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Utilization review is more important than ever

COVID-19 altered the normal utilization patterns for hospitals across the country

While patient volume is rising again, that increase is inconsistent from region to region and favors outpatient visits over inpatient ones.[1] Reduced patient demand also limits recovery. In a Kaiser Family Foundation poll, 48% of adults reported someone in their household postponing or skipping medical care due to COVID-19.

Yet, regulatory pressure remains. Hospitals must still comply with the federal False Claims Act while commercial payers continue to issue medical necessity denials. Utilization review (UR) remains as important as ever, and, in fact, is the key to hospital financial recovery.

Every dollar counts

Many hospitals' revenue integrity was precarious even before the pandemic. Prior to COVID-19, more than 1,200 hospitals lost money in at least two of the previous five years.[3] Since then, hospitals have incurred additional sunk costs as they implemented expensive measures to protect their patients from hospital-acquired conditions. Meanwhile, a reduced patient count has heavily diminished reimbursement and the funds available to pay for these costly preparations.

Many hospitals furloughed or reassigned staff – such as utilization review (UR) teams – to other duties because of this financial pressure. However, these employees are the key to hospitals recovering from the negative financial impact of the pandemic. Every dollar counts, and utilization review can help hospitals uncover sources of revenue they may have overlooked in the past. A hospital that doesn't review all cases against evidence-based criteria and conduct comprehensive physician advisor reviews runs the risk of missing appropriate reimbursement. Under normal circumstances, that mistake reduces profitability. Amid the current crisis, it can be catastrophic.

About the author

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The rise of gray cases

Because patients deferred care, some hospital visits are permanently lost. Patients who experienced minor strokes in the past months and have some mild weakness, for instance, are unlikely to visit the hospital now. However, treatment for many chronic conditions and newly arising conditions can only be deferred so long before care becomes essential and more complicated. When patients with diabetes, asthma, cardiac arrhythmia and cancer do finally return to the hospital, the intensity and level of care required may be greater than if they continued to seek care regularly. Likewise, delayed preventive testing may identify new conditions at a more advanced stage, further expanding the level of care required.

This delayed disease burden will likely result in patient visits of a higher acuity than normal for those conditions. As a result, hospitals may see an increase the number of "gray cases" — those more complex cases and conditions that are initially difficult to properly status as inpatient or outpatient. With a differential between inpatient and outpatient care being as much as $4,000 per patient encounter, UR will need to operate very effectively to help hospitals secure appropriate payment and avoid denials.

Hospitals should use this short window of lower census to assess the health and effectiveness of their UR process. When visit levels return, they will return quickly — and perhaps in greater levels than before — as patients seek backlogged care. Be prepared when they do.

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Expanding capacity with technology

UR has changed in recent years. New technology has fundamentally altered the revenue impact UR can have on hospital operations. AI technologies like natural language processing (NLP) and machine learning can automatically review for medical necessity nearly instantaneously. Such technology can sort cases by inpatient likelihood and prevent cases from slipping through the cracks.

The right AI technology can expand case manager productivity, allowing your team to process more work with the same number of resources. At the same time, AI can highlight key clinical risk factors for physician advisors and recommend powerful arguments supporting their decisions, accelerating review speed by up to 30% while improving their accuracy and effectiveness. This efficiency will help UR teams identify and defend more appropriate reimbursement without requiring more resources.

Ask questions of any technology vendor to confirm the quality of their AI. Make sure the AI is clinically intelligent, that it understands and can account for how various terminology and concepts are used in clinical settings. Without this capability, AI won't deliver quality results and your staff will spend its time correcting the machine.

Artificial intelligence improves with use, learning from the data it's fed. The most flexible and effective AI is taught by robust and comprehensive clinical knowledge that includes the preliminary first-level admission criteria case managers use to tentatively assess inpatient/outpatient suitability, as well as specific evidence-based research and prior case reviews. This last component is critical to enhancing the effectiveness of AI; a large pool of prior physician advisors case reviews allows the AI to cross-reference the details of the case it's reviewing with many similar cases. The result is a more nuanced and accurate result.

Make every dollar count

Hospital revenue integrity is more important than ever. Clinically intelligent artificial intelligence solutions can streamline UR and identify the overlooked reimbursement opportunities that can help hospitals restore revenue integrity.

1. Cohen, Jessica Kim. "Inpatient volumes, surgeries continue to lag amid COVID-19," Modern Healthcare, https://www.modernhealthcare.com/care-delivery/inpatient-volumes-surgeries-continue-lag-amid-covid-19. Accessed Oct. 26, 2020.
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