

**Draft of Departmental Impact on Reimbursement**

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HCM 345: Healthcare Reimbursement

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## **Introduction**

Riverside Community Hospital is an acute care hospital with a 542-bed capacity, which covers a population of mixed urban and rural backgrounds. In most hospitals, reimbursement is not just related to billing. It relies on the efforts of patient access personnel, clinical teams, coders, case managers, and patient financial services. The paper aims to discuss why reimbursement is important to the hospital and the flow of the patient through the revenue cycle, and the impact of each department on the payment. The environment has the highest reimbursement in the case of the sequential work of departments, the availability of correct data and adherence to compliance criteria.

### **Problem Statement**

The primary issue with Riverside Community Hospital is that reimbursement may be decreased or slowed down when departments fail to recognize their part in the entire revenue cycle. Any registration error, a missing authorization, incomplete physician documentation or a coding mistake can result in a denied claim (Ali & Myers, 2026). Such failures cause cash flow delays, increased administrative expenses, and unnecessary loss of money. In the long term, ineffective reimbursement can restrain personnel, technology acquisition and service growth.

### **Previous Options**

Previously, hospitals tended to react to reimbursement issues in a reactive manner. Claims were only corrected once they were denied by the staff. Departments were operating in silos, and financial data was being reviewed too late to stop repeated errors. The patterns were difficult to identify through manual tracking techniques and limited denial analysis. The ineffectiveness of these older options was that they were aimed at repairing the lost revenue but not preventing it at the first stage.

## Reimbursement and the Revenue Cycle

Reimbursement is what a hospital gets as a result of the care it offers. Such payments can be made through commercial insurers, Medicare, Medicaid, or patients. In the case of Riverside Community Hospital, salaries, medications, supplies, equipment, utilities, and community services are covered by reimbursement. It is the financial outcome of care delivery (Ali & Myers, 2026). Without patients who could get services and without the hospital receiving any payment, the organization could not continue with regular operations. Payroll would be stretched, vendors would not be paid, and necessary services may be cut. Eventually, the financial stability of the hospital would be lost.

The revenue cycle flow of the patient starts before care is provided. First, the patient makes an appointment or presents with an appointment. Patient access employees gather demographic data, check insurance, and take prior authorization where necessary. During registration, the staff verify coverage, update documents and take any copayment (Ali & Myers, 2026). The patient is then assessed and treated by the clinical team. The health record should clearly record the diagnosis, treatment and medical necessity provided by the providers. Following the visit, charges are recorded and submitted to the code. The coding staff assign diagnosis and procedure codes, and the billing team develops and submits the claim. The claim is reviewed by the payer, who pays or denies it, and payment is made (Ali & Myers, 2026). In case of an imbalance, the patient is billed. In case of denial of the claim, the staff should amend, appeal, or restart it. The cycle is completed when the payments are (wholly) received, and the account is settled.



Figure 1 Patient Flow through the Revenue Cycle

The departments, according to their significance to the revenue cycle, include patient access, clinical services, health information management and coding, patient financial services, case management, and compliance (Wagenschieber & Blunck, 2024). The first one is patient access, since any error in entry impacts all subsequent steps. Next are clinical services, since care and documentation form the foundations of all payment. The care is coded and billed, and the accuracy of payments plus regulatory integrity is ensured by case management and compliance.

### Departmental Impact on Reimbursement

A hospital should keep an eye on the reimbursement data. By not doing this, Riverside might miss the increasing rates of denials, underpayment, coding mistakes, and accounts receivable delays. The result would be a situation where decisions are made by leadership based on untrustworthy financial evidence. It may undermine payer performance, decrease collections, and heighten compliance risk. Pay-for-performance incentives also require data collection since numerous payers have recently associated reimbursement with quality outcomes, readmission rates, patient experience, and other quantifiable measures (Wagenschieber & Blunck, 2024). The hospital will not be able to demonstrate performance and receive the entire payment possible without the correct data.

The impact of each department on reimbursement is specific. The patient access staff contribute to reimbursement through coverage verifications, authorization, and correct patient data collection. Clinical departments influence reimbursement by ensuring that documentation is timely and complete (Demsash et al., 2023). The coding and health information management personnel audit records, assign codes, and provide clarifications where necessary. Case management assists with medical necessity, status of admission and payer communication. Patient financial services files claims, makes payments, processes denials and bills patients (Demsash et al., 2023). Compliance personnel conduct audit procedures, train departments, and impose billing and coding policies.

The best reimbursement data are denial rates by payer, clean claim rate, days in accounts receivable, authorization failure rate, coding error trends, net collection rate, bad debt, and underpayment trends. These measures reveal operational change requirements.

Health information management is the department that works closely with the compliance office in matters of compliance with billing and coding policies. The task directly

impacts reimbursement. Compliant billing and coding lead to increased accuracy in claims, reduced denials, and the hospital is less vulnerable to audit, repayment requests, and fines.

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