The Clinical Revenue Leakage Assessment

Revenue leakage in skilled nursing rarely shows up as a missing payment. It shows up as a documentation gap that never gets caught — a comorbidity noted in the physician H&P that never made it to the MDS, a therapy minute threshold that's clinically justified but unsupported on paper, a HIPPS driver that the chart could defend but currently doesn't.

A clinical revenue leakage assessment is the process of finding those gaps before a MAC, an ADR, or a state surveyor does. This article walks through what that process actually looks like, and why "leakage" cuts in two directions most facilities don't expect.

Leakage Isn't Just Money Left on the Table — It's Money at Risk

Most conversations about revenue leakage focus on underbilling: acuity that was real but never got coded, documentation that would have supported a higher PDPM component but wasn't captured. That's real, and it matters.

But the same chart-level gaps run the other direction too. A HIPPS code billed without a clinical note to independently support it isn't leaked revenue waiting to be found — it's revenue already collected that wouldn't survive review. A proper leakage assessment has to look both ways: what's supportable but uncoded, and what's coded but unsupported.

What the Assessment Actually Examines

A clinical revenue leakage assessment works stay by stay, not facility-wide averages. For each stay in the sample, three sources get pulled and cross-checked against each other:

1. **The supporting clinical note** — physician H&P, nursing documentation, therapy notes
2. **The locked MDS assessment** — Section GG, Section I comorbidities, and the other drivers that feed PDPM
3. **The claim that was actually billed** — the HIPPS code and the reimbursement it triggered

The core question at every stay: does the note support the MDS, and does the MDS support the claim? Where any one of those three doesn't line up with the other two, that's a finding — whether it points to unbilled upside or unsupported exposure.

Example Finding Pattern

A representative sample finding looks like this: an NTA comorbidity clearly documented in the physician H&P was never captured on the MDS. The risk cuts both ways — if the comorbidity should have driven a higher NTA score, that's underbilled revenue; if the facility

is relying on that comorbidity elsewhere without the MDS reflecting it, that's a MAC denial or PDPM underpayment risk waiting to surface at audit. The fix in both cases is the same: reconcile MDS Section I to the chart evidence that's already sitting there.

Why This Has to Happen Before the Auditor Sees It

Once an ADR lands or a Targeted Probe & Educate (TPE) cycle opens, the facility is reacting to someone else's timeline, on someone else's terms. A leakage assessment run proactively — on a rolling basis, not just once — changes that. It gives administrators, DONs, and MDS coordinators the chance to coach documentation before a citation lands, not after the letter arrives.

For multi-site operators, this matters even more: the same documentation pattern often repeats across buildings, which means a leakage gap found in one facility's chart review is frequently a preview of what a portfolio-wide audit would eventually surface anyway.

Cross-EMR Consistency Is Part of the Assessment

Multi-site operators face a specific version of this problem: documentation habits vary building to building, sometimes shift to shift, and EMR systems don't always make that easy to see at a portfolio level. A proper leakage assessment reads charts consistently across EMR platforms, without exposing one building's data to another — which is what makes the pattern visible in the first place, rather than staying buried in twelve separate systems.

From Finding to Fix

A leakage assessment is only useful if the findings are actionable. Each finding should come with:

- **The specific issue** (e.g., NTA comorbidity not captured on MDS)
- **The source** (which document contains the supporting evidence)
- **The risk category** (MAC denial risk, PDPM underpayment, or both)
- **The recommended action** (what needs to be reconciled, and where)

That structure — issue, source, risk, action — is what turns a chart review from an academic exercise into something a compliance team can actually execute against before the next survey cycle or ADR request.

Software Finds the Pattern. Expertise Closes the Gap.

Chart-level review at scale is a technology problem — reading documentation consistently across EMRs, stay after stay, without missing what a human reviewer would eventually catch by hand but far more slowly. Closing the gap once it's found — coaching documentation, preparing for a state survey, defending a federal audit — is a different kind of work, one that benefits from an experienced compliance team who has sat across the table from a MAC before.

Getting Started

A leakage assessment doesn't require a facility-wide commitment to see the value. A single anonymized stay review is often enough to show where documentation is costing a facility revenue and audit risk simultaneously — without creating internal friction or requiring a long procurement process. From there, facilities can choose a self-serve software path for ongoing chart monitoring, or an expert-led track when the finding warrants survey or audit-defense support.

RevOptix1 reads SNF charts before auditors do — patent-pending chart intelligence surfacing documentation gaps, supported revenue opportunities, and audit risk before MAC review, ADR, or state survey. See how it works, or view a sample report before subscribing.