



2022

STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY REPORT

MEET OUR ROUNDTABLE

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Revenue integrity manager
UC Health

Sue Bergum

Director of revenue integrity
Olathe Health

Lori Braschler, CCS, CHRI

Revenue integrity coding auditor
CommonSpirit Health

Frank Cantrell, CHRI

Corporate director of revenue integrity
Penn Highlands Healthcare

Adam Dittmore, MBA

Manager of revenue integrity
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Gregg Fanselau, MBA

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Stacy Heller

Team leader of revenue integrity
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Karen Kennedy

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Tina Rosier, MS, PT

Director of revenue integrity acute care services
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2022 STATE OF THE REVENUE INTEGRITY
INDUSTRY SURVEY REPORT

NAHRI is celebrating the fifth annual Revenue Integrity Week to acknowledge the achievements, influence, and dedication of revenue integrity professionals. To uncover the scope and depth of revenue integrity professionals' impact on their organizations, NAHRI's State of the Revenue Integrity Industry Survey collected information on industry trends, essential revenue integrity functions, and how the profession is evolving.

Revenue integrity professionals know the value of data. Understanding how traditional functions, such as chargemaster maintenance, are performed across the industry helps set standards and expectations. It's also essential to keep an eye on emerging trends and opportunities that allow revenue integrity professionals to keep pace with change. The *2022 State of the Revenue Integrity Industry Survey Report* digs into key topics, highlighting stability and change, and shines a light on how different organizations deploy strategies best suited to their needs.

“UNDERSTANDING HOW TRADITIONAL FUNCTIONS, SUCH AS CHARGEMASTER MAINTENANCE, ARE PERFORMED ACROSS THE INDUSTRY HELPS SET STANDARDS AND EXPECTATIONS.”

Background and experience

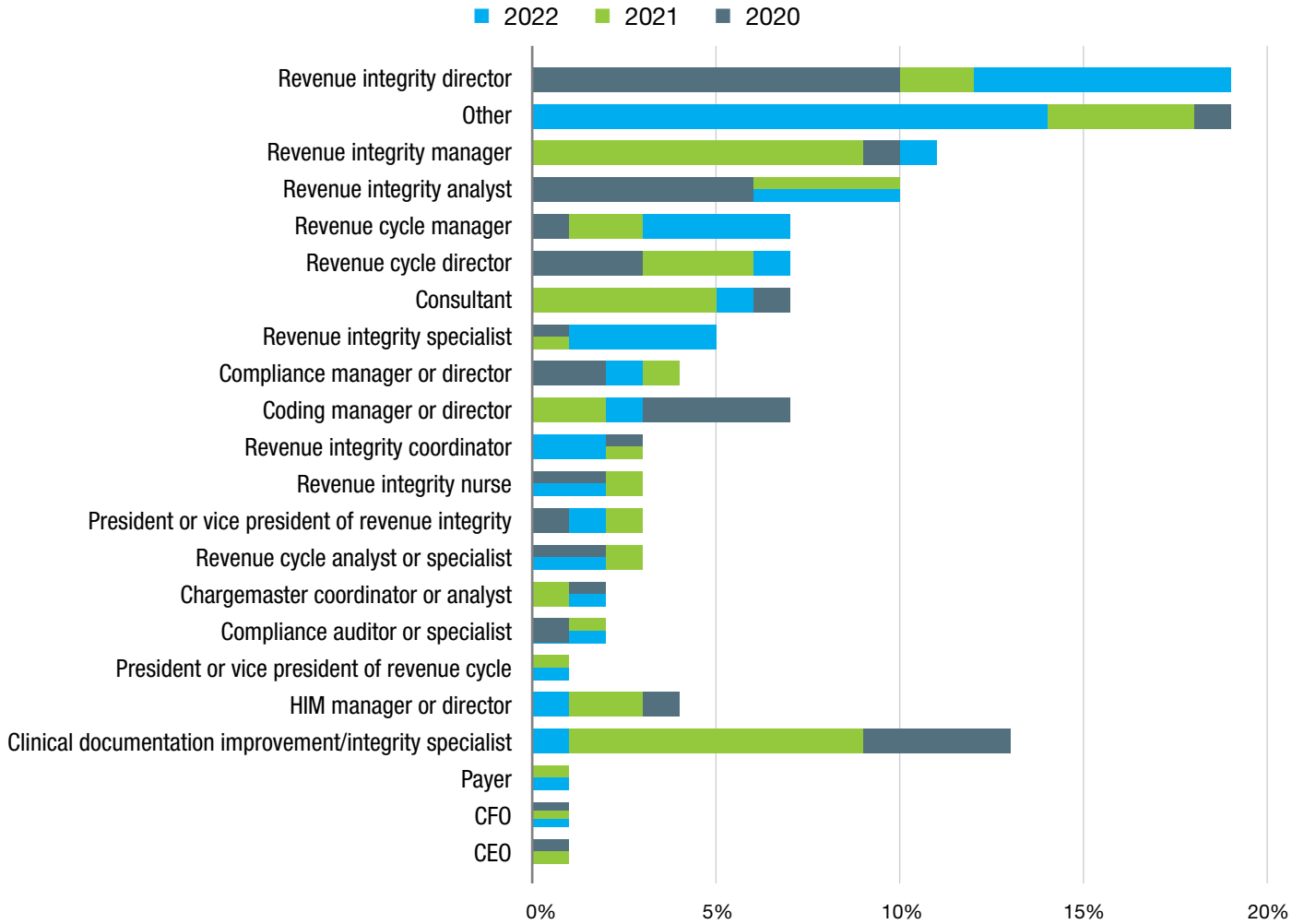
A revenue integrity team requires many skills and positions for success. To help illustrate the makeup of today's teams, NAHRI asked survey respondents to report their job titles. The number of respondents with a revenue integrity-specific job title continued to grow in 2022 as it did in 2021, with 51% of respondents holding such a title compared to 41% of respondents in 2021. Specifically, the amount of revenue integrity managers and directors responding to the survey increased nine percentage points from the 2021 survey report.

Survey respondents had the option to select “other” and state their specific titles. Some job titles of those who selected “other” (14%) were:

- Billing coordinator or supervisor
- Patient access director
- Revenue integrity coding compliance auditor
- Utilization management manager

See Figure 1 for more information on job titles.

Figure 1. Which best describes your title?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

Over half of respondents (64%) stated that they work for an acute care hospital/health system, and 46% reported that their organization has 500 or more beds.

Primary and supporting revenue integrity functions

All revenue integrity programs are different, as each organization has unique and specific needs. Organizations tailor their revenue integrity program to best suit these needs.

To capture trends in revenue integrity program design, NAHRI asked survey respondents to define their revenue integrity program’s level of involvement in a variety of functions.

Respondents specified whether each function is primary in their program, handled as a support function, or

is not handled at all. The top primary functions reported were as follows:

- Chargemaster maintenance (71%)
- Correcting claim edits (53%)
- Charge capture (52%)
- Education (48%)
- Charge reconciliation (44%)

Chargemaster maintenance, charge capture, and charge reconciliation are key components of a revenue integrity program, says **Lisa Stein-Pierce**, director of revenue cycle operations at MaineGeneral Health in Augusta, Maine.

Rather than exclusively correcting claim edits, organizations’ billing, patient access, and coding teams can collaborate to resolve claim edits, identify their causes,

and prevent them from reoccurring, says **Paula Twiss, MBA, CRCS-P, CRCS-I**, supervisor of revenue integrity at Monument Health in Rapid City, South Dakota.

Coding, although lower on the list, is another important revenue integrity function, says **Tina Rosier, MS, PT**, director of revenue integrity acute care services at Community Health Network in Indianapolis, Indiana. Although coding isn't the main focus of her organization's revenue integrity team, several team members do concentrate on coding, specifically for cath lab and interventional radiology cases.

"[We look] at the coding from a compliance point of view as well and [try] to make corrections and get back to the providers if we need to with the additional education

that they may need," says **Priscilla Frost, AGS, CPC, CEMC, CPMA, PCS, PES**, compliance auditor/revenue coordinator at North Caddo Medical Center in Vivian, Louisiana.

Everyone has a different interpretation of revenue integrity and what revenue integrity teams should do, Frost adds.

Revenue integrity departments often provide key support to other departments in a variety of functions. The following were some of the most commonly reported ones:

- Charge reconciliation (45%)
- Decision-support functions (44%)
- Charge capture (40%)

Please define your revenue integrity department's level of involvement in each of the following functions.

Figure 2. What are the primary functions of your revenue integrity department/program?

	2022	2021	2020
Chargemaster maintenance	71%	66%	68%
Correcting claim edits	53%	52%	48%
Charge capture	52%	58%	69%
Education	48%	48%	48%
Charge reconciliation	44%	41%	N/A
Chart auditing	41%	47%	54%
Denials management	39%	39%	N/A
Claims auditing	36%	34%	38%
Internal audit	31%	32%	38%
Decision-support functions	30%	27%	19%
Claims/payment reconciliation	28%	31%	21%
Clinical documentation integrity	23%	22%	31%
Quality	22%	22%	26%
Patient billing	21%	25%	25%
Coding	18%	33%	38%
Financial counseling	17%	17%	12%
Insurance verification	16%	18%	19%
Managed care/payer contract management	14%	20%	N/A
Registration functions	12%	14%	12%

Figure 3. What does your revenue integrity department/program handle as support rather than as a primary function?

	2022	2021	2020
Charge reconciliation	45%	43%	N/A
Decision-support functions	44%	36%	21%
Charge capture	40%	31%	55%
Claims auditing	40%	47%	33%
Coding	40%	34%	55%
Denials management	39%	38%	53%
Education	37%	33%	47%
Internal audit	36%	37%	50%
Managed care/payer contract management	33%	29%	24%
Quality	33%	30%	35%
Claims/payment reconciliation	32%	34%	24%
Clinical documentation integrity	32%	38%	34%
Chart auditing	30%	28%	46%
Correcting claim edits	30%	25%	45%
Patient billing	21%	23%	29%
Chargemaster maintenance	18%	17%	44%
Registration functions	16%	18%	14%
Insurance verification	12%	16%	16%
Financial counseling	8%	15%	6%

Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

- Coding (40%)
- Denials management (39%)

Clinical staffing issues may require revenue integrity departments to provide support for charge reconciliation, according to **Shawishi T. Haynes, EdD, FACHE**, director of revenue cycle, managed care, and revenue cycle integrity at Valley Presbyterian Hospital in Van Nuys, California. This means the revenue integrity team needs to handle the analytics, run the reports, and identify any anomalies in the data.

NAHRI also asked survey respondents to report which functions their revenue integrity team is not involved in. The following were some of the most commonly reported ones:

- Financial counseling (67%)
- Insurance verification (67%)
- Registration functions (65%)

- Patient billing (54%)
- Managed care/payer contract management (47%)

Although most revenue integrity departments aren't involved with financial planning, working with the finance team can be beneficial, says **Sherry Goyal**, supervisor of charge description master at Monument Health. Her department's revenue integrity team collaborates with the finance team to gain a better understanding of the organization's budget.

"[Revenue integrity is] all about working together collaboratively to make sure that at the end of the day, the claim is compliant and that we have good workflows to flow the claim through the system based on the contract," says Haynes.

For more details on revenue integrity functions, see figures 2 and 3.

Q&A: REVENUE INTEGRITY FUNCTIONS

Q: What are some functions that revenue integrity should be more involved in?

Frank Cantrell, CHRI, corporate director of revenue integrity at Penn Highlands Healthcare in DuBois, Pennsylvania:

For managed care and payer contract management, I think [revenue integrity involvement] is key. In our organization, we have a managed care director that handles the contract and language. He relies very heavily on my team if he's negotiating new contracts or renewing contracts because that is the prime opportunity to get some language in your contracts about the number of days you have to appeal, exactly what your process is for reviewing

problem claims, and even just areas where payers are being egregious with some of their rules and policies. While you may not actually do the contracting, I think you have to be a part of that process because you gain so much more from that process if the people who are actually looking at the denials and charging problems [can resolve them].

The other one is chart auditing. We do proactive department auditing. My philosophy has always been, the further upstream we can correct the issues, the fewer billing issues and denials we have. So auditing those outpatient departments specifically for charging compliance and documentation compliance is a huge part of streamlining your back-end revenue cycle to make sure the charges are correct and meet

[medical] necessity before they ever get to the point of billing and potentially being denied.

Priscilla Frost, AGS, CPC, CEMC, CPMA, PCS, PESC, compliance auditor/revenue coordinator at North Caddo Medical Center in Vivian, Louisiana:

Not only is it beneficial [to work with payer contracting], there's many times when you're working on a contract that the timely filing is something not everybody looks at. You can negotiate it. I think it's important that everyone who can review those contracts gives that feedback. You have to go to the areas that deal with the daily stuff to understand what needs to be in that contract. And a lot of places don't. ■

Chargemaster maintenance

Revenue integrity depends on a well-maintained chargemaster, and core revenue integrity responsibilities traditionally center on managing and reviewing chargemaster updates. That’s as true now as it has been since NAHRI first began conducting the State of the Revenue Integrity Industry Survey in 2018.

In 2022, more than half (60%) reported a team is responsible for chargemaster maintenance, compared to 52% in 2021 and 48% in 2019, suggesting a steady shift toward the practice. In contrast, there’s been a steady decrease in respondents who report that one person is responsible for chargemaster maintenance: only 15% in 2022 compared to 23% in 2021 and 26% in 2020.

“I was pleased to see the upward trend to the team approach over the last few years,” says **Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS**, president/CEO of SLG Inc., in Raleigh, North Carolina, and a NAHRI Advisory Board member. “I’ve been a big advocate for that for many years, and to see the increase from 48% to now 60% of facilities [is good]. It really is the way to go because there are just so many facets of [chargemaster maintenance], and you really need input from your ancillary managers, your chargemaster coordinator, your finance staff, and so many others. It’s really refreshing to see.”

Although the industry may be shifting closer to a standard, different organizations may fare better with varying approaches depending on their type and size, as well as the technology that’s available.

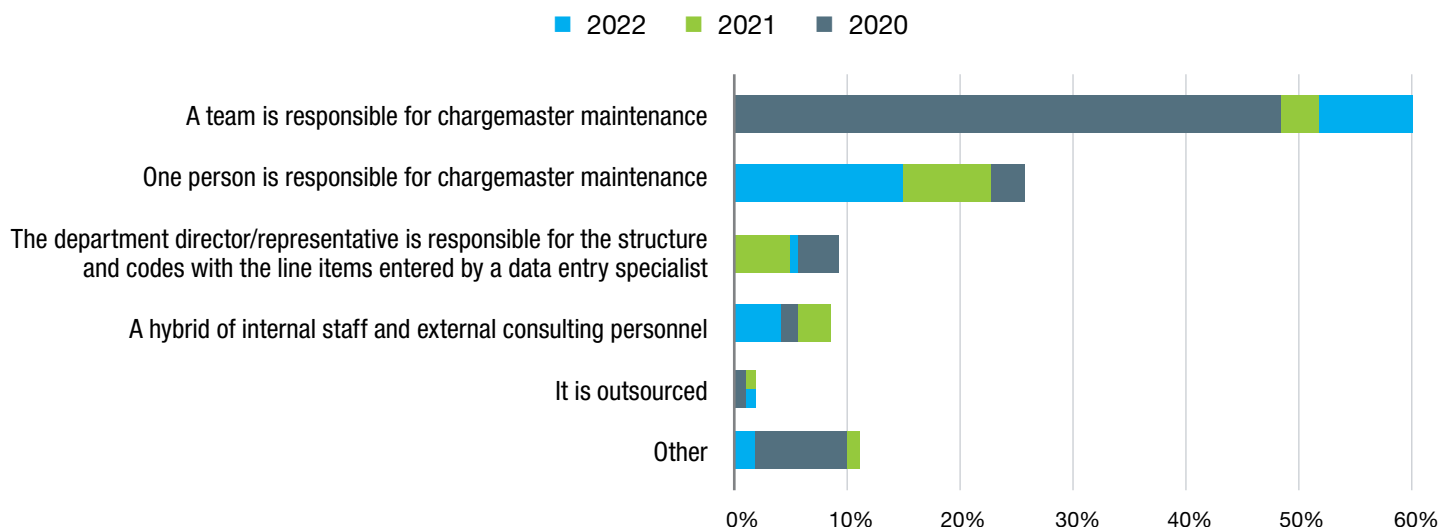
“Right now, in our health system, there is only one person who is doing [chargemaster maintenance] work,” Goyal says. “We are looking to grow our team and add more team members. We do audit from the external vendor for compliance purposes, but updates and management itself is managed by one person.”

At Olathe Health in Olathe, Kansas, the revenue integrity department is fairly new, says Sue Bergum, director of revenue integrity. As part of assembling and designing the department, Bergum determines whether the right person is in the right position. Currently, one person handles Olathe Health’s chargemaster maintenance, and her extensive knowledge and experience make her invaluable to Bergum’s revenue integrity team.

“I feel very, very fortunate to have her because she knows a lot of the background of the system and why some of the decisions were made, whether they were good decisions or bad decisions,” Bergum says.

See Figure 4 for more information on chargemaster maintenance.

Figure 4. How is your chargemaster maintenance structured?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

2022 survey results related to chargemaster approval processes are mostly similar to previous years. More than one-third (35%) of respondents indicated that individual requests are sent to a central person. However, the percentage of respondents reporting that they use an automated approval process via chargemaster software has doubled since 2021.

According to **Lori Braschler, CCS, CHRI**, revenue integrity coding auditor at CommonSpirit Health in Bakersfield, California, her organization is among those that have recently switched to an automated process. Braschler says the automated process went live several months ago after chargemaster management was moved back under revenue integrity and it's been working well.

Although automated processes take the burden of routine work off staff, they can raise new questions such as how to handle requests for custom or unlisted codes and how to set pricing and relative value units (RVU) for such codes. **Karen Kennedy**, director of revenue integrity at Cleveland Clinic in Cleveland, Ohio, says that when such requests come through (typically for procedures that are considered cosmetic or otherwise self-pay and therefore not billable to insurance), the coding department handles code assignment while the pricing team sets pricing and RVUs. Providers may sometimes request an RVU, but that must be balanced against what is realistic, Kennedy adds.

MaineGeneral Health uses a similar process, although theirs is manual, Stein-Pierce says. "If we are asked to add an unlisted code, we work with our coding department and the provider to identify a similar code in order to assign RVUs and to generate pricing. We work a lot with the provider but also with coding to try and identify a fair RVU for those. Our pricing policy is different for cosmetic or self-pay than it is for things that are billed to insurance."

At Valley Presbyterian Hospital, adopting a formal charge approval process meant educating clinical departments on how charges are linked to reimbursement, Haynes says. "Working with the IT and nursing leadership, we now have a much better way of doing that," she says. "In terms of any actual changes that occur to the chargemaster dictionary, it's my revenue

Figure 5. How is your chargemaster approval process structured?

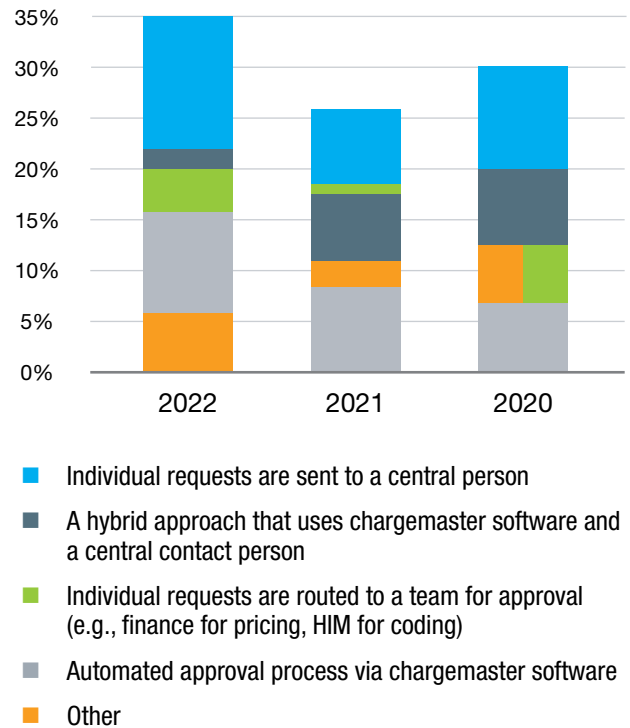
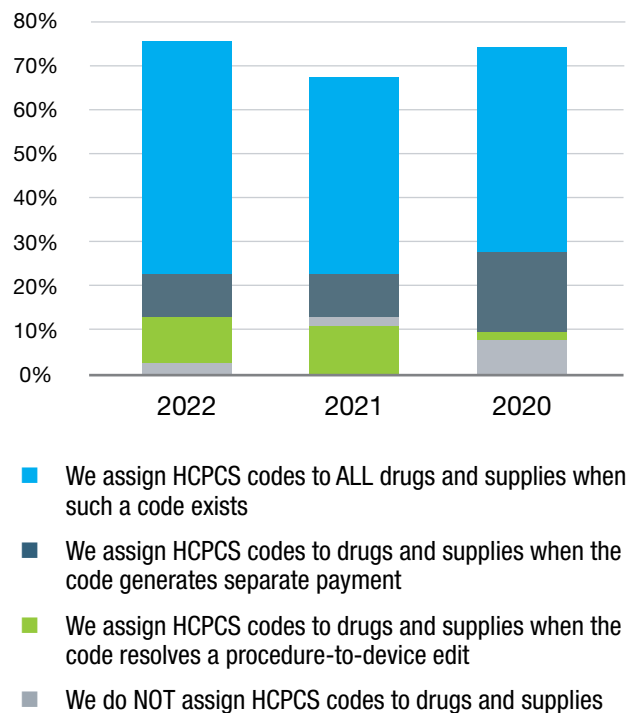


Figure 6. When do you assign HCPCS codes to drugs and supplies?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

integrity manager that will make the changes in the system, and then for supplies and pharmacy, they work directly with us. If there's a new item, they send over information to our revenue integrity team so the process can get started to make sure that the appropriate charges are added in the manner that they need to be added."

Whichever method an organization uses, it's essential to have a clear, defined process. "You can't have a bunch of people going in and making changes and nobody knowing it or being able to track how those changes were done," Frost says.

See Figure 5 for more details on approval processes.

Practices for managing Healthcare Common Procedure Coding System (HCPCS) code assignment to drugs and supplies remained relatively unchanged in the 2022 survey. A majority (76%) of respondents assign HCPCS codes to all drugs and supplies when such a code exists, roughly in line with responses from previous years (see Figure 6 for details).

As payer denial and recoupment efforts have grown increasingly aggressive, it's become more common to assign HCPCS codes to all drugs and supplies, according to Rosier. "Here in Indianapolis, our payers have become very particular about having HCPCS codes reported on claims, even for [revenue code] 272 charge items,

Q&A: CHARGEMASTER STAFFING

Q: How is your chargemaster staffed and managed?

Sue Bergum, director of revenue integrity at Olathe Health in Olathe, Kansas:

Our revenue integrity team and department is fairly new here at Olathe Health, and I'm actually fairly new to this system. So I brought together many of the teams [we're discussing], chargemaster or CDM, audits, appeals, denials, etc., on one team. We have a couple barriers to overcome. One is bringing everyone together as a team, and two is figuring out [whether they] are doing the right thing at the right time. Is the right person in the right position? And are we attacking all of our issues the way we should be?

Speaking specifically about the chargemaster, we do have one colleague who is our chargemaster guru, and I feel very, very fortunate to have her because she knows a

lot of the background of the system and why some of the decisions were made, whether they were good decisions or bad decisions. So we just have one person, one chargemaster, for our whole system.

Shawishi T. Haynes, EdD, FACHE, director of revenue cycle, managed care, and revenue cycle integrity at Valley Presbyterian Hospital in Van Nuys, California:

Chargemaster maintenance is managed by my revenue integrity team. We're a small community hospital, but we do have a position posted right now for a chargemaster coordinator who will do those primary functions with the leader in revenue integrity.

Tina Rosier, MS, PT, director of revenue integrity acute care services at Community Health Network in Indianapolis, Indiana:

All new items do come in through the chargemaster team. The one difference that we have is changes to the chargemaster. As we encounter soft denials with specific payers or other problems, maybe one payer wanting Current Procedural Terminology (CPT®) codes over HCPCS codes, etc., we do have a soft denials meeting with billing. So as those problems happen, if we need to build in alt revenue codes or alt CPT codes, then that's managed through the soft denials meeting we have with billing every two weeks.

Lisa Stein-Pierce, director of revenue cycle operations at MaineGeneral Health in Augusta, Maine:

We have a team who manages the chargemaster at our organization. We've had that structure in place now for probably between 12 and 15 years, and it seems to work well for us. ■

which typically we would not report. We've experienced Anthem going back to 2019 accounts in an attempt to recoup payment because we did not report a HCPCS [code] on a supply. I think that's something the industry has strategized as a way to deny or recoup money. As such, we're applying HCPCS codes more and more into our chargemaster every day."

Exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate can be useful. However, these mechanisms must be reviewed regularly to ensure they're up to date and functioning as intended. Although an annual review process was common in previous years, the industry may be trending away from that. In 2022, 38% indicated they review these types of charges annually, compared to 40% in 2021 and 52% in 2020 (see Figure 7 for the full breakdown of responses).

In fact, almost one-quarter (20%) of 2022's respondents selected "other"; some of those respondents reported that such reviews are handled by another department or even that they aren't performed at all.

Due to the complexity of managing exploding charges, some organizations have minimized their use or are moving away from them entirely.

"We are not using any exploding charges in our system currently because of some issues that had arisen with the way the system was putting them in," Frost says. "Now the only other time is in some of the labs there is a possibility of having [charges] exploding."

Adam Dittmore, MBA, manager of revenue integrity at EvergreenHealth in Kirkland, Washington, agrees that the increase of technical errors, such as parent charges that explode into no charges, can negate the benefits of using exploding charges.

Revenue integrity and IT are splitting responsibility for making changes to chargemaster order sets, based on survey responses. In 2022, 34% of respondents reported this task is assigned to revenue integrity, and 32% said it falls under IT's duties (see Figure 8 for more information). This is in line with trends established in previous years that saw IT taking a larger role. Along with this trend, responsibility for this task has shifted away from clinical staff and clinical department directors over the years.

Although IT has the technical skill and knowledge to make changes in the system, revenue integrity should be responsible for telling them what needs to be changed and how it should be set up relative to chargemaster order sets in the clinical space, Haynes says.

Figure 7. How often do you review exploding charges or similar mechanisms?

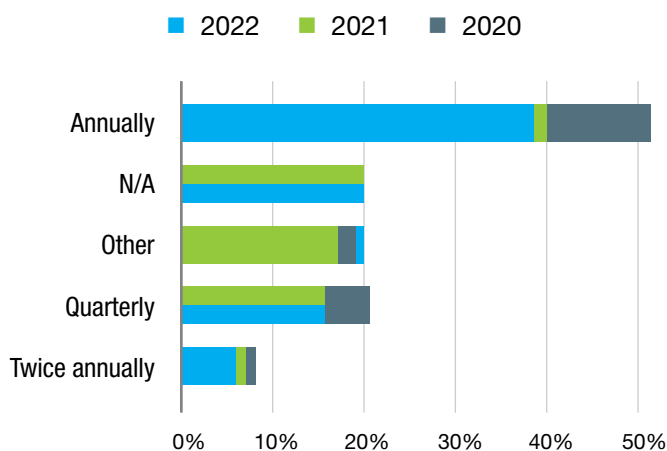
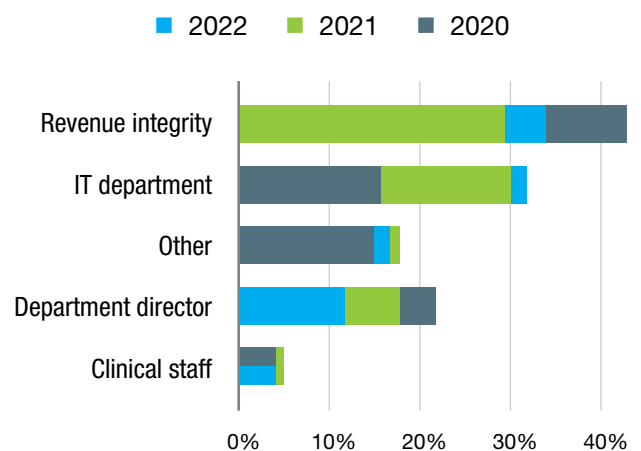


Figure 8. Who is responsible for making changes to chargemaster order sets?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

At Bellin Health in Green Bay, Wisconsin, IT currently makes changes to the chargemaster, but revenue integrity will be stepping in to share responsibility, says **Stacy Heller**, team leader of revenue integrity. “We have a very small revenue integrity department: It’s myself and one other person. Recently we sent my analyst to Epic to get certified, and we’ll be collaborating in the chargemaster maintenance, but today it’s owned by IT. So [we’ll be] trying to streamline that and make some better processes.”

Charge reconciliation practices

The survey also examined who is responsible for charge reconciliation at different organizations. Of the respondents, 43% reported that operational departments are responsible for reconciling their own charges with regular support from revenue integrity, followed by 30% who reported that operational departments reconcile charges on their own. This varies from the 2021 data, when only 31% of respondents reported that operational departments reconcile their own charges with support from revenue integrity (see Figure 9 for details).

Staffing and leadership turnover within an organization can make it difficult for other departments to stay engaged and conduct their own charge reconciliation,

says Rosier. Her revenue integrity team supports these departments by educating new staff on charge capture and reconciliation practices.

Being a rural facility can exacerbate these staffing struggles, Frost adds.

“Finding staff and maintaining that staff is very difficult. You can’t compete with the big hospitals,” Frost says.

For the departments that are able to reconcile their own charges, revenue integrity departments can support them through providing guidance and refresher training, says Twiss.

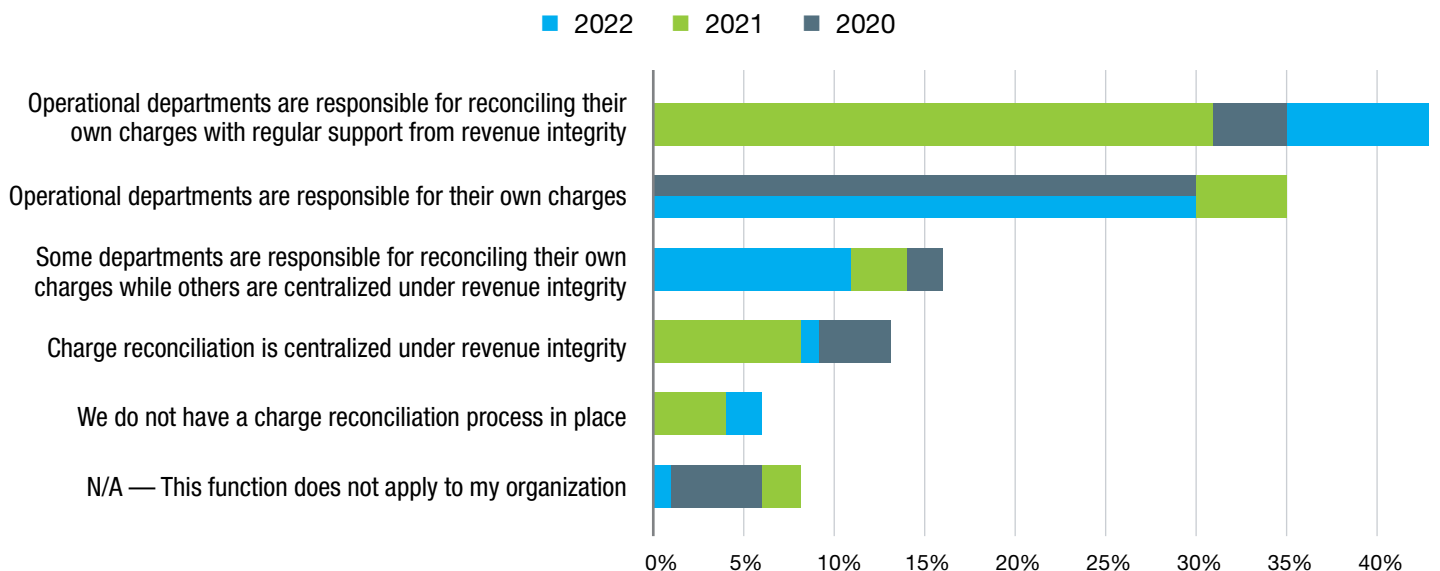
Over half (59%) of survey respondents reported that their department reconciled and corrected charges within one to three business days, which is an increase from the 44% of respondents who reported this in 2021.

While this time frame is the goal for many revenue integrity teams, operational departments reconciling the charges may cause the process to take longer.

“One to three business days is absolutely our goal, but we are working with operational departments, and they are primarily responsible for that reconciliation, so that goal may not be the reality,” says Stein-Pierce.

Twiss agrees. “Our goal is daily. However, that’s not reality.”

Figure 9. Who is responsible for charge reconciliation?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

The switch to remote work due to the COVID-19 public health emergency also increased time frames for reconciling and correcting charges, Goodman says. This was due to employees working remotely and trying to make sure they had everything in place for the telehealth policies that were implemented during the public health emergency.

Survey respondents also reported what types of charges are not entered by clinical staff. Observation hours (44% in 2022 and 48% in 2021) and emergency department (ED) (43% in 2022 and 36% in 2021) charges were reported the most frequently, followed by room and board (40% in 2022 and 45% in 2021) and cardiac cath lab (31% in 2022 and 24% in 2021).

“THE SWITCH TO REMOTE WORK DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY ALSO INCREASED TIME FRAMES FOR RECONCILING AND CORRECTING CHARGES.”

Often, coders may be involved in entering charges for EDs and observation hours. For ED charges, they handle level assignments and may be responsible for carve-outs for observation, Kennedy says.

See Figure 10 for more information on charges not entered by clinical staff.

CMS tasks facilities to have a policy for carving out procedures that include active monitoring. This way, observation hours are not reported for the same time frame. About 29% of respondents reported that HIM/coding handles this task, which is an increase from 22% in 2021, while 26% of respondents reported that revenue integrity handles it, compared to 27% in 2021.

When asked how their organizations monitor charge reconciliation practices for consistency and appropriateness, 46% of respondents reported that they use manual processes, compared to only 35% in 2021. Technology can also assist in this monitoring—whether through a homegrown solution, as 24% of

Figure 10. What types of charges are not entered by clinical staff? (Top 5)

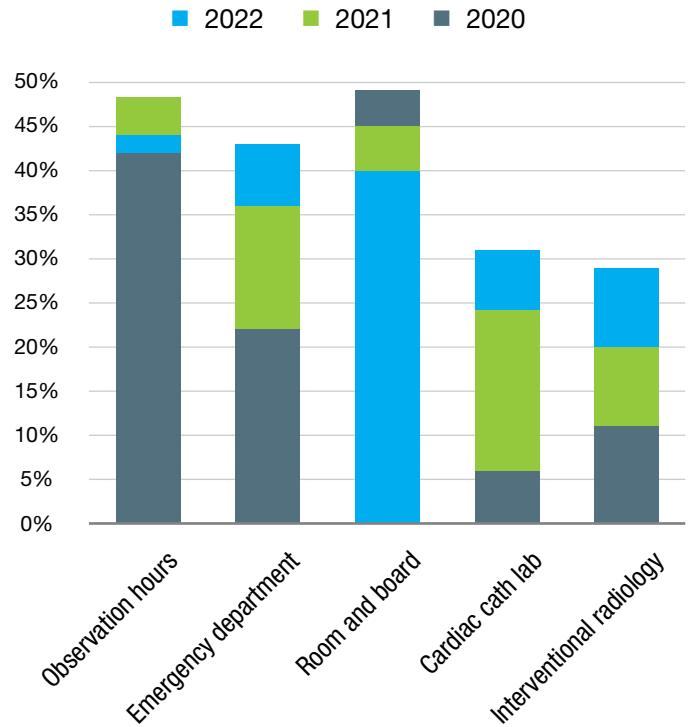
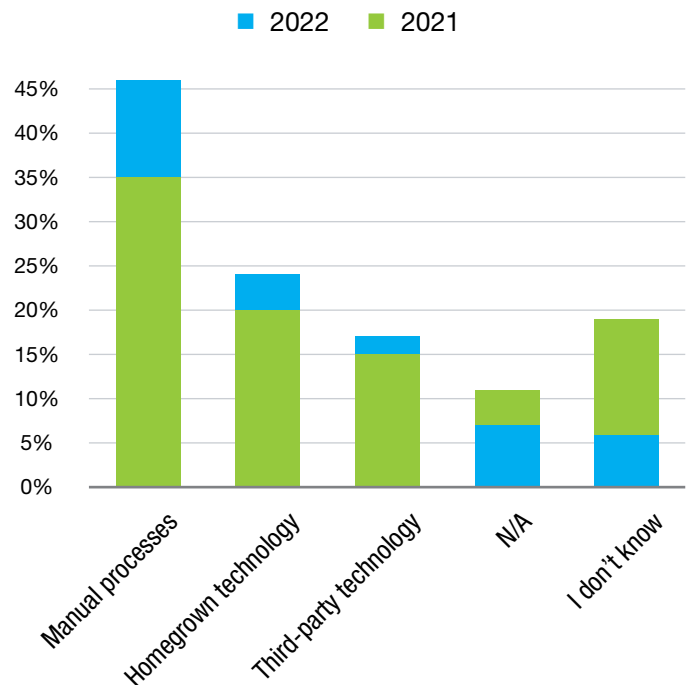


Figure 11. How does your organization monitor charge reconciliation practices for consistency and appropriateness?



Source: 2022, 2021, and 2020 State of the Revenue Integrity Industry surveys.

respondents reported, or a partnership with a third party, as 17% of respondents reported (see Figure 11 for more information).

Denials management

Managing denials has become increasingly important, and with good reason. Changes in reimbursement, the financial fallout of the COVID-19 public health emergency, and a rapidly rising denial rate are straining organizations. With their unique fields of expertise, revenue integrity professionals are well positioned to provide essential support to denials management or take a leading role.

As payers use increasingly sophisticated tactics and issue a higher volume of denials, responsibility for managing denials grows more complex. Denials management often spans multiple disciplines, ranging from responding to records requests to conducting root cause analysis, but organizations' approach often involves common key players and departments. To learn what departments are commonly involved in denials management, NAHRI asked survey respondents to indicate how that responsibility is divvied up at their organizations.

About half (57%) said a dedicated denials management department is one of the departments holding that responsibility, while 49% named the PFS/billing office and 48% pointed to revenue integrity.

At Monument Health in Rapid City, South Dakota, revenue integrity oversees denials management, partnering with areas such as billing, coding, utilization review, contract management, and compliance. "We look for trends and identify root causes through collaborative working sessions that focus on specific denial trends," Twiss says.

The Monument Health revenue integrity team also works with a payment integrity team that's embedded in the contract management department, Goyal adds. "We are looking at the contracts and looking for underpayment opportunities which we can [perform] denial management on because [payers] have reimbursed on the account but whatever they paid was an underpayment as per the contract."

See Figure 12 for more responses.

Denials management depends on solid data. Without facts on why claims are being denied and which payers

Q&A: ENTERING CHARGES

Q: What charges at your organization are not entered by clinical staff?

Lori Braschler, CCS, CHRI, revenue integrity coding auditor at CommonSpirit Health in Bakersfield, California:

Our revenue integrity department does the observation and ED charging. So we're the ones that do the drug administration charges when we do the other charges.

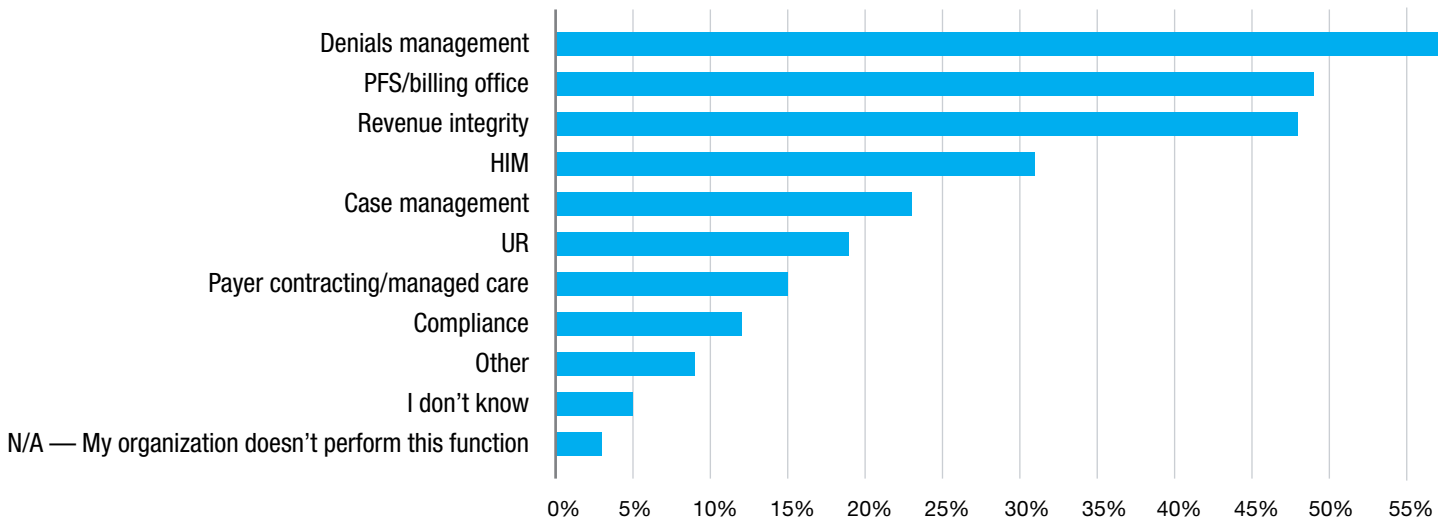
Karen Kennedy, director of revenue integrity at Cleveland Clinic in Cleveland, Ohio:

[For each organization] it's going to depend on what [they have] set up in the EHRs: what can drop from documentation, what is going to explode from something else, whether or not it actually has to be entered by anyone, be that clinical staff or somebody else. Drug administration codes are really hard. As revenue integrity, we have to constantly try to educate to have them used correctly. But honestly, it comes down to having a lot of rules built on the back side to catch things that aren't appropriate and correct them before they go out.

Tina Rosier, MS, PT, director of revenue integrity acute care services Community Health Network in Indianapolis, Indiana:

Over the last two to three years, we've been urged more than usual to automate as much charging as possible. We've also found that as we automate, we tend to get less accurate and have more problems. [I]t's a balance between what we automate, what we let clinical charge, and what we charge through the revenue integrity side. ■

Figure 12. Which departments are responsible for denials management at your organization?



Source: 2022 State of the Revenue Integrity Industry Survey.

are denying them, crucial tasks such as root cause analysis and other preventive and corrective actions won't happen.

Fortunately, the majority of respondents (74%) track denials by reason/type, giving them essential information to stop recurring denials and improve processes. Most (77%) also track denials by payer, giving them insights into potential workflow, communication, or contract issues (see figures 13 and 14 for more details).

Technology can sometimes limit data collection, but savvy revenue integrity professionals can adapt existing tools or combine them with manual processes to drill down into denials data.

“We do track denials by payer but really just our high-volume payers because we are on an older version of Meditech, so a lot of the tracking is manual,” Haynes says. “We also track by the type of denial it is based on the CAS code that comes from the 835 and [similar methods].”

At Penn Highlands Healthcare in DuBois, Pennsylvania, **Frank Cantrell, CHRI**, corporate director of revenue integrity, adapted existing software designed to collect data on RAC activity to also track denials—even digging into granular information about third-party

Continued on page 15. ▶

Figure 13. Do you track denials by reason/type?

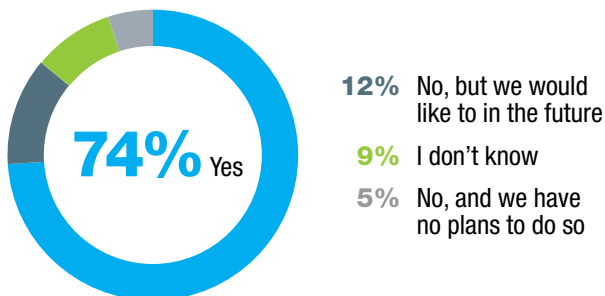
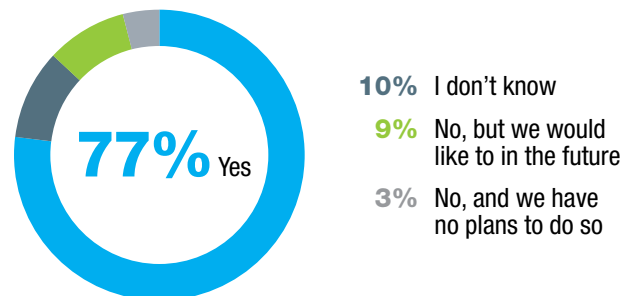


Figure 14. Do you track denials by payer?



Source: 2022 State of the Revenue Integrity Industry Survey.

Q&A: TRACKING DENIALS

Q: What processes do you have in place for tracking and reporting denials data?

Frank Cantrell, CHRI, corporate director of revenue integrity at Penn Highlands Healthcare in DuBois, Pennsylvania:

At my facility, we have software called ComplyTrack, which was really more of a RAC-based program, and compliance was in charge of that. All of that transferred over to me and the revenue integrity department. I hired [an employee] to come in and adapt ComplyTrack to also track our general denials, not just necessarily for RACs. What we were able to do is then not only track by all the different reasons but also by payer, and then we also broke that down. Sometimes it's not necessarily United or Aetna; they've hired HMS and EquiClaim. We can even get that granular to find out which third-party entity they have contracted with and what those people are focusing on. We've been able to find some common threads amongst payers and amongst those third-party individuals, like HMS and EquiClaim, [and] know where they're hitting so we can concentrate our efforts on auditing and education with departments.

Priscilla Frost, AGS, CPC, CEMC, CPMA, PCS, PESC, compliance auditor/revenue coordinator at North Caddo Medical Center in Vivian, Louisiana:

That was something that when I got here I found they didn't have a good process. [I came] from a larger facility where [payers] love to audit and deny things, so we are working on developing that to get a good feedback process of what's being denied. [We're also] looking to see whether the denials are because of coding, whether it be diagnosis coding or payers just not liking what we sent them.

Shawishi T. Haynes, EdD, FACHE, director of revenue cycle, managed care, and revenue cycle integrity at Valley Presbyterian Hospital in Van Nuys, California:

We do track denials by payer but really just our high-volume payers because we are on an older version of Meditech, so all of the tracking is manual. We also track by the type of denial based on the CARC code that comes from the 835. We have a data dump and then we analyze the data in Excel using pivot tables.

Paula Twiss, MBA, CRCS-P, CRCS-I, supervisor of revenue integrity at Monument Health in Rapid City, South Dakota:

I use a combination of different tools for tracking denials. I have

a dashboard that people can see across the system. I also have created two of my own personal dashboards. Our EHR is Epic, so I'm able to go in and look at specific things and target specific areas and any project that I am working on. An example would be we have a National Drug Code issue that we've been working on for a while. On my personal dashboard I have a project dashboard where I'm monitoring that specific denial to see if there's lots of them coming in, if we're maintaining, if we're getting them worked. Also, for professional billing as well, focusing on a dashboard with their denials.

This year I've been focusing on our aging denials and trying to get those cleaned up. I trend that and monitor [whether we're] getting to those older denials. If not, then I'm, as a denial management facilitator and revenue integrity, I reach out to the partners and see if we can make some initiatives to get those done. I also use reports out of our EHR and create pivot tables and initiatives on what's trending, what's our top denial, what's our top denial reason, how do I need to get involved to reduce those. A lot of work has gone into our denial management program at Monument Health, and we are starting to see with our metrics the work that has gone into that. ■

► Continued from page 13.

auditors. “What we were able to do is not only track by all the different reasons, but also by payer, and then we also broke that down. We can even get that granular to find out which third-party entity they have contracted with and what those people are focusing on.”

Cantrell also tracks data on win and lose ratios and recovered revenue. Both Cantrell and Frost have used this type of data to prove their departments’ value and secure approval for additional full-time employees.

Twiss uses a variety of tools to track denials, including a dashboard that individuals across her organization can view. “I also use reports out of our EHR and create pivot tables and initiatives on what’s trending, what’s our top denial, what’s our top denial reason, how can I get involved to reduce that.”

Using the right tool is key, according to **Justin Beinlich**, revenue integrity manager at UC Health in Denver, Colorado. UC Health uses dedicated data analytics software from a third-party vendor to monitor and report on denials and drill down into trends and root causes. “The way that you can really dig in through the data is something I’ve never been able to replicate within Epic or Meditech or anything else. We’re having a lot of success with that tool.”

Twiss agrees that, regardless of the software or methods used, shining a light on the details of denials is essential to reducing them. “You don’t know what you can’t

see, and now we seem like we can see everything. It is very enlightening to be able to pinpoint and focus on pain points and start resolving or identifying the root causes and seeing how you can reduce those specific denials.”

Billing and claims edits

Many elements of revenue integrity are focused on ensuring claims are appropriately coded and billed and are submitted with charges that are correct—and complete.

Pre-billing holds, or suspense periods, are a useful tool for making sure that accounts are complete and accurate before they’re submitted. However, if pre-billing holds aren’t defined properly, they may create more problems than they solve. Almost half (45%) of respondents indicated their pre-billing hold is targeted for a specific scenario (e.g., inpatient-only procedures), and 14% said theirs is a random selection. Some (13%) reported they use other methods for defining pre-billing holds.

About half (51%) of respondents said their pre-billing hold lasts three to four days. Although a three- to four-day hold is the standard, external circumstances can cause delays, Cantrell points out. During the peak of the COVID-19 pandemic, billing departments may have been bogged down managing new billing rules or altered duties and workloads. Now, personnel shortages in these departments can make it challenging for the remaining staff to hit the three- to four-day goal.

Figure 15. Does your organization have a billing hold/suspense period to review encounters/accounts?

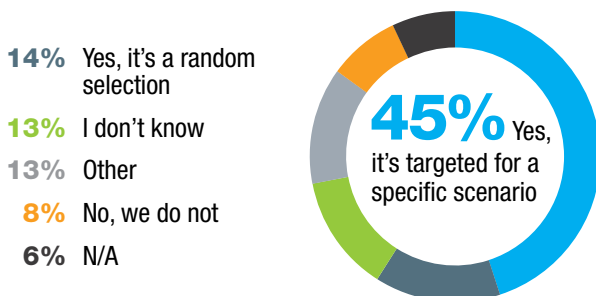
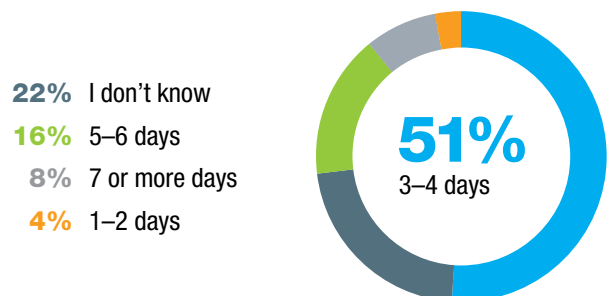


Figure 16. How long is your billing hold/suspense period?



Source: 2022 State of the Revenue Integrity Industry Survey.

“It’s great to have the goal, but I think it does fluctuate based on staff and different things that are going on within any specific organization,” Cantrell says. “Periodic creep up to four, five, or six days may be explainable, but, in my opinion, you would not want that on an ongoing basis. Otherwise, you’ve just got dollars sitting there that you could get out the door.”

Gregg Fanselau, MBA, reimbursement consultant at Childrens’ Hospital Colorado in Aurora, Colorado, recently launched a program to reduce late charges and ultimately tighten up suspense periods. “Last year, I started producing monthly late charge reports that went out to the directors and that summarized, by their cost center and user, who’s being timely and who’s not. We started [an] intensive program with one department as a pilot to help them improve and are producing custom reports for them, because unfortunately in Epic late charge reports don’t work particularly well in our organizational structure with 450 cost centers. It’s going really well. The clinical leaders are receptive to this, and we’re starting to see some good results.”

For more on pre-billing holds, see figures 15 and 16.

It’s not unusual for a claim to hit a coding edit that must be resolved before it can be processed. But not all coding edits can be resolved in the same way or call for the same expertise. Depending on the edit, responsibility

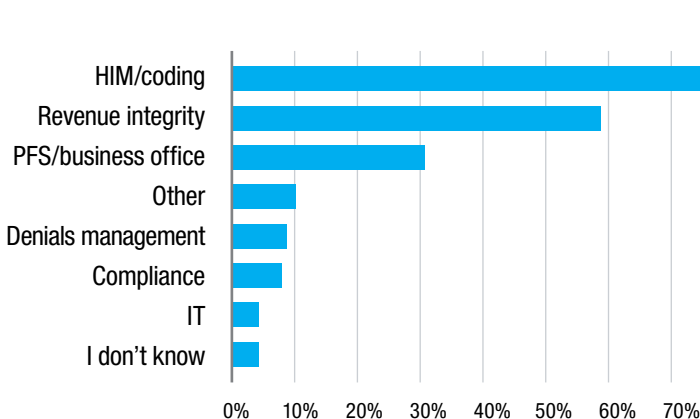
may land with different departments. To shine a light on how that work is done, NAHRI asked respondents to indicate which departments share responsibility for resolving coding claim edits. HIM/coding took first place, with 75% of respondents reporting responsibility falls to them, and revenue integrity (58%) and PFS (31%) rounded out the top three (see Figure 17 for full details).

“At Cleveland Clinic, we have HIM handle any of the coding claim edits for soft-coded codes, but the revenue integrity team of coders would handle things that are related to hard-coded Current Procedural Terminology (CPT®) [codes],” Kennedy says.

Edit resolution may call for various skill sets and knowledge, Goodman agrees. “I think it does depend on the type of claim edit that’s being resolved. Is it a modifier issue? Is it something that’s missing from the claim? Is there something like a C-code device-to-procedure edit? So [responsibility] may vary from time to time.”

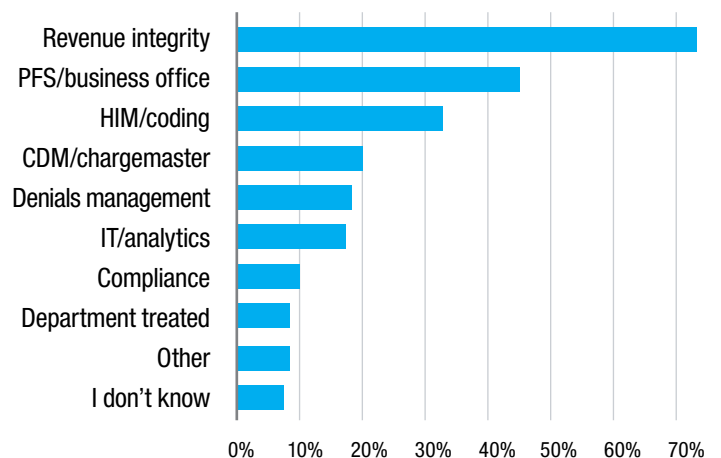
Claim edit patterns often hold the key to resolving recurring problems and compliance concerns and finding revenue opportunities. Reviewing them to conduct root cause analysis offers a wealth of insight into issues that impact revenue. Organizations often pull together multidisciplinary teams to perform root cause analyses of claims. To find out more about this process and how

Figure 17. What departments are responsible for resolving coding claim edits at your facility?



Source: 2022 State of the Revenue Integrity Industry Survey.

Figure 18. What departments are involved in reviewing claim edit patterns for root cause analysis?



revenue integrity is involved, NAHRI asked respondents which departments are involved in reviewing claim edit patterns for root cause analysis. According to respondents, revenue integrity (73%) is most commonly involved, with PFS (45%) and HIM/coding (33%) following (see Figure 18 for more information).

“Revenue integrity at Monument Health helps facilitate collaborative working sessions in regards to claim edits,” Twiss says. “We’ll pull a report and focus on our top edits, and I try to identify the root cause and solution to reduce those edits. In some cases, maybe we can eliminate the edit.”

Beinlich’s revenue integrity team is also involved with root cause analysis of claim edits and works alongside coding and billing staff to manage those work queues.

Challenges and benefits

Revenue integrity departments have faced significant challenges over the past year. As the COVID-19 pandemic continued to drain hospital resources, many departments found themselves facing staffing shortages while grappling with budget cuts that impacted technology upgrades and other resources.

Additionally, they faced the constant challenge of keeping up with new regulations and the regular cycle of payer updates. Revenue integrity departments had their work cut out for them over the past year. Remaining effective meant leaning into strengths and managing problems.

So what factors are boosting the effectiveness of revenue integrity departments, and what factors are creating roadblocks? According to survey respondents, it’s all about building strong relationships. Eighty-eight percent said their department’s relationships with clinical departments have had a positive impact on revenue integrity’s effectiveness, and 88% said their relationships with other middle revenue cycle departments have had a positive effect. When interdepartmental relationships are thriving and everyone is united in a common goal, even complex tasks are made easier through teamwork, resource sharing, and cooperation.

Frost has firsthand experience of how launching a revenue integrity department can break down a siloed culture and jump-start interdepartmental communication. “I think that revenue integrity helps people understand the whole overall process instead of all the silos and [staff members] just worrying about their one little piece. I think

Figure 19. Please rate the effect the following have had on your revenue integrity department/program’s effectiveness over the past 12 months.

	Positive effect	Negative effect	No effect	N/A
Use of automation (e.g., automation charges, edit management)	85%	4%	4%	7%
Resolving claim edits	71%	9%	15%	5%
Managing denials	65%	4%	26%	5%
Conducting internal audits	60%	7%	24%	9%
Lack of qualified staff	7%	57%	21%	14%
Use of productivity measures	57%	9%	23%	11%
Relationship with IT/analytics	76%	7%	13%	4%
Relationship with other middle revenue cycle departments	88%	2%	7%	4%
Relationship with clinical departments	88%	2%	7%	4%
Expansion of duties to functions unrelated to revenue integrity	43%	14%	27%	16%

Source: 2022 State of the Revenue Integrity Industry Survey.

the whole grouping of revenue integrity makes them understand we're all the same team and we're all ultimately trying for the same goal."

Another major positive effect on revenue integrity comes from use of automation (e.g., automating charges, edit management): 85% said this has improved revenue integrity's effectiveness.

What about the roadblocks? About half (57%) of respondents said a lack of qualified staff has had a negative impact on revenue integrity. A variety of factors have led to major shifts in the available workforce and tipped the scales in favor of job seekers and employees. Organizations need to be flexible and consider whether their benefits and culture are truly competitive in today's job market.

Another challenge revenue integrity departments may be facing: returning to projects that were put on hold due to the COVID-19 pandemic. Staff that weathered the strain of rapidly changing regulations and initiatives related to COVID-19 might not get a break before they need to jump into long-delayed but essential projects.

"We all struggled through the mass change of direction over COVID-19, and now we're kind of getting back into other things," Kennedy says. "At the Clinic we have three Epic go-lives this year. Everybody is mass entered into these go-live teams, which then puts a great burden on everyday maintenance and everyday work. So, for us, that's honestly the biggest [challenge], that there's so much to do this year with the same amount of staff."

Monument Health's revenue integrity team is running into similar issues, according to Twiss. "One of our big goals right now is automation. That is something that we started two years ago, and we're just now picking that back up."

See Figure 19 for more information on positive and negative effects on revenue integrity.

To uncover other struggles for revenue integrity teams, NAHRI asked survey respondents to share the biggest challenges they're facing at their organizations.

Some survey respondents named the existence of conflicting and shifting priorities.

"We have had five senior vice presidents (SVP) of revenue cycle in the past five years: three permanent positions and two interim positions," a survey respondent wrote. "Each SVP comes with his/her own priorities, so the constantly changing priorities have been a challenge. One priority that has not changed is increasing cash collections. Cash collections have increased consistently by 20% each month over the past year. It feels like no matter how much cash revenue cycle collects, it will never be enough. At some point, hospital departments must be held accountable for operational changes that will increase cash, either from increased revenue or decreased expenses."

"STAFF THAT WEATHERED THE STRAIN OF RAPIDLY CHANGING REGULATIONS AND INITIATIVES RELATED TO COVID-19 MIGHT NOT GET A BREAK BEFORE THEY NEED TO JUMP INTO LONG-DELAYED BUT ESSENTIAL PROJECTS."

"Revenue integrity has been tasked to report/find most billing/charging/claims issues such [that] we are not able to reconcile charges the way we would like to," another survey respondent wrote. "With revenue integrity's priorities on finding and reporting root causes of issues, we do not have the availability we would like to look for and research new revenue opportunities."

Respondents cited staffing shortages as a common pain point, along with new priorities and tasks created by shifting or emerging regulations, such as the No Surprises Act.

Revenue integrity professionals are also finding it difficult to advance opportunities for automation or fine-tune existing automation. Some survey respondents noted problems ensuring that automated tasks are as effective as the manual tasks they replace. Others are struggling to secure funding for automation or to automate charge capture and reconciliation in a meaningful way.

Other survey respondents discussed issues around charging and documentation.

“Inaccurate, missing, or overcharging practices seem to be a recent trend that I expect to continue, unfortunately,” a survey respondent said.

Finally, several survey respondents mentioned standardization of revenue integrity functions, processes, and structures. Whether a revenue integrity department or program is new or established, success depends on having consistent processes and clearly defined functions and goals.

See the sidebar below for more on revenue integrity challenges.

As revenue integrity professionals turn the corner on the barrage of new regulations related to COVID-19 and return to plans and projects that were put on hold, what are they hoping to tackle first? To find out, NAHRI asked survey respondents to share what changes they're looking to implement.

CHALLENGES FACING REVENUE INTEGRITY

What roadblocks are in the way of your revenue integrity department? NAHRI asked respondents of the 2022 State of the Revenue Integrity Industry Survey to identify the biggest revenue integrity challenges facing their organizations. Here's what some of them told us:

- The number of changes that revenue integrity is responsible for has exponentially grown over the last three years. It has made routine functions like investigations into revenue more difficult to complete.
- Size of organization and extremely fast-paced growth have presented challenges to management of revenue integrity initiatives. Trained and experienced revenue integrity staff are difficult to come by.
- Keeping up with lab and drug charges, as they are not overseen by revenue integrity.
- Charge reconciliation consistency through five organizations. HIM accepting input when accounts are reviewed for accuracy in coding.
- Finding qualified staff is a problem at the moment. Finding a revenue integrity technology vision that provides the most value to an organization, while still performing necessary tasks that are needed.
- Staffing is a major challenge. Finding skilled team members. Volume of initiatives pulling on resources also a challenge.
- Moving away from the work that has always been done by this department, which is more accounting/finance work, and developing a true revenue integrity department. Having knowledgeable leaders and staff in the revenue cycle to drive change.
- Staffing, growing faster than we can keep up, changes in payer policies and audits.
- Getting buy-in from clinical departments.
- Turnover in the clinical departments, which then pulls resources from revenue integrity, inability to implement efficiencies as quickly as we would like due to limited IT resources, changing payer rules.
- Clear documentation of intent for level of care matching the actual order.
- High turnover in patient financial services; lack of buy-in from some clinical areas; late charges in some areas.
- Payer-specific denials [that are] non-standardized; every payer wants a claim a different way.
- Reimbursement for long stay observation cases, partnering with care management to mitigate, or at least align, denials appeal strategy. We can't sustain being the community financial safety net.
- Denial management, inpatient NSR reviews and recoupments, varying revenue code/Current Procedural Terminology (CPT®) combinations required by different payers, Healthcare Common Procedure Coding System [codes] being required on all 272 items. ■

“I would like to divide out non-revenue integrity functions currently performed by revenue integrity into other teams (i.e., medical necessity edits should be owned by coding, system maintenance for reporting codes and modifiers by non-CMS payers should be owned by billing),” one survey respondent said.

“Implementing Epic in Q4 along with VitalWare for chargemaster maintenance,” another survey respondent said. “This will improve denials workflow, underpayments identification, charge reconciliation, and chargemaster maintenance—everything I wished for!”

One survey respondent said that they’re in the process of creating a denials prevention program that will be centralized under revenue integrity, moving away from their organization’s current model of decentralized ownership by revenue cycle directors and clinical department heads. “As the system director of revenue integrity, I will be looking for accountability from revenue cycle directors and hospital department heads, but yet I have no authority over them,” the survey respondent said. “This will create a challenge.”

See the sidebar below for more changes and improvements survey respondents would like to implement. ■

A LOOK AHEAD

Revenue integrity doesn’t stand still. There are always new projects, initiatives, and requirements to implement, processes to monitor, and areas to improve. To find out what program goals revenue integrity professionals are working toward, NAHRI asked respondents of the 2022 State of the Revenue Integrity Industry Survey what changes they’d like to implement. Here’s some of what they told us:

- Central controls over charge capture.
 - Increase charges dropped from documentation.
 - Improve communication with providers and residents/interns to get them to understand we are not trying to tell them how to practice but to document what they are currently thinking and not just cutting and pasting information that does not explain what is currently being treated.
 - I would like to see our revenue integrity department/program have ownership over the charge description master content and auditing processes.
- Without this oversight, there are controls lacking and there is high opportunity for inconsistency across the health system.
- The ability to be more focused and not managing multiple regions and service lines at the same time.
 - I would like to bring all revenue integrity functions under one team to start collaboration, focus points for KPI goals as one team.
 - More standard workflows and accountability processes and escalation.
 - I would like to add revenue integrity analysts and implement more fully standardized charge
- reconciliation practices across our health system.
- More flexibility to audit, research, and educate, with less manual work for the departments who need help capturing charges or resolving edits.
 - Expanded coding presence in clinical departments to help address revenue concerns at the clinic level.
 - Develop a better audit program and develop payer scorecards for contract negotiations.
 - I wish that revenue integrity had the ability to hold individual department leadership accountable for their roles in the charging process when there is pushback from the department.
 - Staffing levels based on the entirety of our work, not just the productivity levels that are captured by the automated system of how many accounts we work per day.
 - More staffing to support additional education efforts. ■