
# STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY

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# STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY

In the spirit of Revenue Integrity Week, which is designed to celebrate the diligence and dedication of revenue integrity professionals, NAHRI's State of the Revenue Integrity Industry Survey once again took a deep dive into the roles of revenue integrity professionals, the activities they are responsible for, and the backgrounds from which they came. Though many respondents have been performing duties that align with revenue integrity work for upwards of decades, established revenue integrity titles and roles have been around for a shorter period. As we compare results from last year, we can only begin to see a shift as facilities establish departments and programs and further define revenue integrity.

## Background and experience

The revenue integrity profession is made up of a variety of titles and a wide range of experience. As a starting point to investigate a move toward standardization in the healthcare industry, we asked respondents to list their titles. The top responses were as follows (see Figure 1 for a detailed breakdown of responses):

- Revenue integrity director (16%)
- Revenue integrity manager (13%)
- Revenue integrity analyst (8%)
- Coding manager or director (7%)
- Revenue integrity coordinator (6%)
- Chargemaster coordinator or analyst (6%)
- Compliance auditor or specialist (6%)
- Other (13%)

While revenue integrity director remains the most common title compared to 2018, notable changes from last year's survey show a jump in respondents with the title revenue integrity manager from 7% to 13%. The title of chargemaster coordinator or analyst has dropped from 9% of respondents in 2018 to 6% in 2019. Revenue integrity specialist came in at 7% of respondents in 2018 and only 3% in 2019.

Respondents who checked off their title as "other" were asked to specify their title in an open-ended field, which yielded the following responses:

- Accounts receivable coordinator
- Assistant vice president of revenue integrity
- Coder
- Data scientist
- Director of nursing
- Educator
- Executive director of revenue integrity
- Finance director
- Front office
- Inpatient coder
- Laboratory billing coordinator
- Medical biller/QA
- Nurse auditing director
- Officer of revenue integrity
- Patient financial services supervisor
- Regional director, reimbursement
- Reimbursement analyst

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

| | |
|---|---|
| Revenue integrity director | 16% |
| Revenue integrity manager | 13% |
| Revenue integrity analyst | 8% |
| Coding manager or director | 7% |
| Revenue integrity coordinator | 6% |
| Chargemaster coordinator or analyst | 6% |
| Compliance auditor or specialist | 6% |
| Revenue cycle director | 4% |
| Clinical documentation improvement specialist | 4% |
| Revenue integrity specialist | 3% |
| Revenue integrity nurse | 2% |
| Revenue cycle analyst or specialist | 2% |
| Revenue cycle manager | 2% |
| President or vice president of revenue cycle | 2% |
| Consultant | 2% |
| President or vice president of revenue integrity | 2% |
| HIM manager or director | 1% |
| CFO | 1% |
| CEO | 1% |
| Other | 13% |

Source: 2019 State of the Revenue Integrity Industry Survey

- Reimbursement manager
- Revenue integrity consultant
- Senior coding analyst
- Senior director of revenue integrity
- Vice president of quality and value-based care

## Compared to last year, there is less variety among settings, which may indicate a trend in hospital mergers.

Close to two-thirds of respondents (63%) work in acute care hospitals, an increase from 55% in 2018, and the remainder work in the following settings:

- Critical access hospital (6%)
- Consulting (5%)
- Physician practice (5%)
- Skilled nursing facility (1%)
- Multi-specialty clinic (1%)
- Children's hospital (1%)
- Other (16%)

Among respondents who selected "other," 69% reported working for a health system. Others were more specific about their facility type, including teaching hospital, community hospital, and university healthcare network. Compared to last year, there is less variety among settings, which may indicate a trend in hospital mergers.

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

| | |
|---|---|
| Less than 1 year | 11% |
| 1–2 years | 12% |
| 3–5 years | 32% |
| 6–10 years | 22% |
| 11–15 years | 7% |
| 16–20 years | 8% |
| More than 20 years | 9% |

Source: 2019 State of the Revenue Integrity Industry Survey

Out of those respondents who do work in a hospital setting, about 38% work in a facility with 500 or more beds. This is similar to last year's findings, where 34% worked at 500+ bed facilities.

Because revenue integrity is still a relatively new term in hospital departments, most respondents (77%) have been in their current role for 10 years or less, and 55% have been in their role for five years or less. This is a decrease from last year's survey, where 62% of respondents had been in their role for five years or less. This trend is likely to continue as revenue integrity departments become more established. One the other end of the scale, 7% have held their position for 11–15 years, 8% for 16–20 years, and 9% for more than 20 years. As expected, these numbers are similar to 2018's results. See Figure 2 for more details.

Although job titles and departments may be shifting, 24% of respondents answered that they have more than 20 years of experience as a revenue integrity professional. Overall, 73% of respondents have six or more years of revenue integrity experience. The overall breakdown of experience was as follows:

- Less than one year (8%)
- 1–2 years (5%)
- 3–5 years (15%)
- 6–10 years (21%)
- 11–15 years (13%)
- 16–20 years (15%)
- More than 20 years (24%)

When asked if you consider yourself a revenue integrity professional, of the respondents who wrote in a response, an overwhelming majority (87%) answered yes. Of those who did not respond affirmatively, most had another clearly defined role, and the remaining respondents mentioned being in transition or still working on getting a defined revenue integrity role at their facility.

This wealth of experience is coming from a variety of backgrounds. When asked to provide the healthcare field that best aligns with their background, the top answer was chargemaster at 16%, which is down from 20% in 2018. Other top answers include:

- Nursing (17% in 2019, up from 14% in 2018)
- Coding (14% in 2019, up from 7% in 2018)

- Patient financial services (10% in 2019, down from 15% in 2018)
- Health information management (9% in 2019 and 2018)
- Other (8% in 2019)

Among those respondents who chose other, backgrounds include clinical, managed care, patient access, or a combination of the listed categories. See Figure 3 below for more information.

Many of the respondents are credentialed, with the two most commonly held credentials being CPC (26%) and RN (26%). The other most commonly held credentials are CCS (17%), RHIA (16%), CCDS (10%), and COC/CPC-H (9%). This breadth of credentials speaks to the wide range of backgrounds that come together in the field of revenue integrity and the years of education and training among its workforce. See Figure 4 for more detail.

## Dedication to revenue integrity

Given the variation in the way revenue integrity is addressed in the healthcare industry, NAHRI also asked respondents to indicate whether their facility has a dedicated revenue integrity staff, program, department, or committee, as well as whether there is a budget for revenue integrity education opportunities.

Most facilities have dedicated revenue integrity staff members (70% in both 2019 and 2018). It is less common to have a department, program, or committee. Approximately 61% of respondents have a revenue integrity department, which is similar to last year's findings (60%). Approximately 33% of respondents have a revenue integrity program and 22% have a revenue integrity committee. Only 25% of respondents said they have a budget for revenue integrity education, which is down from 29% of respondents in the 2018 survey.

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

| | |
|---|---|
| Nursing | 17% |
| Chargemaster | 16% |
| Coding | 14% |
| Patient financial services | 10% |
| Health information management | 9% |
| Billing | 7% |
| Auditing | 6% |
| Finance | 6% |
| Clinical documentation improvement | 4% |
| Case management | 2% |
| Compliance | 1% |
| Consulting | 1% |
| Other | 8% |

Source: 2019 State of the Revenue Integrity Industry Survey

Figure 4. **Do you hold any credentials?** (Multi-response)

| | |
|---|---|
| RN | 26% |
| CPC | 26% |
| CCS | 17% |
| RHIA | 16% |
| CCDS | 10% |
| COC/CPC-H | 9% |
| RHIT | 8% |
| CHC | 4% |
| CPMA | 4% |
| CHFP | 3% |
| CHRI | 2% |
| CCA | 2% |
| CPC-I | 2% |
| CPHQ | 2% |
| CCS-P | 2% |
| CRCS | 2% |
| CRIP | 1% |
| CIC | 1% |
| CHCAF | 1% |
| Other | 35% |

Source: 2019 State of the Revenue Integrity Industry Survey

"These lack of adequate budget for education does not surprise me but it certainly disappoints me," says **Ronald Hirsch, MD,** vice president at R1 RCM in Chicago.

In response to this question about having a dedicated department, one respondent said of revenue integrity at their facility: "Unfortunately, it appears that these [revenue integrity] functions are not clearly known to us in the corporate compliance dept. It is fragmented and not shared so that everyone is aware of the processes or the individuals responsible for those processes."

Given the similarity to last year's results, this shows that many revenue integrity professionals are without a structured department or program to offer guidance and

support. And even fewer revenue integrity professionals are being funded for revenue integrity training and education, which indicates that many are footing the bill themselves or have been put in a position to learn as they go at their workplace. We noted the concern of this lack of funding in our 2018 report, and the decrease in funded departments and programs may indicate that budgets are tightening even more.

Among those who do have a revenue integrity department at their facility reported the following benefits:

- "Decrease in missed charges, more efficient workflows for charge capture, accurate understanding of compliant billing practices."
- "We are collecting more revenue due to understanding payer contracts and reporting charges per contract terms."
- "Increased revenue and decreased length of stay with the integration of utilization review. Documentation improvement with nurses reviewing diagnoses related claim edits."
- "Timely charge review, faster claim edit resolution, reduction of late charges, increase in dept involvement in charge capture with education from RI associates, input in to systematic corrections, reduced DNB days."
- "Increased charge capture, decreased denials, improvements in efficiencies across the system."
- "Identify trends in more timely fashion. Identify/correct data prior to claim submission—reducing rebills. Reducing denials. "

## Primary and supporting functions of revenue integrity

**"In our eyes, the primary function of revenue integrity is to compliantly ensure organizations are being optimally reimbursed by providing an additional layer of support to each of the various front-, middle-, and back-end revenue cycle processes. For example, middle processes revolve around account coding and charging, but extra effort is needed to keep up with the intricacies surrounding new CMS updates and regulatory changes in real time. In this case, the primary function of**

# 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:

- "Understanding the value of the processes performed by revenue integrity and adequately staffing to be able to adequately cover the needs imposed on revenue integrity throughout the organization."
- "Getting department directors to care about charges."
- "Administration and management's lack of knowledge of what a revenue integrity department can do."
- "Keeping up with the workload and changes."
- "Finding qualified people."
- "We need a dedicated team/department to allow standardization and coordination."
- "Support from leadership. Lack of understanding of the relevance/need for a revenue integrity department."
- "Lack of team members to perform all needed functions of a revenue integrity department."
- "We are a low-income hospital. Our challenge is keeping our prices low but fair and yet high enough to stay in business."
- "Ever changing regulations, commercial insurance rules."
- "Ensuring revenue-generating departments reconcile their charges daily."
- "With a clinically-driven revenue cycle it is often difficult to get the data and support to produce a clean, complaint claim."
- "Keeping the organization educated on complexity of systems, processes, structure, and payer variables."
- "Developing a robust revenue integrity program due to lack of resources and/or guidance and support."

Source: 2019 State of the Revenue Integrity Industry Survey

**revenue integrity would be to support these middle processes with retrospective reviews that incorporate real-time regulatory updates and ensure HCPCS, ICD codes, and charges are accurately billed."**

*— Andrew Stieve, vice president, revenue integrity, R1 RCM*

We asked the respondents who stated that their organization has a revenue integrity department or program to identify the functions they are responsible for at their facility. The responses to this question show the breadth of responsibilities that revenue integrity professionals take on at their facilities. Of the 172 respondents, 80% included chargemaster maintenance as one of their responsibilities. This is similar to the 2018 survey.

Other functions revenue integrity departments are responsible for include:

- Charge capture: 77%
- Chart auditing: 61%
- Correcting claim edits: 55%
- Denials management: 51%
- Education: 50%

For the full list of responses, see Figure 5. Some respondents wrote in revenue integrity functions that did not appear on the list, including reimbursement, payer contracting, data analytics, utilization review, managed care contracting, fee schedule, and physician advisor services. Multiple respondents reported that they were responsible for all of the above.

We also sought to identify those tasks for which the revenue integrity department would assist but may not have full oversight of. Compare the results in Figure 6 with Figure 5, and you can see that the list of revenue integrity

*Continued on page 9*

Figure 5. **If you have a revenue integrity department or program, what functions is the department or program responsible for at your organization?** (Multi-response)

| | 2019 | 2018 |
|---|---|---|
| Chargemaster maintenance | 80% | 79% |
| Charge capture | 77% | 73% |
| Chart auditing | 61% | 60% |
| Correcting claim edits | 55% | 49% |
| Denials management | 51% | 46% |
| Education | 50% | 62% |
| Claims auditing | 43% | 42% |
| Internal audit/compliance | 42% | 43% |
| Coding | 35% | 27% |
| Compliance | 35% | 43% |
| Claims/payment reconciliation | 34% | 20% |
| Quality | 29% | 19% |
| Clinical documentation integrity | 28% | 32% |
| Patient billing | 24% | 10% |
| Decision-support functions | 23% | 32% |
| Insurance verification | 18% | 8% |
| Registration functions | 14% | 6% |
| Financial counseling | 12% | 7% |
| Other | 10% | 14% |

Source: 2019 State of the Revenue Integrity Industry Survey; 2018 State of the Revenue Integrity Survey

Figure 6. **If you have a revenue integrity department or program, what functions do you assist with, act as a resource, or support?** (Multi-response)

| | 2019 | 2018 |
|---|---|---|
| Charge capture | 63% | 68% |
| Denials management | 60% | 60% |
| Chart auditing | 56% | 46% |
| Correcting claim edits | 56% | 55% |
| Chargemaster maintenance | 54% | 58% |
| Coding | 51% | 59% |
| Internal audit/compliance | 50% | 47% |
| Education | 50% | 60% |
| Claims auditing | 45% | 43% |
| Compliance | 44% | 55% |
| Clinical documentation integrity | 40% | 46% |
| Quality | 39% | 30% |
| Patient billing | 38% | 45% |
| Claims/payment reconciliation | 32% | 32% |
| Decision-support functions | 28% | 38% |
| Insurance verification | 19% | 11% |
| Registration functions | 18% | 18% |
| Financial counseling | 15% | 11% |
| Other | 6% | 9% |

Source: 2019 State of the Revenue Integrity Industry Survey; 2018 State of the Revenue Integrity Survey

SPECIAL FEATURE

# OPTIMIZING REVENUE INTEGRITY INITIATIVES WITH A FOCUS ON PAYER CONTRACTS

**ANDREW STIEVE,** vice president, revenue integrity solutions at R1 RCM

It's no secret that one of the most challenging aspects in revenue cycle management is keeping track of the numerous complexities associated with managed care contracts. Getting it right (or missing the opportunity) can greatly impact revenue integrity initiatives and financial performance—both positively and negatively.

By not carefully monitoring payer contracts at every step opens the door for payers to process accounts without thoughtful consideration to the contractual obligation to which they have agreed.

Despite the risk, many providers are still using manual processes to try to stay afloat among payers' complicated multi-tiered structures and rules that seem to always be changing. Pricing may be off against competitors in the market, and either direction (too high or too low) poses problems as marketing services and consumer choice become more prevalent. Another unintended and far-reaching result is that the cost to provide services could exceed the reimbursement received, therefore increasing charges. This could unduly put more financial responsibility onto the patient.

When considering your revenue integrity program, a focus on payer contracts can improve your revenue lift and compliance:

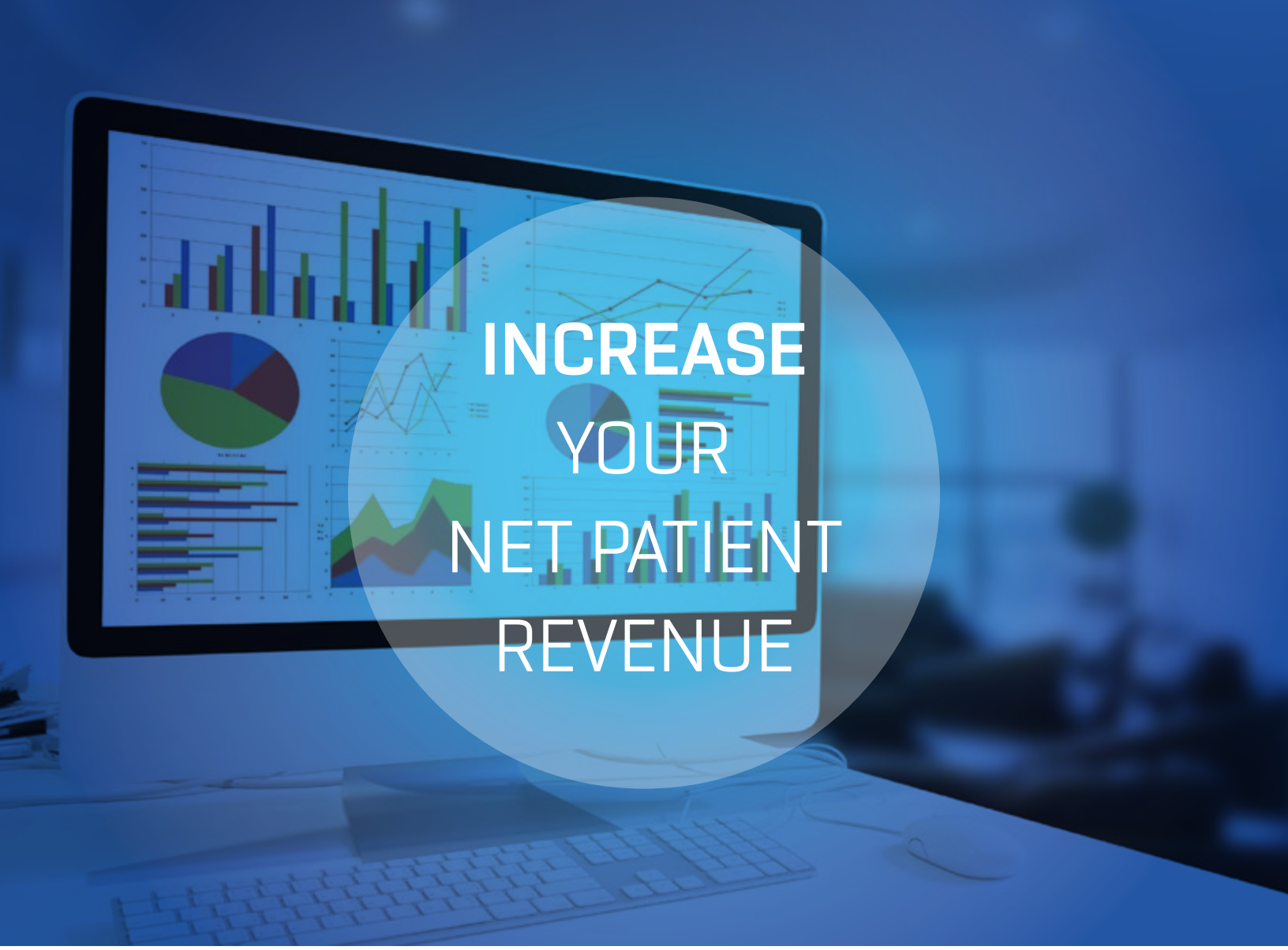
1. **Ensure you are keeping up with revenue carveouts in your contracts.** Implement a process to highlight these scenarios and determine the proper revenue code to CPT/HCPCS alignment. There may be situations where your contract specifies certain revenue code assignments that allow for higher reimbursement. Typically filtering charges through a robust set of rules that takes detailed and current payer contract data into account can assist in this endeavor.
2. **Ensure the contract is correctly modeled according to the hierarchy of services provided.** Determine a clearly defined process to ensure maintenance of the contracts are completed in a timely manner. This includes reviewing specific account detail information and comparing it to payer payments.
3. **Use contracts to better understand how changes in prices impact reimbursement across all of your payers.** Analyze the gross and net revenue for a price change to validate how the negotiated rate impacts the organization as a whole. Showing a comprehensive view of impact across all payers can aid in contract negotiations to leverage key areas of sensitivity.
4. **Gain a national view of payer rates.** Gain the requisite knowledge to seek leverage at the negotiating table to show solid proof as to why the reimbursement should differ from the proposed rate a payer is offering. The reliance on individual market leaders and managed care analysts to determine rates can be a limiting factor. Understanding national market conditions provides improved support as to why the reimbursement should differ from the proposed rate a payer is offering.
5. **Look for opportunities related to reimbursement caps.** When reimbursement for a service is more than the total dollars billed, the payer often caps reimbursement to the amount of the total charge. A simple increase in the chargemaster could provide additional reimbursement if it aligns with the overall pricing strategy.
6. **Develop a feedback loop that highlights opportunities for correcting payments going forward.** As with many parts of the revenue cycle, identifying root cause of problems is an excellent way to prevent future occurrences. Dealing with payers and payer contracts is no different.

These steps can bolster the success of any revenue integrity program and ensure more complete payment for services provided. ■

## R1 Revenue Integrity Solutions Description

R1 Revenue Integrity Solutions leverage advanced technology and analytics, a proprietary rules engine, and extensive project management and healthcare expertise to help providers gain accurate reimbursement for the care provided. Building solid and compliant foundations for pricing, coding and charging while monitoring reimbursements for accuracy is at the core of any revenue integrity initiative. R1 Revenue Integrity Solutions include:

- Chargemaster Optimization
- Charge Capture
- Contract Management and Modeling
- HIM Coding Reviews
- Transfer DRG Reviews
- Payment Variance Analysis
- Strategic Pricing and Modeling




R1 Revenue Integrity Solutions provide a holistic approach to revenue cycle transformation. Our solution combines advanced technology, robust analytics, a proprietary rules engine and a seasoned team of RCM experts to ensure providers get accurate reimbursement of the care they provide. From scheduling to patient access through claims and reimbursement, R1 can help you manage your revenue cycle from end to end or any part in between.

CHARGE CAPTURE

CHARGEMASTER OPTIMIZATION

PAYMENT VARIANCE ANALYSIS

STRATEGIC PRICING

HIM CODE/CHARGE RELATIONSHIPS

TRANSFER DRG REVIEW

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functions expands when departments and programs assist or act as a resource. Notably, 51% of respondents assist with coding, compared to 35% of respondents marking it as a department responsibility; 38% assist with patient billing, compared to 24% for whom it was a responsibility; 40% assist with clinical documentation integrity, compared to 28% responsible; 44% assist with compliance, compared to 35% responsible; and 60% assist with denials management, while 51% are responsible.

Additional responsibilities that respondents assist with include managed care contracting, contract management/expected reimbursement, system design, payer enrollment, budget, reimbursement, and payer contracting.

Noting the benefit of establishing a revenue integrity committee to oversee the breadth of revenue integrity functions, one respondent stated, "We are just starting a committee to include chargemaster coordinator, HIM director, controller, business office director, and Epic director. So far, we seem to be engaged with new procedures, coding, charges, and education."

## Revenue integrity department structure

Revenue integrity departments vary in size, so we asked respondents how many full-time employees (FTE) their department supports. Results were similar to last year's findings, with the two most common department sizes being 2–4 employees (25% of respondents, the same as in 2018) and more than 20 (22% of respondents, up from 20% in 2018).

It may be the case that revenue integrity departments are just starting to form and may grow in the future, but numbers are similar to last year's findings. The breakdown of the remaining department sizes is as follows:

- 5–7 FTEs (17%)
- 8–10 FTEs (12%)
- 11–15 FTEs (12%)
- 0–1 FTEs (7%)
- 16–20 FTEs (5%)

In terms of reporting structure, most respondents stated that their revenue integrity department reports up to the vice president or director of revenue integrity (48%). This is down slightly from 50% in 2018, but results were generally similar to last year's findings. Other revenue integrity professionals report to a chief financial officer (23%), vice president or director of finance (10%), HIM director (3%), compliance director (3%), and chief executive officer (1%).

**One respondent stated that their reporting structure was split, with part of the team reporting to the CFO and part to the financial management director.**

Approximately 13% of respondents reported a different structure, writing in to specify who their department or program reports up to. Some of the roles listed include: chief operations officer, vice president of revenue cycle, vice president of quality, executive director, vice president of patient financial services, director of professional billing, patient business services director, decision support director, and director of hospital CDI, coding, and revenue integrity. One respondent stated that their reporting structure was split, with part of the team reporting to the CFO and part to the financial management director. Another respondent at a large healthcare system reported that the various facilities in different regions have different reporting structures.

Finally, we asked respondents with a dedicated revenue integrity team to provide a little insight about their internal structure, asking how frequently regularly scheduled revenue integrity team, committee, department, or task force meetings occur. Results were as follows:

- Monthly: 37% (44% in 2018)
- Weekly: 24% (26% in 2018)
- Do not have regularly scheduled revenue integrity meetings: 24% (20% in 2018)
- Quarterly: 5% (10% in 2018)
- Other: 10%

Among those who responded other, the most common responses were bi-weekly or every other week. One respondent said it varies depending on need. Another respondent reported that the revenue integrity team meets weekly and the committee meets monthly.

## Chargemaster maintenance and price transparency

It's no secret that chargemaster maintenance is one of the essential functions of revenue integrity as is evidenced by the fact that 79% of respondents listed it as a primary function of revenue integrity in our 2019 and 2018 surveys.

As a result of the role chargemaster maintenance plays in overall revenue integrity and the emphasis placed on price transparency over the past year, we dug a bit deeper into the chargemaster in this year's survey starting with a look into the overall structure of chargemaster maintenance. More than half (55%) of 2019 respondents stated that a team is responsible for the maintenance, which remained unchanged since 2018. However, this year we drilled down into alternative forms of maintenance by looking at the potential role of outsourcing or relying on consulting firms for maintenance. No dice there. Just 4% of respondents stated that a hybrid of internal staff and external consulting personnel are responsible for chargemaster maintenance with no one reporting that outsourcing is used. More than one-quarter of respondents (29%) stated that a single person is responsible for chargemaster maintenance rather than a team (see Figure 7 below for more information).

Changes to chargemaster order sets typically fall to revenue integrity as well, according to 45% of respondents, although some facilities opt to have this work completed by IT (22%), the director of the department to which the charges are applicable (15%), or clinical staff (4%).

Figure 7. **Chargemaster maintenance—How is your chargemaster maintenance structured?**

| | |
|---|---|
| A team is responsible for chargemaster maintenance | 55% |
| One person is responsible for chargemaster maintenance | 29% |
| A hybrid of internal staff and external consulting personnel | 4% |
| The department director/representative is responsible for the structure and codes with the line items entered by a data entry specialist | 3% |
| It is outsourced | 2% |
| Other | 7% |

Source: 2019 State of the Revenue Integrity Industry Survey

Figure 8. **Chargemaster approval—How is your chargemaster approval process structured?**

| | |
|---|---|
| Individual requests are sent to a central person | 30% |
| All of the above | 17% |
| Individual requests are routed to a team for approval (e.g., finance for pricing, HIM for coding) | 16% |
| A hybrid approach that uses chargemaster software and a central contact person | 14% |
| Automated approval process via chargemaster software | 9% |
| Other | 14% |

Source: 2019 State of the Revenue Integrity Industry Survey

Chargemaster approval processes remained relatively unchanged year over year with the plurality of respondents (30%) again stating that individual requests are sent to one person (see Figure 8 above for more information).

Starting January 1, hospitals were required to post a list of their standard charges on the internet. CMS enacted this policy in the name of price transparency, but for hospitals, and potentially the public, it may have raised more questions than it answered. To understand how this requirement changed chargemaster processes and perspectives, we asked survey respondents how their facilities adapted to the new requirements.

Now that the chargemaster is online for anyone to view, we asked whether facilities are tracking who views their public list of items and services. More than half (51%) of respondents stated that they do not currently track this information and have no plans to do so. However, the other half of respondents either had plans to one day track this information (37%) or already track it (12%). The small fraction who have already started tracking who views and downloads their information found that viewership was a mixed bag. Respondents were asked to select all applicable viewers seen in the mix, including the following:

- Patients (28%)
- Payers (28%)
- Local media (20%)
- Consultants (20%)
- Other providers (12%)
- National media (4%)

"In preparation for an upcoming presentation, I reviewed the publicly available chargemaster for several

hospitals," says Hirsch. "And not one site required me to declare who I was or why I was looking. So, it is unclear to me how these hospitals knew who was viewing their chargemaster. And as expected, in most cases the information was nearly indecipherable with many service names abbreviated and only about half including HCPCS codes."

Curiosity is only natural, so we also wondered whether revenue integrity professionals were looking to neighboring facilities to see how they stack up. Nearly half of respondents (49%) admitted to comparing their own charges to that of a neighbor. When asked what sparked their curiosity, professionals wrote in to state they were interested in the following:

- "Use to do comparisons for pricing to make sure we remain in the ballpark and also use as a mechanism for room and board pricing."
- "Looking at tests that patients may shop around for."
- "Seeing what other hospitals offer for services."
- "Determining whether other hospitals posted by CPT/HCPCS or MS-DRG."
- "Reviewed other local hospitals for pricing of high-volume services and to see if there are any services that they may be charging for that we are not."

So what method are facilities using when posting their chargemaster? We were just as curious as some of our write-in respondents who peeked at their neighbors' data, so we dug in.

Another new question this year centered on what facilities included on their public list of items and services.

Figure 9. **Public list of items and services—Which of the following did you include in your public list of items and services?** (Multi-response)

| | |
|---|---|
| All supplies | 57% |
| All drugs | 54% |
| CPT/HCPCS codes | 52% |
| Charges by MS-DRG | 38% |
| A summary of drugs by HCPCS or drug name | 20% |
| Zero priced items | 18% |
| A summary of supplies by HCPCS code | 14% |

Source: 2019 State of the Revenue Integrity Industry Survey

The top three responses included all supplies (57%), all drugs (54%), and CPT/HCPCS codes (52%) (see Figure 9 for more information).

"I found the percentage—52%—of facilities posting CPT/HCPCS codes in response to the price transparency initiative to be higher than I would have expected, and the number reporting all supplies—56%—to be low, especially since the CMS criteria stated in its FAQs document that hospitals must make public a list of their standard charges for all items and services provided," says **Sarah L Goodman, MBA, CHCAF, COC, CCP, FCS,** president/CEO of SLG, Inc., in Raleigh, North Carolina.

**Curiosity is only natural, so we also wondered whether revenue integrity professionals were looking to neighboring facilities to see how they stack up.**

When looking into the use of HCPCS codes for drugs and supplies, the majority of respondents (88%) will assign HCPCS codes to all drugs and supplies when one exists.

For respondents who posted charges by MS-DRG, we sought to explore which method they chose to do so. An average of one quarter of respondents chimed in on this question with half of that group (50%) stating that their charges posted by MS-DRG were based on an average. Just 8% based their posting on the median and just 6% on the range. However, 16% of respondents who answered this question considered the range, average, and median when posting charges by MS-DRG. The remaining 20% of respondents indicated they use other methods, which they were asked to write in, the majority of which indicated the respondent does not know which method was used or their facility is not posting by MS-DRG at this time.

"What I'm most curious about is whether the Medicare price transparency initiative will force hospitals to really understand all of the rules around setting charge/prices for new technology type services such that hospitals use appropriate mark-ups without fear of repercussions because without setting appropriate charges and

involve understanding your own overall cost to charge ratio, hopitals may be leaving money on the table which will impact their reimbursement today for certain types of service, and will surely impact future reimbursement since CMS uses historical claims to set future payment rates," says **Jugna Shah, MPH,** president of Nimitt Consulting, Inc., in Spicer, Minnesota. "It's incumbent on hospitals to understand provider charging rules and how they can charge all payers the same while actually sending out bills to payers that have varying charges for a single drug or device etc. Understanding all of this is critical in light of the more costly, more innovative therapies coming to market."

Also new to this year's survey were questions about miscellaneous charge numbers. Materials management/central supply (59%) and pharmacy (58%) topped the list of departments that have a miscellaneous charge number that can be used for new items/services that don't have a permanent chargemaster number (see Figure 10 below for more information). Approximately 35% of respondents who use miscellaneous charge numbers do so until someone reviews the activity whereas others set a two-week (16%) or 30-day (11%) time limit before requiring a permanent number. The remaining respondents use other approaches that they described, including the following:

- "Trial items will not get a permanent number in materials management until it becomes a stocked item."
- "Certain items are left in the miscellaneous number and updated when used for the specific supply."
- "If the item is billed more than five times in a year, it becomes a CDM number."

Figure 10. **Miscellaneous charge numbers—Which departments have a "miscellaneous" charge number that can be used for new items/services that don't have a permanent chargemaster number?** (Multi-response)

| | |
|---|---|
| Materials management/central supply | 59% |
| Pharmacy | 58% |
| Laboratory | 47% |
| Surgery | 42% |
| Sterile supply | 26% |
| Cath lab/EP lab | 21% |
| Radiology/Interventional radiology | 21% |

Source: 2019 State of the Revenue Integrity Industry Survey

This year's survey examined exploding charges, panel charges, and other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate. Most respondents (71%) use such charges and of those using them more than half (60%) update the charges annually.

**Pre-billing holds can help ensure accounts are accurate before they go out the door but failure to properly define pre-billing processes can often do more harm than good.**

## Billing and charging processes

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

Pre-billing holds can help ensure accounts are accurate before they go out the door but failure to properly define pre-billing processes can often do more harm than good. When looking at the method by which facilities target a pre-billing hold, responses remained relatively unchanged since 2018. More than half of 2019 respondents (57%) stated they perform a pre-billing hold that is targeted for a specific scenario (e.g., inpatient-only procedures on outpatient claims, certain DRGs) compared to 62% who reported this method in 2018. The percentage of respondents who perform a random pre-billing hold rose from 5% in 2018 to 9% in 2019. The remainder of respondents either forgo the hold or wrote in to specify the rules around their hold, which include the following:

- "All accounts are held for four minimum days unless a software edit is triggered."

- "We have a pre-billing hold for specific payers, along with some across all payers, and some that are targeted for a scenario."

Digging a bit deeper into these practices, more than half of respondents who have a pre-billing hold (51%) stated that it lasts 3–4 days.

When it comes to processing late charges, nearly half of respondents (40%) stated they process all late charges whereas 32% process only those that exceed an internally set threshold. This is a shift from 2018 when 32% processed all late charges whereas 40% processed only those that exceeded an internally set threshold (see Figure 11 below for more information).

But what exactly is a late charge? The answer can vary based on the facility, but more than half of our respondents (54%) stated that they define a late charge as being more than three days from the date of service, which was also the standard definition of the plurality (47%) of 2018 survey respondents (see Figure 12 for more information).

Much like last year, HIM is still the go-to when it comes to resolving coding claim edits despite a slight drop (33% in 2019 versus 38% in 2018), which may be due in part to an increase in the percentage of respondents saying several departments (i.e., HIM, compliance, business office, revenue integrity) work together for a resolution (30% in 2019 versus 23% in 2018).

Clinical staff are sometimes tasked with entering their own charges, but limitations are typically applied. For example, clinical staff at respondents' facilities are not permitted to enter the following charges:

- Emergency department (31%)
- Observation (30%)
- Drug administration (6%)
- Other (33%)

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

- Vaccine administration
- Respiratory therapy
- Surgery
- Wound care
- Pain
- Professional fees

Daily charge reconciliation is a critical part of ensuring that charges are correct and charge capture processes are working well. A little more than half (51%) of respondents indicated that revenue integrity has some level of involvement in departments' daily charge reconciliation:

- 30% reported that operational departments are responsible for daily charge reconciliation with regular support from assigned revenue integrity staff
- 14% said that some departments are responsible for their daily charge reconciliation while others are centralized under revenue integrity
- 6% indicated that daily charge reconciliation is centralized under revenue integrity

The remainder (50%) responded that operational departments are responsible for their own daily charge reconciliation.

When it comes to resolving device-to-procedure and procedure-to-device edits, revenue integrity takes the lead with 42% of respondents reporting that responsibility for resolving these edits falls to revenue integrity. However,

## Figure 11. **Processing late charges—Does your facility process all late charges?**

| | 2019 | 2018 |
|---|---|---|
| Yes, we process all late charges | 40% | 32% |
| We only process late charges that exceed an internally set threshold | 32% | 40% |
| We only process late charges if separate payment is involved with the charge | 16% | 14% |
| We only process late charges from certain payers | 2% | N/A |
| Other | 10% | 14% |

Source: 2019 and 2018 State of the Revenue Integrity Industry Survey

## Figure 12. **Time frame for late charges—What is the time frame for charge entry before it is considered a late charge at your facility?**

| | 2019 | 2018 |
|---|---|---|
| More than three days from date of service | 54% | 47% |
| Three days from date of service | 40% | 38% |
| One day from date of service | 5% | 6% |
| Two days from date of service | 1% | 9% |

Source: 2019 and 2018 State of the Revenue Integrity Industry Survey

20% indicated that responsibility falls to the department where the patient was treated while 15% said the task falls to HIM and 12% reported those edits are handled by the business office. The remainder (10%) said that the responsibility falls to another department. Of those who responded "other," the following responses were reported:

- "Revenue integrity for surgery, interventional radiology and cath lab their own centralized audit staff."
- "Edit is worked by the business office, but then sent on to either the service department or revenue integrity."

To help us dig into edit resolution, respondents were asked to describe their process for reviewing claims that contain a device dependent procedure to ensure the appropriate reporting of supply/implant HCPCS C-codes. The majority (83%) indicated the claim is only reviewed if the claim hits an edit for lack of a device or procedure code and that claims are not reviewed if they pass the edits. Other respondents indicated they use the following processes:

- We review a sample of claims on a monthly basis (8%)
- We review a sample of claims on a quarterly basis (6%)
- We look at issues that are found on our annual audit (3%)

Most (55%) respondents reported that they have some method for reviewing claim edit patterns to identify root causes and resolve them before claims reach the billing process. Respondents were asked to write in to describe their process. Of those who wrote in, some reported the following processes:

- "Currently, we meet with our system vendor and bill scrubber vendor once a week to work on resolution of edits."
- "Reports from claims scrubber give detail reviewed by business office coordinator."
- "Revenue Integrity staff work with the billing office to troubleshoot and resolve as necessary."
- "When a pattern is discovered, we work to create processes within our software that will eliminate the situation (i.e., work queues, modifiers, etc.)."

Those who indicated that they have a process for reviewing claim edit patterns were asked to select from a list of departments that might be involved in the review. The majority (81%) selected revenue integrity. Additional departments are as follows:

- Business office (64%)
- HIM (59%)
- The department where the patient was treated (46%)
- IT (23%)
- Compliance (19%)

Staying on top of payer billing instruction updates is a team sport, according to survey respondents. When asked what department is responsible for monitoring and communicating information about updates to payers' billing instruction, most (41%) said that revenue integrity, compliance, HIM, and the business office share responsibility. Of those who assigned primary responsibility to a single department, revenue integrity is the go-to choice for 24% of respondents. See Figure 13 for more information.

Figure 13. **Who is responsible for monitoring and communicating information at your facility when payers update their billing instructions** (e.g., annual OPPS updates, CMS transmittals)**?**

| | |
|---|---|
| Revenue integrity | 24% |
| Business office | 19% |
| Compliance | 6% |
| Health information management | 2% |
| All of the above | 41% |
| N/A - Individuals are responsible for keeping up with changes on their own | 8% |

Source: 2019 State of the Revenue Integrity Industry Survey

## Auditing functions

Practices around auditing remained relatively unchanged from 2018 to 2019 with 35% of respondents year over year stating that revenue integrity has oversight of determining which areas will be audited. To a lesser extent, facilities may place this responsibility in the hands of compliance (14%) while 6% of respondents said audits are performed by request rather than by the oversight of a department or committee.

*Continued on page 21*

# Q&A: BILLING AND CHARGING

Billing and charging processes are at the heart of revenue integrity but creating replicable, compliant processes that suit a particular organization can be challenging. As part of the second annual Revenue Integrity Week, NAHRI conducted an interview with NAHRI Advisory Board member **Denise Williams, COC,** senior vice president of the revenue integrity division and compliance auditor at Revant Solutions, Inc., in Trussville, Alabama. Williams, a nationally known expert on billing and charging topics, helped NAHRI develop this portion of the survey. For questions, contact NAHRI Editor Nicole Votta at nvotta@hcpro.com.

**Q: What are your overall thoughts on the responses to this section of the survey? Did anything jump out at you as a strong positive or an area of concern?**

**A:** I think it is very positive that the percentage has risen for those that are using the team approach to resolve edits. This suggests that there is a root cause analysis being initiated to correct the reason rather than just resolving the edit for an individual claim. My concern is that some may not understand what a root cause actually is and that it is something that happens upstream, such as missing documentation or a data entry error. Resolving the root cause may mean working with other departments to ensure the error itself is addressed. Root cause analysis isn't just a way to resolve an edit for a subset of claims before they get to the scrubber.

**Q: Pre-billing holds can help hospitals ensure that claims are accurate and complete. But properly defining the parameters of the pre-bill hold can be difficult. What are your recommendations for defining pre-bill holds? Are there any special considerations that come into play?**

**A:** There should be some sort of monitoring and reporting on the types of accounts and situations that cause a claim to be held past the "typical" account hold. An organization establishes a typical account hold period for all accounts to ensure that all charges are captured, HIM has the full complement of documentation from which to code, and to satisfy the one-day or three-day payment window for Medicare outpatients that are readmitted as inpatients.

This window generally is enough time for the above parameters to be met. However, in certain circumstances that typical account hold period isn't long enough. When this happens, it is crucial for the provider to monitor the frequency with which those exceptions occur. Bill hold parameters can be created to be very specific to a scenario that has presented itself. One question to consider is does an additional pre-bill hold component need to be permanent? It is important to get the CFO on board for why claims are being held and why these additional edits are indicated. While they want the claims billed as soon as possible, most are open to considering that a clean claim with all of the components present is worth waiting an extra day or two to receive accurate reimbursement. It is also important to explain, and prove, that the time and resources required to get it right on the front end are less expensive than fixing the claim on the back end. It also raises fewer red flags than submitting and recalling a claim to correct and resubmit.

One consideration is to provide education and feedback to departments regarding improvement in their processes that can stop claims from hitting the same edits over and over. These improvements can be part of departmental Quality Assurance processes and become a "win-win" for the organization. If an edit was created for a specific internal scenario, once the process has been refined and the situation corrected, the edit could be disabled.

**Q: In general, survey respondents report processing all late charges rather than only those that exceed an internally set threshold. What are the pros and cons of each approach? What are the factors that revenue integrity should consider when setting policies for processing late charges? Do you have any best practice recommendations?**

**A:** The processing of late charges is very individual to a provider and based on many criteria as noted in the survey results. The pros of reporting all late charges is that complete cost is reported, which will be considered for future rate setting, whether this be under a CMS methodology or for contract negotiations. The cons of this method are the number of resources that are required to rebill an account multiple times, and this process can raise a red flag to the payer that something is amiss. In addition, the provider can run into timely filing limitations.

Setting a charge threshold can be useful as this prevents the constant reprocessing of a claim. The con is that this keeps all cost from being reported to the payer.

Considerations for either methodology center around the resources required to process late charges, refile a claim, and the amount of reimbursement that will be recouped for the items. Education for the department and charge entry staff should include the ramifications of late charges. When the total cost for what they provided to the patient is not reflected on the claim, this can negatively affect reimbursement – either now or at the next contract negotiation. Department representatives may not always realize that even if they put a charge through, if the charge was late it may not have been submitted to the payer.

Best practice recommendation is that the provider reviews the late charges to identify patterns and possible resolutions. For example, if there is a specific supply item that is constantly being charged late, can it be included in a procedure charge rather than being an individual charge line? One methodology for decreasing the number of chronic late charges is charging the cost of the items back to the department's budget. This typically triggers a very quick process improvement in the department.

**Asking clinical staff to add charge entry on top of caring for patients means that charge entry in many instances gets put on the back burner, as care of the patient is their main focus.**

**Q: Charge entry is critical and according to survey respondents the responsibility for charge entry varies depending on department or service/item. Most respondents said that clinical staff aren't permitted to enter charges for observation or emergency department services, and many wrote in to describe additional charges that clinical staff don't enter. What comes into play when determining charge entry responsibility? What are some of the key steps to creating a process that works for everyone?**

**A:** Clinical staff members are focused on caring for patients. It is more important for staff to thoroughly document the care (i.e., procedures, tests, services, supplies) that is provided and ensure there is a complete physician's order for same. Asking clinical staff to add charge entry on top of caring for patients means that charge entry in many instances gets put on the back burner, as care of the patient is their main focus.

The responsibility for charge entry should lie with staff for whom that is a large part of the focus of their daily responsibilities. This may be staff within the clinical department or the appropriate staff may be in another department.

The separation of responsibility also leads to more accurate reporting of services. Clinicians often may charge based on what they know they did rather than what was documented in the record. Charge entry must be based on the actual documentation, regardless of what additional services and items clinical staff know were provided. In the age of EHRs, it is possible for some systems to tie the charging to the clinical documentation. This is a great mechanism, but best practice is that this process is reviewed at intervals to ensure that the mechanism is working appropriately and is correctly tied to complete and accurate documentation.

**Q: According to survey respondents, revenue integrity plays at least a supporting role in charge reconciliation. What are the benefits of looping revenue integrity into this process? And how can organizations determine what level of involvement is practical?**

**A:** Revenue integrity often holds the key to resolving some charge issues and should be looped into the process. Charge reconciliation processes identify what was not charged but that should have been, what was charged and should not have been, and helps identify items that were charged with a "miscellaneous" charge description master (CDM) item. Revenue integrity is instrumental in educating departments on why a service should/should not be charged separately, and in finding a resolution to report cost without a separate line item. This in turn means there are fewer line items for the department to charge which will decrease the time spent on charge reconciliation.

Revenue integrity should reach out to departments that charge items with a miscellaneous CMD item. By asking questions and providing feedback, revenue integrity can quickly help determine if a CDM number should be created, especially if a HCPCS code is involved. There is also an opportunity for education when departments request a new CDM number for expensive drugs/biologics and those that have a HCPCS code.

**Q: What are some common claim edit pitfalls? Why is it important that organizations have processes for each type of claim edit? In your experience, what are the trickiest types of claim edits that are likely to impact revenue integrity?**

**A:** One of the most common edit pitfalls is applying modifiers -59 or X-{EPSU}. The pitfall lies in the interpretation of "separate and distinct" as providers tend to think of services at the department level rather than at the procedure/service level. The National Correct Coding Initiative (NCCI) Manual contains instructions and information on why certain services are not reported with other services. One example is fluoroscopy performed during any type of endoscopic procedure. NCCI states the fluoroscopy is always integral and not separately reported. However, some providers consider that the fluoroscopy was performed by radiology and the endoscopic procedure was performed by surgery, so the procedures are separate and distinct. This mindset implies that modifier -59 or -XS should be appended to the fluoroscopy code. However, the intent is for the fluoroscopy cost/charge to be included in the procedure cost/charge; therefore, the CPT® code for fluoroscopy should not be reported. The organization must have a process for reviewing all claim edits to create a resolution that allows claims to be billed cleanly and without additional delay. In the example above, radiology typically needs a CDM number to carry the order/service into the radiology system for the results to be reported. This could be accomplished several ways to ensure that the department has what they need for operations and that. it is correctly reported for the claim.

The trickiest edits for organizations are those that involve services provided in separate departments. The industry has long equated departmental budgets to departmental revenue, and that is more difficult when a department's service must be billed as part of another department's service. The reporting process does not address the requirements of the billing process. Suddenly, one department is not generating the revenue that they once did but still has all of the same expenses. This requires a behind-the-scenes look at how revenue gets booked in these instances as just "stripping off the charge" is not the answer.

**Q: What are your recommendations for review processes for claims that contain a device dependent procedure to ensure the appropriate reporting of supply/implant HCPCS C-codes? Most respondents said they only review those claims if they hit an edit for lack of a device or procedure code.**

**A:** It is very important to be sure that the correct HCPCS code was reported for the correct device. We have noticed this with pacemaker/AICD insertions. The leads and guidewires were reported but the generator (the most expensive item) was not. However, the edit was satisfied by the codes that were reported. The best way to ensure that the

HCPCS C-codes are reported is to build the specific device-to-procedure edits into the internal claim process, especially for those procedures that are the most commonly performed and those that have the most expensive devices involved. Build the edits to stop the claim if one of the specific items is not reported on the claim. A process can also be created to have these specific scenarios reviewed during the charge reconciliation process. If a pacemaker generator was inserted, the department should ensure that a generator was charged using an established CDM number. If this is true upon the department's review, then the claim should pass the edit.

**Q: Most survey respondents said they have a process for reviewing claim edit patterns to identify and resolve root causes. Taking a proactive approach and preventing repeat errors definitely supports revenue integrity, but what are your thoughts on the processes respondents described? Is there a gold standard process that organizations can consider adapting? What departments/staff should be involved? What elements need to be considered when developing a process or revising an existing one?**

**A:** Based on the responses, most organizations have a process for identifying the issue (i.e., reports, work queues, random audits, and data mining) and specific members of the organization that are involved. The gold standard is that this should be a team effort, the root cause must be identified, and a solution must be instituted. The team should consist of revenue integrity, patient financial services (PFS)/billing office, HIM coding, IT, and the individual clinical department(s). This team can dissect the issue from the beginning of the process and determine where the breakdown is. Everyone on the team must be fully committed to examining the process and making it better for all involved. The team can then determine if the situation requires education for a team member(s), requires intervention in a system, or both. One of the most important steps in identifying and resolving root causes happens after the resolution is implemented. The new process or the fix applied to the existing process must be audited immediately after implementation and at ongoing intervals. It is also vital that these remedies be audited after any system upgrade or new process is instituted because things can break and go unnoticed for a long time.

Some noted they have an outside billing company that is responsible for the edits. It is very important that the provider knows what mechanism the outside billing company is using to correct the edits. This is important not only for the provider's revenue integrity but because the provider is ultimately the responsible party.

**Q: Staying informed of payer billing guideline updates is a common pain point. Each commercial payer might use a different method for communicating updates, and updates could land with someone who either isn't involved in billing or doesn't know who else to alert. CMS updates are comparatively easy to locate but as anyone who's visited cms.gov knows, the site can be difficult to navigate. What are some tips for staying on top of payer updates and ensuring they're shared with the right people?**

**A:** A team made up of PFS/billing office, HIM, revenue integrity, compliance, contracting/managed care, and decision support representatives is important to the success of communicating updates. Although an individual person may not know exactly who needs the information, the team would. Some facilities have one person who monitors the CMS website, providing update information to the rest of the team. This person needs to know what is important and relevant to the facility but does not have to be the person to read, digest, and explain the information. Many facilities find it helpful to have one person monitoring and communicating rather than many to prevent duplication of effort and for ease of locating the information. The team would also evaluate the overall impact of the update/change. If clinical or ancillary departments are specifically affected, they could be invited to the meeting. Communication that summarizes the changes should be sent to all departments and be discussed in department leadership meetings. ■

SPECIAL FEATURE

# IMPROVING A/R PERFORMANCE: WHAT YOU MAY NOT KNOW

**PATRICK MURPHY,** vice president of business services at TruBridge

More hospitals are cash strapped than any time since the 2008 financial crisis, according to a 2017 Moody's Investors Service survey. Not-for-profit and public hospitals, in particular, are feeling the squeeze with median operating cash-flow margins at a 10-year low. High labor costs and lower payer reimbursements are key contributing factors. Furthermore, according to a 2018 Black Book™ revenue cycle survey, 90% of small and community hospital respondents anticipate declining-to-negative profitability in 2019 due to diminishing reimbursements, unrecovered collections, and underutilized or inefficient billing and records technology. Patrick Murphy, vice president of business services at TruBridge, shares common accounts receivable (A/R) operational issues that hospital leaders may not even know they have, along with the top five key performance indicators (KPI) and best practice metrics.

**Q: What are the most common A/R operational issues you see?**

**Patrick Murphy:** Hospitals are experiencing five major A/R problems today. The first area is patient access challenges, including inaccurate patient information as well as lack of patient collections due to insufficient training, quality assurance tools, and accountability. Second, hospitals are having difficulties with their charge capture process. Many have an incomplete or outdated charge description master (CDM), which causes revenue leakage.

Medical coding quality and timeliness of coding charts is another problem for organizations. We are seeing facilities that do not have a formalized QA process or a good documentation review process. There is also a shortage of qualified staff because of the high demand for certified coders. The fourth issue is hospitals still manually touch too many accounts instead of only working the exceptions. The use of advanced technology, when implemented correctly, can significantly reduce or eliminate this bottleneck. Finally, many hospitals still do not use any type of data analytics. You cannot drive success if you do not measure the key indicators that quantify success.

**Q: What are the top five A/R KPIs?**

**Murphy:** The most important KPI is cash collections to net revenue conversion, followed by point of service cash collections, discharge not final billed (DNFB), denial percentage, and A/R days. See chart below for each KPI and its best practice metric for an average hospital.

**Q: What are your top three recommendations for hospitals that want to improve A/R processes?**

**Murphy:** Start by focusing on the patient's front-end experience. Patients expect a retail healthcare experience today, and it begins with top-notch patient access processes supported by strong training and advanced technology. Use eligibility tools to load accurate insurance information and a patient liability estimator to provide accurate estimates to ensure a smooth transition from data collection and point of service cash collections to clinical care. Secondly, focus on people, processes, and technology, which will enable you to do more with less. For example, take advantage of revenue cycle management technology to drive productivity by pushing work to staff and allowing them to work by exception. Lastly, you cannot improve what you do not measure, so it is critical to drive and operationalize data analytics across the entire enterprise. Things will start to change as analytics give you a better understanding of what you may not know. ■

## AVERAGE HOSPITAL BEST PRACTICE METRICS

- Cash collections to net revenue conversion: 97%
- Point of service cash collections: 2–3% of total monthly cash collections
- DNFB: Three days
- Denial percentage: 3%
- A/R days: 35–49 days depending on the type of facility

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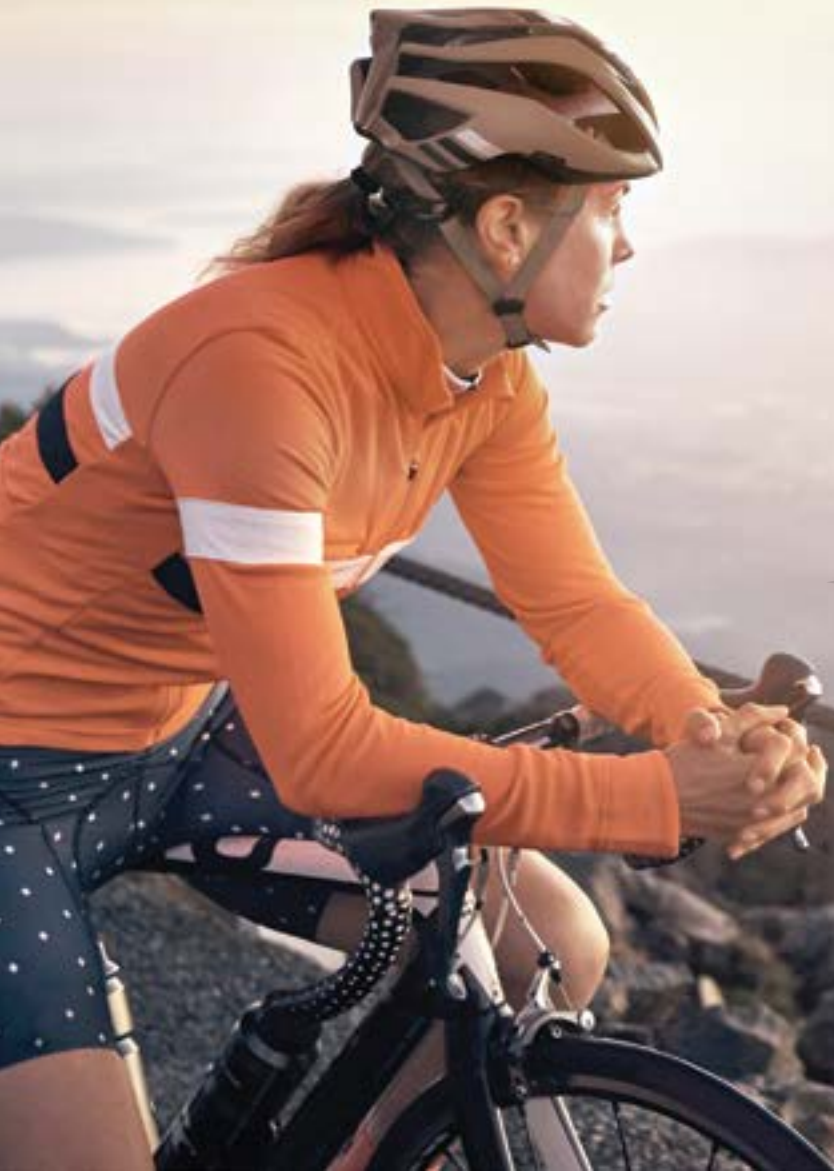

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When revenue integrity is performing audits they are primarily (80%) looking at chart-to-bill and charge capture (see Figure 14 on p. 21 for more information). Throughout the audit process, revenue integrity may also find itself managing reimbursement and payment reconciliation (58%) or coding audits (50%).

Though not as common, a number of respondents wrote in and stated that revenue integrity also performs the following types of audits:

- Focus areas from OIG and PEPPER reports
- Documentation deficiencies
- Medical necessity
- Post-payment audits
- Drug usage/wastage
- Modifiers
- Facility E/M

If an issue is uncovered during the course of revenue integrity audits, the plurality of respondents (58%) stated their course of action is to share the results with the department that delivered the service so that the department and revenue integrity can work together to educate, train, 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 the department that has an issue, and revenue integrity mostly does the education, training, or follow-up (25%)
- Results are shared with the department that has an issue, and it is up to that department to educate, train, and follow up (25%)
- Results are shared with a committee or senior leader who identifies next steps (22%)

For revenue integrity departments or programs that dedicate a staff member solely to auditing, this job is primarily (33%) assigned to nurses. Some departments and programs also rely on coders (16%), charge capture specialists (12%), or billing and claims experts (7%), responses which remained relatively unchanged year over year. This year, approximately 32% 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:

Figure 14. **Performing an audit—What types of audits are performed by your revenue integrity department or program?** (Multi-response)

| | |
|---|---|
| Chart-to-bill/charge capture | 80% |
| Reimbursement/payment reconciliation | 58% |
| Coding | 51% |
| Other | 13% |

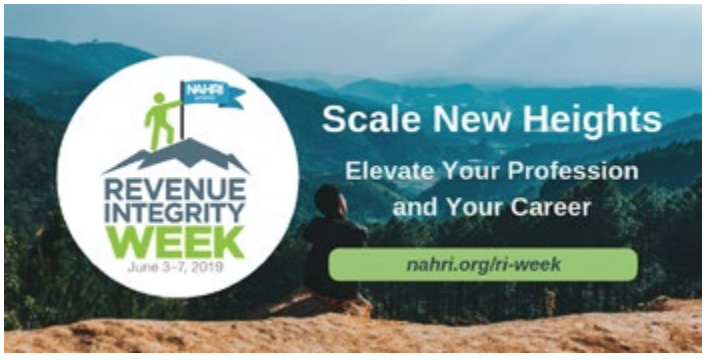
Source: 2019 State of the Revenue Integrity Industry Survey

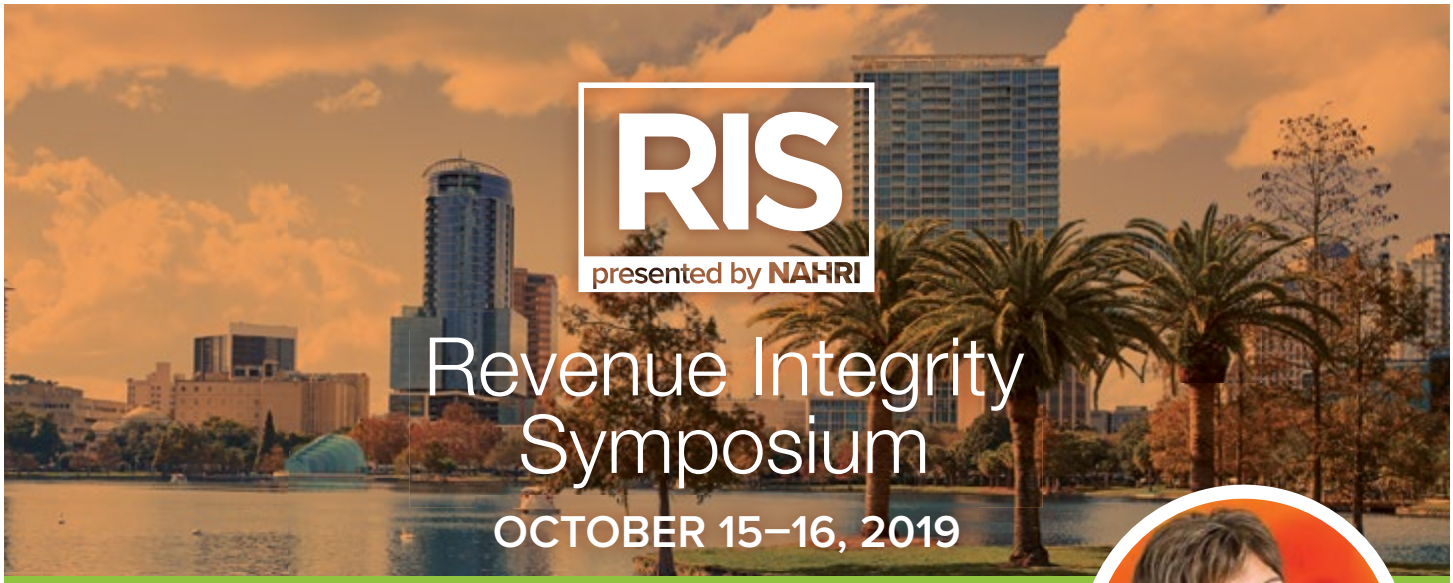
- Both coders and nurses
- Chart auditor
- Audit specialist
- Revenue integrity analyst

Yet some respondents wrote in to say that it is not one person's sole job to audit:

- "It depends on the audit. We have a combination of nurses, coders, and claim editors who audit for specific areas of the encounter."
- "We currently do not have this position, but I am a strong proponent for this!"
- "I have all of the above. We audit a sample from each department, so the person auditing is dependent on the audit being performed."

For the first time, we sought some insight into the link between auditing and the chargemaster by asking whether facilities perform claims auditing after changes are made to the chargemaster to ensure new items and charges are processing correctly. Most respondents (69%) stated that they do perform such audits. When asked who is responsible for such audits, more than half of respondents (54%) stated it was revenue integrity. The responsibility may also fall to the chargemaster coordinator (14%), chargemaster maintenance team (11%), or nurse auditor (5%). ■



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Our resort is just minutes from Walt Disney World® and other attractions for you to discover. RIS 2019 attendees will receive special discounted rates to attend select local attractions.