



National Association  
of Healthcare Revenue Integrity

# 2018

## State of the Revenue Integrity Industry Survey



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As the revenue integrity profession evolves, there will be a greater need to streamline its roles and responsibilities. While some revenue integrity professionals have been in the game for years and have established departments or programs, others find themselves in new roles without much direction from facility leadership as to what their focus should be. In the spirit of **Revenue Integrity Week**, which celebrates the diligence and dedication of revenue integrity professionals, **NAHRI** took a deep dive into the activities, backgrounds, and challenges of revenue integrity professionals.

### Revenue Integrity's Wide Range of Job Titles

An array of titles make up the revenue integrity profession, but to get a clear picture of potential standardization occurring in healthcare organizations, we asked our 137 respondents to list their titles. The top responses were as follows (see *Figure 1 for a detailed breakdown of responses*):

- Revenue integrity director: 18%
- Chargemaster coordinator or analyst: 9%
- Revenue cycle director: 8%
- Revenue integrity manager: 7%
- Revenue integrity analyst: 7%
- Revenue integrity specialist: 7%
- Other: 14%

Respondents who replied “other” were asked to specify their title further, which yielded the following responses:

- Appeals author
- Process excellence
- Executive director of compliance and revenue integrity
- Travel nurse
- Chief compliance officer and director of audit services
- Vice president of revenue and reimbursement
- Reimbursement analyst
- Senior coding analyst
- Revenue integrity clinical liaison
- Staff registered nurse
- Senior director of revenue integrity
- Reimbursement and decision support manager
- Provider auditor
- Revenue finance and reimbursement director

**Figure 1: Which best describes your title?**



- Manager of patient financial services
- Director of fiscal services
- Vice president of education

More than half of respondents (55%) work in acute care hospitals, and the remainder work in the following settings:

- Consulting: 10%
- Critical access hospital: 5%
- Home health: 2%
- Freestanding ambulatory surgery center: 2%
- Physician practice: 2%
- Psychiatric/behavioral health hospital: 1%
- Other: 23%

Respondents who selected “other” went on to specify their setting. Some survey takers work for more specific facility types, including acute care sole community hospital and physician practices, teaching hospitals, corporate health

systems, and multisystem hospitals. Others work for vendors, software companies, and insurance companies.

“Many organizations—depending on the specialization within the revenue integrity domain—require a coding background to enable the successful interaction with pre-claim edits that include NCCI, LCDs, NCDs, OCE, MUE, and revenue capture opportunities,” says **Cassi L. Birnbaum, MS, RHIA, CPHQ, FAHIMA**, systemwide director of health information management and revenue integrity at UC San Diego Health. “Also, this department typically interacts with cases that bump into an edit associated with simple visit coding. A clinical background is best suited for revenue integrity functions which involve clinical appeals and the coding appeals should be routed to a revenue integrity analyst with a clinical background. Defense auditing also should be an integral part of the revenue integrity umbrella.”

For those respondents who do work in a hospital setting, just over one-third (34%) of those hospitals have 500 or more beds.

In the April 2018 issue of the **NAHRI Journal**, we took a close look at the titles of our members, and found the following broader titles are representative of the overall NAHRI membership:

- Revenue integrity and revenue cycle: 25%
- Senior leaders: 19%
- Clinical documentation improvement (CDI): 8%
- Auditors: 6%
- HIM: 5%
- Finance: 4%
- Compliance: 3%
- Chargemaster: 2%
- Managers of departments other than those listed above, including business and practice managers: 4%
- Other titles, including physician advisors and coders: 24%

While the State of the Revenue Integrity Industry Survey captured responses from a mix of NAHRI members and non-members, one thing remains true when comparing the variance in titles across the two groups: Revenue integrity has something to offer everyone who checks the pulse of their facility’s financial health.

“I believe the wide variation in titles, job responsibilities, and organizational/departmental structures validates the need for a pro-

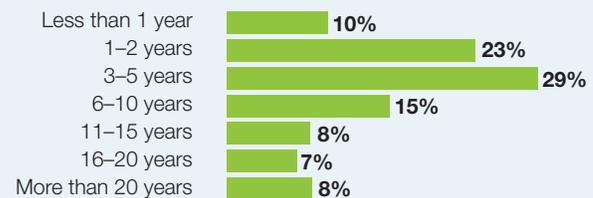
fessional organization that can serve as a unifying advocate and defining beacon for the industry and its stakeholders,” says **John D. Settlemyer, MBA, MHA, CPC**, associate vice president, revenue cycle at Atrium Health in Charlotte, North Carolina. “Clearly, we must wrap our arms around a broad array of topics and tasks to ensure the ultimate goal of right code, right charge, right time to support complete and accurate timely claim generation.”

The chargemaster function has evolved from a maintenance function to a strategic interaction with departmental experts to ensure a competitive price, linkage to the correct cost center/bill area, and guide departments with determining compliant charge capture practices, says Birnbaum. “Charge testing as new systems are launched is critical to ensuring that revenue capture is enhanced and sustained post-implementation,” she adds.

## Background and experience

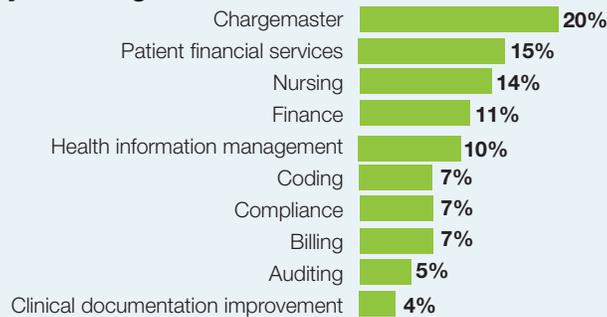
Revenue integrity is still the new kid on the block as far as hospital departments and roles are concerned, so it’s not surprising that more than half (62%) of respondents have held their current role for five years or less. When broken down further, 29% of respondents have been in their role for 3–5 years, 23% for 1–2 years, and 10% for less than one year. On the other end of the spectrum, 15% of respondents have held their position for 6–10 years, 8% for 11–15 years, 7% for 16–20 years, and 8% for more than 20 years. (See Figure 2.)

**Figure 2: How long have you been in your current role?**



The plurality of respondents (20%) listed chargemaster as the field that best aligns with their healthcare background and experience. Other top answers included patient financial services (15%), nursing (14%), and finance (11%). A smaller percentage of respondents reported a background in health information management (10%), coding (7%), compliance (7%), billing (7%), auditing (5%), and CDI (4%). (See Figure 3 on p 3.)

**Figure 3: What healthcare field best aligns with your background?**

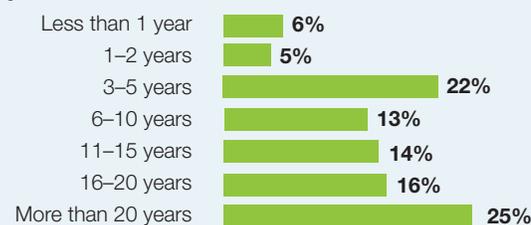


Respondents were also asked how many years of experience they have in revenue integrity, and despite the fact that many are in new roles, nearly one-quarter (24%) stated they have more than 20 years of relevant experience. However, nearly the same percentage of respondents (22%) indicated they have just 3–5 years of revenue integrity experience, which more closely aligns with the average length of time respondents reported being in their current role. Considering the broad range of respondents' backgrounds and the fact that many revenue integrity roles and departments are just picking up speed and adding staff, those who have only been in a dedicated revenue integrity role for 3–5 years likely have a decade or more of relevant experience in a related healthcare field.

Outside of those ranges, respondents indicated they possess the following amount of experience in revenue integrity (see Figure 4):

- Less than one year: 6%
- 1–2 years: 5%
- 6–10 years: 13%
- 11–15 years: 14%
- 16–20 years: 16%

**Figure 4: Approximately how many years of experience do you have as a revenue integrity professional?**



## Dedication to revenue integrity

Because revenue integrity as a mission, program, or department has been rolled out to different degrees at individual facilities, NAHRI sought to determine whether respondents are working at organizations with dedicated revenue integrity staff, departments, programs, or committees.

While most facilities have dedicated revenue integrity staff members (70%), instances of departments, programs, and committees are slightly less common. Approximately 62% of respondents have a revenue integrity department. The 8% gap between facilities with revenue integrity staff and those with departments indicates what we all hold to be true: Too many revenue integrity professionals are functioning on their own or lack a structured department to rely on. (See Figure 5.) For example, one revenue cycle director stated that their facility's greatest challenge with regard to revenue integrity is its lack of a dedicated revenue integrity program or department.

"Right now, I am a single person trying to promote and develop revenue integrity at our facility. The concentration has been on just chargemaster, and the facility is thrilled to have someone with experience in the role. I have been here for a little over a year, and I am trying to bridge the gap between clinical and financial. I expect over the next year steps will be taken to develop a revenue integrity team as there will be transition in leadership and the new leaders are very much aware of the importance of revenue integrity," said one chargemaster coordinator.

**Figure 5: Which is true of your facility? (Check all that apply.)**



Even fewer respondents work in a facility with a revenue integrity program (35%) or revenue integrity committee (33%). And despite the existence of official programs, departments, and committees, just 29% of respondents stated their facility has the budget for revenue integrity training and education, indicating revenue integrity professionals are likely footing the bill for

much of their needed education or simply picking up whatever they can through any freely available resources they can find. Given how critical it is to ensure that facilities are accurately coding, billing, and charging claims, the lack of funding for education to ensure revenue integrity professionals are up to speed on these tasks is concerning.

Those who do have a revenue integrity department at their facility reported the following benefits (*see the sidebar below*):

- “More focused, project-driven efforts with specific goals, data collection, trendspotting, and inter-communication between members.”
- “Improved net revenue from claims review. Timely knowledge and implementation of solutions to comply with CMS regulations. Improved communication between hospitals.”
- “Adherence to state and federal regulations, correct claims processing, chargemaster efficiency, appeals success.”
- “We’ve seen a more structured process in identifying and improving potential issues related to revenue integrity.”

Working closely with our corporate compliance team, we are constantly looking for improvements to our processes.”

- “Increased charge capture, reduced days in accounts receivable (AR), fewer charge errors through education, reduction of denials, successful audits and increased cash.”

## Primary and supporting functions of revenue integrity

The respondents who stated their organization has a revenue integrity department or program were asked to identify the functions revenue integrity handles at their facility. Top responses include:

- Chargemaster maintenance: 79%
- Charge capture: 73%
- Education: 62%
- Chart auditing: 60%
- Correcting claim edits: 49%

## The proven benefits of revenue integrity

NAHRI asked revenue integrity professionals to share the positive outcomes their facilities have seen as a result of implementing a revenue integrity program. The following is a selection of comments from respondents:

- “Increased charge capture, reduced days in AR, fewer charge errors through education, reduction of denials, successful audits, and increased cash.”
- “Increased charge capture, decreased denials, improved denials recoveries, decrease in claim edits, enhanced claims automation, and underpayment identification/recovery.”
- “Enormous ROI from overturned denials, charge capture and education of hospital staff.”
- “Improved net revenue from claims review. Timely knowledge and implementation of solutions to comply with CMS regulations. Improved communication between hospitals.”
- “Our claims go out the door clean the first time.”
- “Better handle on our claim edit and denial management. Charge capture and CDM is better streamlined. CDI is now also responsible for clinical integrity of the record.”
- “We’ve seen a more structured process in identifying and improving potential issues related to revenue integrity. Working closely with our corporate compliance team, we are constantly looking for improvements to our processes.”
- “Reduction denials, improved documentation, correct charging.”
- “Decrease in denials. Increase in charge accuracy the first time around.”
- “Increased compliance and increased net revenue.”
- “Enhanced charge capture, increased compliance.”
- “Adherence to state and federal regulations, correct claims processing, charge master efficiency, appeals success.”

“These functions are the key activities necessary to ensure charges are accurately captured for a clean claim,” **Rose T. Dunn, MBA, RHIA, CPA, FACHE**, chief operating officer at First Class Solutions, Inc., in Maryland Heights, Missouri.

Some respondents wrote in to identify revenue integrity functions that were not listed as options on the survey, including external third-party audits, maintaining department charge sheets, charge monitoring, clinical trials billing, system reporting and data analysis, claim edits and denials management, and designing workflows. *(See Figure 6 for a complete list of responsibilities identified as being within the scope of a revenue integrity department or program.)*

“The NAHRI survey is crucial step in defining who and what revenue integrity encompasses. It was striking how diverse the respondents were as well as the scope of responsibilities.” says **Elizabeth Lamkin, MHA, ACPA**, CEO and partner at PACE Healthcare Consulting, LLC, in Bluffton, South Carolina. “As we tackle our new and complex environment of billing and compliance, this group’s role will expand to include the assembly line of clinical departments

and medical staff needed to reduce errors on the front end. Revenue integrity professionals will lead the coordination and collaboration whether as a program or a department. As such, NAHRI is crucial in as a platform to define and formalize this vital role.” Since most healthcare professionals wear many hats, we also sought to identify tasks that revenue integrity would assist with but not necessarily oversee. Not surprisingly, the list of revenue integrity functions expanded further, as respondents reported assisting with, acting as a resource for, or supporting the following functions:

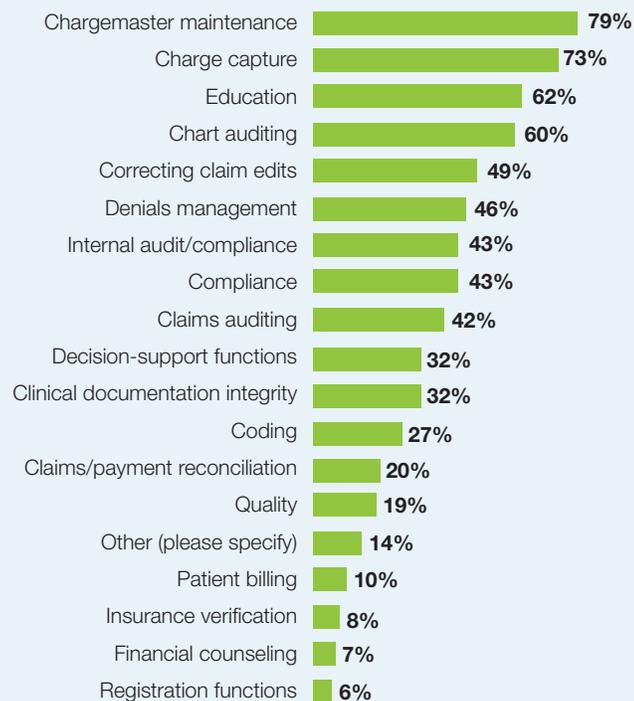
- Charge capture: 68%
- Coding: 60%
- Education: 60%
- Denials management: 60%
- Chargemaster maintenance: 58%
- Correcting claim edits: 55%
- Compliance: 55%

“The depth and breadth of topics and issues revenue integrity professionals handle every day is astounding, and I am so glad NAHRI exists to nurture these professionals especially when education is mentioned as a top challenge,” says **Valerie Rinkle, MPA**, a lead regulatory specialist and instructor for HCPro in Middleton, Massachusetts, and a NAHRI Advisory Board member. “It is important to celebrate as a community of like-minded and talented professionals, which NAHRI brings together to share and develop resources that apply to the focus of their everyday complex tasks.”

While these tasks are familiar to revenue integrity, they are not necessarily simple. When asked about top challenges in revenue integrity, one revenue integrity coordinator wrote in to say their facility’s top challenge is around education; another revenue integrity manager pointed to denials management as a top challenge.

Just as with primary functions, respondents were asked to write in functions they assist with or support that were not listed in the survey. The write-in responses included utilization management, health IT, project management, reporting on billing activity (e.g., days in AR, payments, denials), and pricing. For a complete list of functions revenue integrity professionals support, *(see Figure 7 on p. 6 for more information.)*

**Figure 6: If you have a revenue integrity department or program, what functions is the department or program responsible for at your organization? (Check all that apply.)**

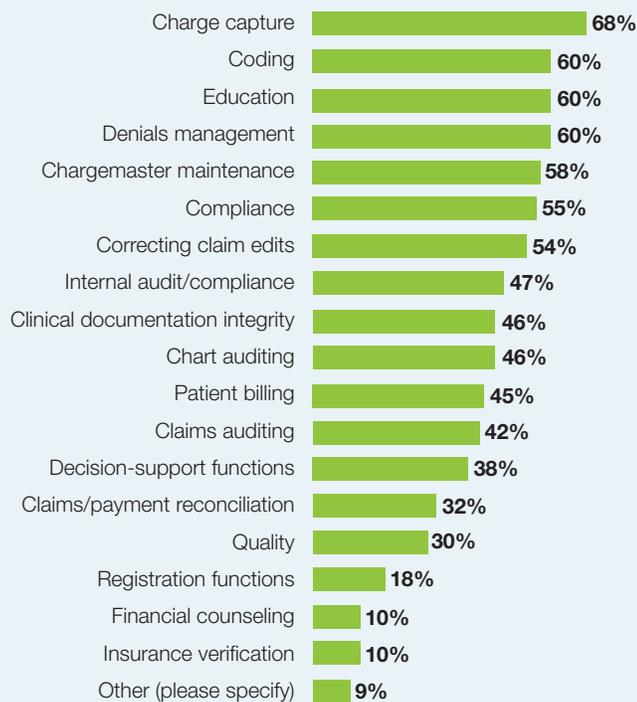


## Revenue integrity department and organizational structure

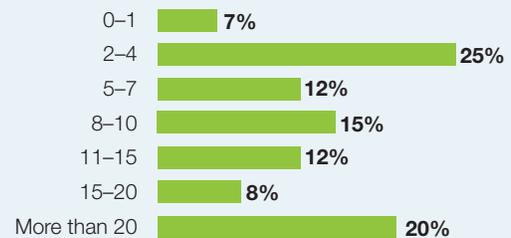
As revenue integrity continues to become more prominent in healthcare organizations, departments and programs are likely to grow in numbers. The plurality of respondents (25%) stated their program or department currently supports 2–4 full-time employees. Interestingly enough, falling just behind that figure at 20% are departments or programs with more than 20 full-time employees. It appears that while some facilities are just starting out and have a lower number of revenue integrity staff members, others are in full swing.

“We have a huge responsibility to make sure the revenue cycle is intact. Our revenue integrity department has recently grown from four to 14, which is allowing us to really concentrate on our departments and try to be proactive on issues. I am finally the first contact that my managers turn to for all kinds of help,” one revenue integrity director said of their department growth.

**Figure 7:**  
If you have a revenue integrity department or program, what functions do you assist with, act as a resource, or support? (Check all that apply.)



**Figure 8:**  
If you have a revenue integrity department or program, how many FTEs support it?



More than half of respondents (64%) stated that their facility cross-trains staff to ensure sufficient coverage at times when a person with primary responsibility for an essential function is out of the office.

In terms of reporting structure, half of respondents (50%) stated their revenue integrity department reports up to the vice president or director of revenue integrity. Respondents also reported revenue integrity oversight from the chief financial officer (21%), vice president or director of finance (5%), HIM director (5%), CEO (2%), and compliance director (1%). Approximately 15% of respondents do not report to one of the roles listed and wrote in to specify whom their department or program reports up to; those responses included chief revenue officer, director of revenue and reimbursement, and director of finance and reimbursement. One respondent stated that they only have a revenue integrity program rather than a department and the reporting structure is unknown. Another stated that the reporting structure changes frequently so it is currently unclear whom revenue integrity should report to—while this is not optimal, it’s also not surprising for departments and programs that are still taking shape. (See Figure 8.)

Most respondents whose facilities have a dedicated revenue integrity department or program reported meeting monthly (44%), weekly (26%), or quarterly (10%). However, 20% of respondents stated their facility does not have a regularly scheduled meeting time for revenue integrity. One HIM director wrote in to say their top challenge is that “the revenue integrity committee does not meet often enough.”

“It is great to hear that the majority of respondents are meeting formally at least monthly,” Settlemeyer says. “This promotes visibility of ongoing issues and ensures continued focus and attention. These are also occasions to celebrate successes.”

## Chargemaster maintenance and approval processes

Chargemaster maintenance is one of the essential functions of revenue integrity, as evidenced by the fact that 79% of respondents listed it as a primary revenue integrity function, placing it above charge capture, chart auditing, and correcting claim edits. At most facilities (57%), chargemaster maintenance is managed by a team of professionals. However, some facilities (38%) have assigned a dedicated team member to this responsibility. Still others (6%) take a different approach, either placing a director and team members or a chargemaster coordinator and manager over chargemaster maintenance.

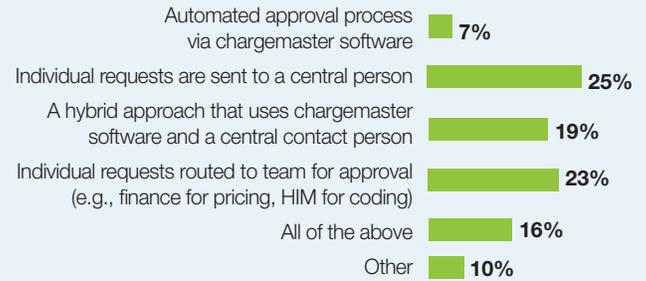
Responses were varied when it came to the chargemaster approval process, with the plurality of respondents (25%) stating that individual requests are sent to a central person and others (23%) stating that individual requests are routed to a team for approval. Additional structures for chargemaster approval include the following (see Figure 9):

- A hybrid approach that uses chargemaster software and a central contact person: 19%
- Automated approval process via chargemaster software: 7%
- All of the above: 16%
- Other: 10%

Respondents who answered “other” wrote in to describe the following chargemaster approval processes:

- “Request (ticket) is placed with IT and routed to CDM team for research and review.”
- “Requested are routed via software to the appropriate revenue integrity service line owner for review, approval, and pricing.”
- “Chargemaster requests from revenue departments are routed to the revenue integrity analysts over their department. Together, they work on the coding and operational flow if necessary. Revenue integrity analyzes prices based on policy and IT is engaged to setup for electronic selection by clinical staff.”
- “Requests to charge management analyst by service line. Coding, pricing, naming convention completed by chargemaster analyst, then forwarded to CDM IT analyst for build.”

**Figure 9: Who does the revenue integrity department report to at your facility?**



## Billing and charging processes

Many of the key elements of revenue integrity revolve around ensuring claims are properly coded and billed, with charges that are accurate and complete.

“With the ever-changing reimbursement world, we must capture charges, and code/bill correctly in order to obtain all that is due,” said one revenue integrity director.

For this reason, we asked respondents whether they work with a pre-billing hold to ensure encounters and accounts are accurate before they go out the door. More than half of respondents said yes (67%), with most of them (62%) stating that the pre-billing hold is targeted for a specific scenario (e.g., inpatient-only procedures on outpatient claims, certain DRGs) and 5% stating that the pre-billing review is random (see Figure 10 on pg. 8). Approximately 20% of respondents do not have a pre-billing process in place, and 13% have a process not listed on the survey, including the following:

- As needed when issues are identified
- A staff member reviews batches
- Catching errors through charge review work queues or claim edits
- Electronic review of accounts

We also dug into how facilities define and process late charges. For nearly half of respondents (47%), a charge is considered late if it is not entered three or more days from the date of service, although more than one-third (38%) of respondents set the cutoff at three days from the date of service. Some facilities have shorter timelines for what they would consider a late charge, with 9% considering a charge late if it is not entered after two days from the date of service and 6%

drawing the line at one day from the date of service (see Figure 11). One HIM director wrote in to say that late charges are the top challenge at their facility.

“The only way to meaningfully reduce late charges is for operational leaders to buy in and enforce a formalized and highly visible charge reconciliation policy/process,” Settlemeyer says. “Finance cannot solve a late charge problem without operations wholly committed support.”

When it comes to processing late charges, (see Figure 12), nearly half of respondents (40%) stated they only process late charges that exceed an internally set threshold, whereas 32% process all late charges and 14% only process late charges if separate payment is involved with the charge. Approximately 13% of respondents wrote in to identify a different process for handling late charges, including the following:

- Outsourcing to a billing company
- All government payers are processed, but for commercial payers it depends on the threshold and additional net revenue generation
- Only if permitted by payer

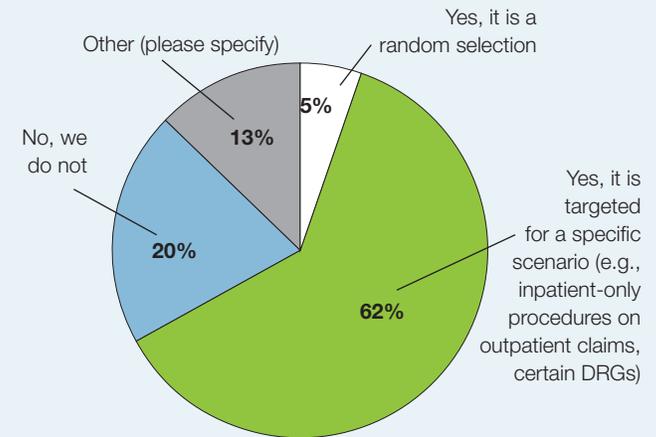
Whether you’re like the 49% of respondents who listed correcting claim edits as a primary revenue integrity function or the 55% who indicated it is a revenue integrity support function, it is important to understand how claim edits are resolved at your facility. More than one-third of respondents (38%) stated HIM is responsible for resolving claim edits at their facility, 7% stated it is a business office function, and 5% stated it is a compliance function. Nearly one-fourth (23%) stated that HIM, business office, and compliance all work together to correct claim edits. More than one-fourth (26%) wrote in to specify who is responsible for resolving claim edits and identified the following roles:

- Coding
- Patient financial services coding lead
- Revenue integrity and revenue integrity coders
- Claim edits specialists

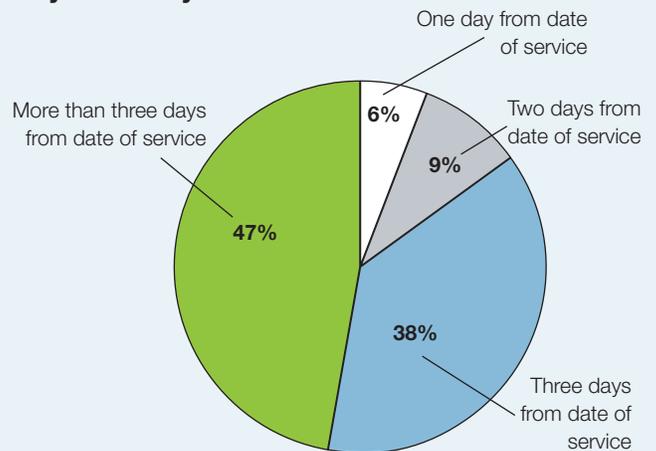
Often, clinical staff are tasked with entering some charges but forbidden from entering others. Clinical staff at respondents’ facilities are not permitted to enter the following charges:

- Observation (28%)
- Emergency department (25%)
- Drug administration (4%)
- Other (43%)

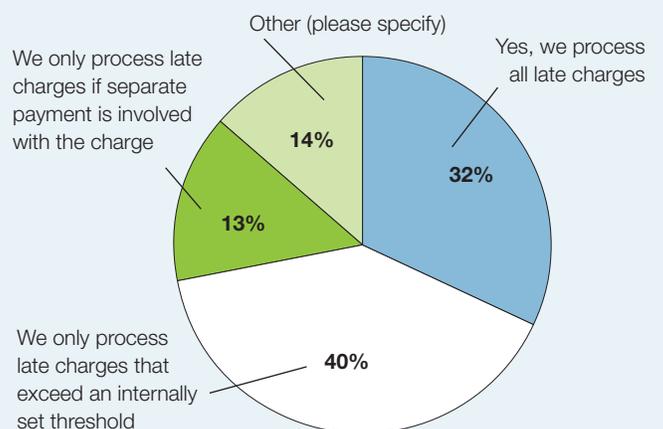
**Figure 10: Does your facility have a pre-billing hold to review encounters or accounts for accuracy?**



**Figure 11: What is the time frame for charge entry before it is considered a late charge at your facility?**



**Figure 12: Does your facility process all late charges?**



For those who responded “other” and wrote in to specify, the following responses were collected:

- Both ED and drug administration
- Both observation and drug administration
- Observation, ED, and drug administration
- Professional charges
- Day surgery
- Operating room
- Room and board

## Auditing functions

Where audit functions are concerned, 32% of respondents stated that revenue integrity has oversight of determining which areas will be audited. Other facilities have placed this responsibility in the hands of compliance (10%), patient accounts (4%), coding (4%), or a committee (4%). At approximately 13% of facilities, audits are managed by request. The remaining 33% of respondents stated that determining audit areas is not tied to the revenue integrity department at all, is managed by a combination of the roles listed, or is managed by a role not listed in the survey.

“An effective revenue integrity program needs to have a structured audit program,” says Dunn.

When revenue integrity does have oversight of audits, they typically manage the following audit types (see Figure 13):

- Chart-to-bill/charge capture (73%)
- Coding (43%)
- Reimbursement/payment reconciliation (52%)

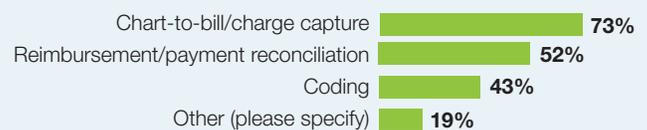
Some respondents wrote in and stated that revenue integrity also performs the following types of audits:

- 2-midnight rule
- Medical necessity
- Pharmacy
- Professional billing

In the event that revenue integrity uncovers an issue during an audit, 66% of respondents stated that the next step would be to share the audit findings with the department to which the findings apply for collaborative education, training, and follow-up. Other approaches include the following (note that respondents were asked to select all approaches that apply to them, so some may employ several of the approaches identified):

- Results are shared with a committee or senior leader who identifies next steps (22%)
- Results are shared with the department that has an issue, and revenue integrity mostly does the education, training, or follow-up (20%)

**Figure 13: What types of audits are performed by your revenue integrity department or program? (Check all that apply.)**



- Results are shared with the department that has an issue, and it is up to that department to educate, train, and follow up (15%)

For revenue integrity departments or programs that dedicate a staff member to the sole job of auditing, this job is primarily (30%) assigned to nurses. Some departments and programs also rely on coders (13%), charge capture specialists (13%), or billing and claims experts (5%). Approximately 38% of respondents either did not have a sole person whose responsibility is it to audit, or wrote in to say that the responsibility is assigned to one of the following roles:

- Revenue integrity analyst
- Revenue integrity coordinator
- Compliance manager
- Auditor
- Financial analyst

## Ongoing challenges

Helping ensure revenue integrity is by no means easy. NAHRI asked survey respondents to identify the top challenges they face and received the following responses (*see the sidebar on p. 11 for more information*):

- Denials management
- Education
- Late charges
- Capturing all the charges on the claim
- Volume of audits
- Multi-department accountability
- Complexity of revenue cycle processes
- Charge capture/charge reconciliation
- Missing charges
- Charge capture from EHR modules
- Staffing
- Having a dedicated department or program
- Claims getting held up in work queues
- Making process improvements
- Not enough qualified and trained resources
- Lack of organization and support

"I am excited this profession is finally being recognized for the importance and value it represents. For years, the titles were chargemaster coordinator and analyst and that was very undervalued for what had to be done," said one respondent. "I built a revenue integrity program at my last hospital and was proud it had the recognition and value for the importance to the financial success of the organization and solid support of the clinical work that was done."



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## Top revenue integrity challenges

NAHRI asked survey respondents to identify top challenges they face and received the following responses:

- Denials management.
- Education.
- Becoming less reactive and more outward facing to our clinical departments.
- Late charges.
- Capturing all the charges on the claim.
- Volume of audits.
- Multi-department accountability.
- Complexity of revenue cycle processes.
- Charge capture/charge reconciliation.
- Missing charges.
- Charge capture from EHR modules.
- Proving our worth with executive leadership and getting the clinical departments engaged.
- Staffing.
- Having a dedicated department or program.
- Claims getting held up in work queues.
- Increasing denials, particularly due to insurance authorization requirements.
- Just went live with EPIC. Clearing work queues appropriately is now my biggest concern.
- Making process improvements.
- Documentation to support the charges and level of care.
- Resources to complete all tasks being requested. System not robust enough to support the reporting needs.
- The biggest challenge is actually capturing the true impact of processes put in place (quantity, reimbursement, education hours, etc.).
- Getting departments to perform daily charge reconciliation.
- Not enough qualified and trained resources.
- Keeping up with increasingly complex CMS regulations.
- Lack of organization and support.
- Hard-wiring necessary process changes at revenue generating departments.
- Ensuring department directors are involved.
- Lack of education, and constant management changes.
- Automating the charge capture process house wide.
- Lack of vision in inexperienced manager.
- Authorizations and continue audits by payers.
- Getting on board with revenue integrity as a valid discipline.
- Denials prevention.
- Getting cooperation from departments.
- Obtaining skilled staff.
- Silos. No one person who leads the revenue integrity team consistently.
- Educating all the clinicians on complex regulatory rules for charge capture.
- We have not had a strong emphasis on revenue integrity in the past and are just now exploring it. So, that in itself is a huge challenge.
- Decreased reimbursement.
- Missing charges.
- Accurate clinical documentation to support the coding/charging.
- Our current electronic system does not provide meaningful reports so we spend too much time creating reports to monitor results.
- Too fragmented and lack of dedicated program.
- Inability to quickly reconcile charges and find missing revenue.
- Rising costs, lower payments.
- Ensuring all charges are being captured given our current system configuration.
- Ongoing need to re-educate clinical staff on compliant documentation to support charges.
- The department was established in the past two years. Obtaining resources and clearly defining responsibilities have been the biggest challenges for us.