to process. Nearly all back office staff today are overburdened. A recent survey from Brigham and Women's Hospital cited in The Harvard Gazette analyzes healthcare workforce burnout—the productivity-sapping malaise that occurs when the amount of work overcomes one's ability to complete it.

Among its 42,000 respondents are 11,000 non-clinical, administrative staff. Of these, 47.4 percent "perceived work overload" (compared to 37.1 percent of physicians).

Researchers found this work overload to be "significantly associated" with both burnout and intent to leave the job. Indeed, 32.6 percent of surveyed non-clinical staff reported plans for leaving.

Extra pressure doesn't help the work get done accurately.

The more staff is pressured to rush through a large workload, the more errors occur. Worse, a sense of being continually behind becomes demoralizing, leading to a lack of care and even more errors. Of course, underpayments often follow.

Likewise, moving work around—a common practice in healthcare offices—does little to solve the claims volume problem. Staff simply does not have a bottomless capacity. Study author Lisa S. Rotenstein, a primary care physician at the Brigham and Women's Hospital and assistant professor at Harvard Medical School, provides some guidance. Citing a critical need to improve the well-being of all healthcare team members, she recommends leaders adopt, "more innovative approaches that do not simply shift responsibilities from some members of the healthcare workforce to others, but to automate or reimagine some of these responsibilities."

Staff inexperience with handling underpayments

Another impediment impacting the healthcare industry and fueling higher underpayments is the staff's widespread lack of awareness that underpayments even occur.

For staff to flag underpayments, they have to compare payments received to what's stipulated in the contract. Lack of familiarity with payer contracts plagues providers of all sizes from single physician practices to large hospital systems.

Moreover, underpayments require specific expertise to identify, manage, and rectify. You need to understand the intricacies of payer contracts, detect underpayments, and successfully appeal for the correct amount. Without directing staff to carry out this task, underpayments will not be addressed.

Insufficient prioritization due to perceived lack of value

Even when staff do examine contracts, many offices put this task lower on the priority list. Time constraints send staff after the higher-dollar claims roadblocks- denials. Taking this step when higher-dollar value denials wait to be appealed and accounts receivable must be collected can seem like too much effort for too little gain. It is just simpler to locate and reconcile a denied claim than research and challenge one instance of missed incremental revenue involved in underpayments. Because they perceive far lower revenue recovery, staff rarely reworks underpaid claims.

This mindset misses the fact that flagging repeated types of underpayments can alert you to trends. The money lies in rectifying these trends rather than addressing single instances one by one. Bringing them up to the payer helps align you both so that future claims are reimbursed at the correct contracted rate. Never tolerate chronic underpayment by insurers.

Lack of familiarity with payer contracts

Given that providers typically juggle between 16 and 20 payer contracts, most don't have the time or bandwidth to explore let alone assimilate the intricacies of each. When contracts are on auto-renewal, staff often haven't touched them in years. (We still have some clients whose contracts live in hard copy form in filing cabinets. Those are very hard to parse for information.)

Add the amount of data in the contract to the complexities of the patient's treatment(s), and pinpointing each underpayment can be like finding a needle in the haystack. Finally, clinicians and staff both prioritize patient care, after all. If they're going to shortchange tasks, it's often contracts.

Similarly, when contracts get updated (yearly or more), the new information often gets filed and forgotten, and underpayments ensue. If a payer has increased reimbursement for treatment by 3% due to an annual update, often provider staff can miss it and submit at the previous year's lower rate.

To reduce underpayments, many providers outsource contract management to a third-party provider to track and pursue them. Some find using a third party separates the providers from the payers, however, leading to loss of control and transparency.

Other providers use a contract management software solution that tracks underpayments and makes payer contracts easier to compare. This software frees staff from reconciling multiple spreadsheets, updating fee schedules, and spending time researching their contract database or on payer portals. At the same time, it keeps staff close to procedures provided and the patient's healthcare journey overall.

Inadequate technology

The healthcare staffing shortage has left many providers with a skeleton crew often made up of their most loyal staff. While loyalty has its benefits, we've found that these employees can get entrenched in their trusted processes and known technology. They were hired on as billers and made their way up to revenue cycle manager or director. After enduring chaos starting from the federal rollout of the EMR mandate in 2009, they may resist the idea of new technology or yet another platform.

And yet...healthcare leaders repeat that new technology is one of the few solutions for optimizing revenue and navigating the healthcare staffing shortage. We discuss technology's potential to capture more revenue and ease staff burden ahead.

Payer-Related Sources Of Underpayments

Now that you understand how common healthcare industry challenges cultivate an environment for rampant underpayments, it's time to focus on underpayments that occur because payers make mistakes or write in unfavorable contract language.

Keep in mind that the AMA shares that commercial health insurers' claims-processing error rate stands at 19.3 percent. It estimates that eliminating these payment errors would save providers $17 billion. Of course, some of these errors will spawn underpayments.

AMA Board Member Barbara L. McAneny, MD finds this shortfall inexcusable, stating, "A 20 percent error rate among health insurers represents an intolerable level of inefficiency that wastes an estimated $17 billion annually." Let's focus on where payers' actions lead to underpayments.

Contractual Items

Below you'll find the most common payer errors that result in underpayments, followed by examples for each. These are issues you can dispute. Remember that spotting a group of similar errors or a trend will lead to meaningful revenue recovery.

Annual escalators

Payers include “annual escalators” in their contracts which allow for an annual increase in payment rates. Sometimes, payers make errors with these escalators.

- For example, a contract may stipulate a 3% annual increase in provider rates. If the payer bases the payment on the prior year’s rate, the provider is underpaid.

Carve-outs

Payers establish “carve-outs” for specific services or procedures they delegate to other plans. Underpayments can happen when payer representatives get confused about what services, treatments, and medications the plan covers and which another insurer covers.

- Health plans often cover most medical services but carve out behavior or mental health services to another payer.

Combined accounts

Underpayments occur when the payer incorrectly combines accounts.

- For instance, confusion on the payer end can occur when a patient has two separate procedures on different days. Sometimes the payer combines these into one account and pays only one procedural fee when the contract stipulates the provider is entitled to two procedural fees.

Interest payments

Payers are often obligated to pay interest to payers when they delay payments. Most contracts stipulate certain timeframes when interest begins accruing.

- For instance, if a payment is made 60 days late, and the contract states that interest accrues after 30 days, interest must accompany the payment.

Processing errors

Processing claims can be tedious, hard work. Payer staff mis-key or mis-read figures frequently. They may also misunderstand contract terms. These issues are open to dispute.

- For instance, a simple inversion of numbers can result in an incorrect CPT code, prompting an underpayment.

Contract items written into contracts

While the following items may trigger a “payment variance” notification, they have been written into a contract your organization accepted. Refer to your contract, and if the revenue lost is significant, consider lobbying to change that term during the next contract update.

“Lesser of” Language

Contracts often include "lesser of” clauses that state that the payer will pay the lesser of the charged amount or the contracted rate. These terms can significantly affect your expected reimbursement. Reviewing and renegotiating these “lesser of” clauses can help you capture all revenue earned from that point forward.

- For example, if a service costs $200 and the contracted rate is $250, the payer only uses your $200 cost in your reimbursement.

Reduction of Charges

Some contracts allow payers to reduce charges for specific services. These have a direct impact on your reimbursement.

- If a contract allows a 10% reduction for a certain procedure, you’ll lose that 10% or possibly more if the reduction is applied incorrectly.

Stop Loss

A stop loss provision in a contract sets the maximum amount that the insurer will pay. This provision can cause significant underpayments if you don’t account for them during pre-billing.

- For example, if a patient’s treatment costs $200,000, but the stop loss clause stipulates $150,000 for that treatment, you’ll be on the hook for the remaining $50,000.

Policy

Aside from contractual issues, healthcare underpayments can also stem from a payer’s overarching policies. These policy-related factors often contribute to underpayments:

Charge Audits

Payers routinely audit charges to ensure that they align with the services provided and the agreed contract terms. (If only providers could audit payments that frequently...). However, during this audit process, errors can occur, leading to underpayments.

- For instance, a payer may mistakenly identify an overcharge due to misinterpretation of the billing codes. When an unnecessary deduction follows, the provider is underpaid.

Implant Definitions

Underpayments can arise from disagreements or misunderstandings over what constitutes an "implant" according to the policy terms. A healthcare provider may consider a certain medical device an implant and charge accordingly. However, if the payer's policy defines the item differently and refuses to cover it as an implant, they may refuse to pay the entire amount.

- For example, UHC doesn't consider liquid or absorbable materials like hemostats and sealants, synthetic sealants, topical absorbable hemostats and topical thrombins, bone morphogenetic protein, bone putty or cement, catheters, staples, and clips to be implants. They must be billed under a different designation.

Supplies Definitions

As with implant definitions, disputes can occur over the definition of "supplies." Providers and payers may have different interpretations of what items fall into this category, according to their respective policies.

- For instance, a healthcare provider might categorize certain specialty bandages as supplies. However, if the payer's policy does not recognize these items as supplies, the payer might refuse to reimburse the full amount.

Revenue Cycle-Related Causes Of Underpayments

Sometimes underpayments are caused by issues in your overall revenue cycle. Each of the areas we cover here are followed by an example:

Billing

Indirect Medical Education (IME) Adjustments

IME adjustments are additional payments made to teaching hospitals to account for the higher patient care costs associated with medical education. If these adjustments are not correctly calculated or applied when billing, underpayments may result. If a hospital neglects to include the IME adjustment in their invoice, they may be underpaid for services provided to Medicare patients.

- If a hospital incorrectly calculates or reports the ratio of residents to beds, this could lead to a smaller IME adjustment than the hospital is entitled to. For instance, if some residents are omitted from the calculation or if temporary bed increases aren't accounted for, the resident-to-bed ratio could be understated, leading to an underpayment.

Invoices

Mistakes in preparing or sending invoices lead to underpayments. An invoice might mistakenly exclude certain services provided, or an incorrect billing code might be used. If the payer processes the payment based on this incorrect invoice, you may be shortchanged.

- Not mentioning a payment due date, sending invoices to the wrong payer, failing to itemize services correctly, and adding the wrong tax rates are a few of the common invoice errors that lead to underpayments.

National Drug Codes (NDC)

NDCs are unique codes assigned to each drug marketed in the United States. Errors in including or inputting these codes during billing can lead to underpayments. If a healthcare provider uses an incorrect NDC for a specific medication on their invoice, the payer may reject the charge or underpay it.

- Common NDC errors include using an unverified code, failing to use a 5-4-2 grouping, and putting dashes or special characters in the NDC field.

Payer-Specific Edits

Each payer is entitled to a unique set of requirements for processing claims. If you fail to meet these payer-specific requirements during billing, claim denials or underpayments result.

- For instance, a payer might require a set of specific radiology films to support an ACL tear diagnosis; if your claim doesn't include these, the claim might be partially paid or rejected.

Revenue Code Alternate Logic

Sometimes, payers use alternate logic or methodology to interpret your revenue codes. This mismatch can result in underpayment. You might bill a procedure under a certain revenue code expecting a specific reimbursement rate, but the payer might interpret the code differently and reimburse at a lower rate.

- In the early 2000s, the United States was still using ICD-8 and ICD-9 code sets while the rest of the world had upgraded to ICD-10. This made gathering worldwide health data a challenge. By 2013, the US implemented ICD-10, a move that made navigating the COVID crisis more manageable.

Trailer Billing

Trailer billing refers to billing for services after the initial claim has been processed, usually for procedures or services that have delayed reporting, like certain laboratory tests.

- A healthcare provider treats a patient but delays submitting the claim due to administrative backlog. In the meantime, the patient's insurance policy changes to cover less of the procedure's cost. When the provider eventually submits the claim, they receive less reimbursement than they would have under the original policy.

Charging

The complexity of healthcare charging practices can also contribute to underpayments. Here are some examples of how payer charging issues cause underpayments.

Close to Stop Loss

As reviewed above, stop loss is a provision in a health insurance policy that sets a maximum limit on the amount the insurer will pay. However, charging glitches can arise when the costs of care approach this limit. If you don't accurately track accumulative charges for a patient and unknowingly exceed the stop loss limit, the payer may refuse to pay the excess charges, leading to an underpayment.

- For instance, imagine a policy stipulates a stop-loss cap of $150,000 for breast cancer therapies. As a patient's accumulated costs draw close to this limit, they unfortunately experience a relapse, necessitating further treatment. Due to the urgent nature of this additional care, the incurred expenses surpass the
- stop-loss cap before the reconciliation process can occur, leading to a temporary underpayment scenario for the healthcare provider. This discrepancy typically isn't resolved until after the treatment is administered, leaving the provider potentially under-compensated in the interim.

Lesser of Language

Above, we discussed how "lesser of" language impacts reimbursements. "Lesser of" also comes into play when providers make errors. If the billed charge is incorrectly lower than the contracted rate, the obligation falls to the provider.

- For example, if a procedure costs $300 but you mistakenly charge $250, and the contracted rate is $275, you'll only receive $250.

New/Deleted Codes

Medical billing codes are constantly updated. As mentioned above, the AMA this year created 225 new codes, deleted 75, and revised 93.

- For instance, in 2023 home care plan oversight codes 99339 and 99340 were deleted. If you use one of these (or one of the 73 others that were deleted), the payer may refuse to pay for that service.

Pharmacy Multipliers

Pharmacy charges often involve complex calculations, including the use of multipliers of dosage, days, and packaging. Errors in applying these multipliers can result in charging mistakes and subsequent underpayments. Miscalculating a multiplier when charging for medication can lead to a lower billed amount and, therefore, an underpayment.

- For example, getting the medication dosage off by one decimal point can significantly reduce the total amount of medication prescribed and billed.

Revenue Capture

Revenue capture refers to accurately documenting and billing for all services provided. If you fail to capture all provided services when charging, underpayments follow. Neglecting to bill for an additional procedure performed during a patient's visit will create an invoice for less than you're entitled to.

- For instance, major surgeries are based on time, but less invasive procedures often get charged separately. When a group of separately chargeable procedures occurs, one or two tend to get missed.

Coding

Coding is an integral part of the healthcare revenue cycle. However, errors or oversights in this area can lead to underpayments. Here are some common coding-related issues that contribute to underpayments.

DRG Validation

Diagnosis-Related Group (DRG) validation is the process of verifying that the services provided align with the billed DRG code. Errors in this process can lead to underpayments. If you incorrectly assign a DRG code that represents a less complex (and therefore less costly) service than what was actually provided, the payer will reimburse you based on the lower rate.

- DRG validation also takes into account the patient's complications or co-morbidities (CCs), which can increase the DRG weight and thus the reimbursement. If a provider fails to record or code these CCs correctly, it could lead to the assignment of a lower-weighted DRG and result in underpayment.

Missing Diagnosis

Failure to code or document a diagnosis can lead to underpayment. The absence of a relevant diagnosis code can cause the billed service to appear unnecessary or inappropriate, leading to lower reimbursement or claim denial.

- For instance, two patients may both have a diagnosis code for pneumonia, but if one also has co-morbidities, you must include those diagnosis codes as well. The treatments for the patient with co-morbidities will be more extensive and costly than the one without.

Modifiers

Modifiers are additional codes used to provide more information about a procedure. Incorrect use of modifiers can lead to underpayments. Missing modifiers are one of the most common reasons medical claims are denied. Omitting a modifier that indicates a service was more complex than usual can result in the payer reimbursing at a lower, standard rate.

- Medical coders often miss modifier 59 – "Distinct Procedural Service." Modifier 59 indicates that clinicians performed two or more procedures during one visit to different areas of the body. Coders tend to apply it to prevent a service from being bundled with another service on the same claim. Rather than making this attempt to bypass the insurance carrier's edit system, they should use another modifier that more accurately describes the services.

Procedure Ordering

The order in which procedures are coded can impact reimbursement. If a less significant procedure gets coded first, the payer may apply a multiple procedure payment reduction, resulting in underpayment.

- In cases where two surgeries occur at the same event, sometimes coders code the less costly procedure first. In these cases, the payer might reduce the payment for the more costly procedure.

Transfers

Transfers, particularly for inpatient stays, have specific coding requirements. Misinterpretation or incorrect application of these requirements can lead to underpayment.

- For instance, if a patient is transferred from one hospital to another, the first hospital should bill with a specific transfer DRG. Failure to do so can result in the claim being paid as if it were a regular discharge, which is typically a lower reimbursement.

How To Establish Effective Underpayment-Limiting Processes And Support

Detect

The first step in managing underpayments is detecting them. Given the complexity of healthcare plans, their restrictions, and the patient's challenges, tracking down underpayments requires a multi-pronged approach, namely: seasoned experts, advanced technology, and dedicated analysts.

Leverage Seasoned Experts

Draw on the knowledge and experience of experts who understand the nuances of healthcare reimbursement. These individuals can develop necessary rules and guidelines to help identify underpayments. Their insights can help your organization navigate complex contract terms, payer policies, and coding requirements. If current staff doesn't have the experience or is stretched to thin with current duties, providers can find outside revenue cycle audit experts with underpayments expertise. Eventually, after making some headway, this professional can train your staff to increase collection rates and resolve your systemic errors.

Review Variance Reports

Regularly review variance reports, which pinpoint discrepancies between expected and actual payments. Remember, you're not trying to find underpayments and errors one by one. The robust recouped revenue comes from spotting and addressing underpayment trends.

Keep in mind that not all discrepancies indicate underpayments as defined as the payer not reimbursing per contract terms. You must also focus on where your operation is triggering underpayments. Over time, this process will help you build your "black book," a comprehensive understanding of where your coders and other staff need to avoid errors and where payers tend to underpay.

Use the most current technologies like software, machine learning, AI, and natural language processing

Healthcare leaders are unanimous in urging providers to adopt technical solutions.

In "The gathering storm: the uncertain future of US healthcare,", healthcare leaders at the renowned consulting firm McKinsey explain,

"The healthcare industry faces an acceleration in costs of nearly $600 billion in 2027, which could make healthcare less affordable and threaten the sustainability of industry margins. However, a path to weather the storm exists—the staggering $1 trillion opportunity to create value and improve healthcare by transforming the delivery of care, improving clinical productivity, applying technology, and simplifying administrative procedures. What's more, this level of opportunity is based on innovations already in use and available to executives today. The imperative for companies that seek to thrive in coming years will be scaling up these innovations much more quickly than they currently do."

When technology is one of the few paths to providing patient care and remaining viable, resilient providers are overcoming inertia to invest in revenue cycle solutions. Revenue cycle technology adoption is expected to expand at a compound annual growth rate (CAGR) of 10.3% from 2023 to 2030.

Many healthcare leaders feel their operation lacks the time, budget, and bandwidth to implement sophisticated technology. Rest assured, third-party solution partners have worked hard to make sure their solutions integrate seamlessly with your current EMR, billing, and other systems.

They want your experience to be as "touchless" as possible, meaning insights and data are delivered to you without much thought or work on your part. In fact, the information mostly bubbles up through your existing systems. Your partner also provides thorough onboarding and support every step of the way.

Best of all, despite initial resistance, researchers share that employees quickly embrace the automation that comes with new technology. In "2019 Kofax Intelligent Automation Benchmark Study," Forbes surveyed 302 senior executives who implemented new technology that involved automation in business processes. Of these executives, 92 percent reported employee satisfaction improved once fully onboarded.

Benefits of automation for providers

For managed services providers, improving operational efficiency is their primary path to steady growth and profitability. In 2021, The Healthcare Financial Management Association's (HFMA) Pulse Survey of 400 chief financial officers and revenue cycle leaders at U.S. hospitals revealed that 78% of providers use automated solutions. Benefits of RCM automation include:

- Workflows - Automation solutions speed and streamline back-end processes like claim submissions and coding. Automation reduces manual errors and speeds up the reimbursement process, leading to faster payments and increased revenue.
- Patient payment estimation - solutions generate accurate estimates for patients that include deductibles, copays, and coinsurance. Some companies' estimates even prompt patients to make up-front deposits directly from their online estimates.
- Patient experience - by analyzing patient data and preferences, healthcare providers can tailor care plans to the specific needs of each patient, increasing patient satisfaction and referrals.
- Payer underpayment recovery - software solutions help providers track and analyze payer performance down to the procedure code level to rapidly identify revenue opportunities.
- Contract management - when contracts are digitized and consolidated, providers can search them, retrieve accurate benefits and compare payments among other providers and to benchmarks.
- Front and back-end administrative labor costs - many providers implementing software solutions avoid hiring new staff and even cut staff by 50% or more.
- Improved interoperability - connecting different software solutions enables accurate data to flow end-to-end, creating powerful new solutions to previously siloed problems.

AI / ML benefits for providers

A recent survey shows that 65 percent of hospitals and healthcare systems currently use AI in RCM. However, its utilization is limited and doesn't consistently encompass the entire revenue cycle process. It's worth noting that, while this percentage may appear significant, the survey uses a broad definition of AI. It lumps together machine learning, predictive analytics, natural language processing, and optical character recognition as "AI." Most common functions employing AI:

- Eligibility verification
- Patient estimates

Natural Language Processing benefits for providers

Natural Language Processing (NLP) uses machine learning and algorithms to understand natural human language as input. NLP provides the ability to analyze the unstructured data that often appears in contracts and many documents. Even without NLP, contract software can automatically extract key terms, clauses, and obligations and add this data into a structured database.

This software helps providers stay on top of contract changes and derive the most value from current contacts by performing:

- Extraction of contract terms
- Flagging of potential non-compliant clauses
- Key performance indicator efficiency
- Flagging of missed renewals, rate changes, and billing discrepancies

Providers use this information to ensure they are limiting underpayments. Moreover, with the data to compare contracts, they can more confidently negotiate better terms. We believe NLP is integral to the future of efficient contract management.

Deploy Dedicated Analysts

Beyond technology, human insight remains crucial in detecting underpayments. Revenue cycle analysts review the claims in question and identify any processing errors that may have caused the underpayment. Once they pinpoint the root cause, they implement workflow changes to avoid similar future underpayments, a move that drives revenue consistently upward. Analyzing under and overpayments is crucial to identify any areas of improvement and to control leakage.

To control underpayments, revenue cycle analysts:

Stay informed about changes in payer policy.

- Stay informed about changes in payer policy.
- Automate the revenue cycle process so that underpayments are quickly flagged.
- Negotiate the terms of the contract with insurance providers, ensuring terms that support revenue growth for the healthcare provider.
- Coordinate with payer representatives to resolve underpayments.

By shouldering the underpayment tasks, revenue cycle analysts help providers maintain their focus on patient care and outcomes.

Recover

Once underpayments have been detected, the next step is recovering your funds. Optimal recovery takes dedicated resources, organization, and proactive management.

Dedicate Resources

Assign a dedicated team or individual (internal or external) to focus solely on collecting underpaid accounts. This team will be responsible for communicating with payers, providing necessary documentation, and managing the collection process. Their focus on underpayments will ensure timely and persistent efforts to recover the full entitled reimbursement.

Group and Prioritize Accounts

To expedite the recovery workflow, group and prioritize accounts based on various factors such as:

- The amount of underpayment
- The payer
- The age of the claim

Prioritize accounts with substantial underpayments and those nearing the end of the claim submission window.

Automate appeals wherever possible to speed up the recovery process. Tools that can generate templated appeal letters, for example, can save time and streamline the process.

Automatically Identify and Escalate Payer Issues

Use software tools to identify recurring underpayment issues associated with specific payers automatically. These tools:

- Detect and flag underpayments from insurers by comparing any returns to bills and codes applied.
- Schedule regular underpayment detection and review incoming payments for manual review as needed.
- Automatically notify your staff to appeal when underpayments arise.
- Track patterns of underpayment to alert providers to payers most likely to underpay.

Once you take action on these issues, prepare to spend time with the payer renegotiating contract terms or clarifying billing procedures.

Resolve Root Causes for Long-Term Efficiency & Revenue Recovery

The final step in addressing underpayments is resolving the underlying issues that trigger them. You want your improved revenue to stay improved for years to come.

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Analyze Root Cause Reporting and Trending

Conduct a thorough analysis to identify the root causes of underpayments. Again, you may need a revenue cycle analyst with experience in underpayment recovery to achieve this goal. You or this professional will want to look for trends in your data such as:

- Are certain payers consistently underpaying?
- Do underpayments frequently occur with specific procedures or codes?
- Are coders missing common charges?
- Are missed contract updates causing underpayments?

Root cause analysis can help you understand the 'why' behind underpayments so you can rectify them.

Provide Direct Feedback to Revenue Cycle Teams

Share the findings of your analysis with your revenue cycle management teams. Direct feedback involving all team members justifies workflow adjustment and gets everyone on the same page. Encourage their feedback to fuel your group's continuous improvement.

Automatically Detect Underpayments With MD Clarity

MD Clarity can bring transparency to your entire revenue cycle, boosting your bottom line and improving the patient experience. RevFind is designed to help you detect, recover, and resolve underpayments efficiently and accurately. It scrutinizes every payment against contract terms, flagging any discrepancies and potential underpayments automatically.

From leveraging seasoned experts' rules to reviewing variance reports and detecting anomalies, RevFind makes underpayment detection an easier and more manageable task. Not only does it detect underpayments, but it also supports you through the recovery process and helps identify the root cause to prevent future underpayments. Get a demo to see it in action.