NAHRI presents

REVENUE INTEGRITY WEEK

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STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY

REVENUE INTEGRITY INVESTIGATION: THE CASE OF THE MISSING REVENUE

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STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY

For the third consecutive year, NAHRI is hosting Revenue Integrity Week to celebrate the hard work, dedication, and remarkable achievements of revenue integrity professionals across the country.

As part of Revenue Integrity Week, NAHRI takes an in-depth look at trends across the industry with the 2020 State of the Revenue Integrity Industry Survey. The survey explores the roles and responsibilities of revenue integrity professionals, their backgrounds, and the key functions of the job.

"This 2020 survey, along with previous surveys, highlights how the professional role in revenue integrity is evolving," says **Elizabeth Lamkin, MHA,** CEO and partner at PACE Healthcare Consulting, LLC, in Bluffton, South Carolina, and an Emeritus NAHRI Advisory Board Member.

Revenue integrity professionals have been critical to healthcare organizations for decades, but established revenue integrity titles and roles are a more recent development as the industry continues to evolve. In the 2020 State of the Revenue Integrity Industry Survey, we analyze responses and compare them to those of past years to help paint a clear picture of the industry as it stands today.

Background and experience

Because revenue integrity professionals possess a wide range of skills and bring various types of experience to the table, there are many job titles within the profession. As a starting point for our 2020 State of the Revenue Integrity Industry Survey, we asked respondents to list their job titles. The top responses were as follows:

- Other: 19%
- Clinical documentation improvement/integrity specialist: 13%
- Revenue integrity director: 10%
- Revenue integrity manager: 10%
- Coding manager or director: 7%
- Consultant: 7%
- Revenue integrity analyst: 6%
- HIM manager or director: 4%

Those who checked off "other" were asked to provide specific titles in an open-ended field, which included the following responses:

- Coder/medical coder (16% of all responses in "other" category, most common "other" response)
- Revenue integrity billing director
- Risk adjustment coding analyst
- Revenue integrity senior director
- Revenue integrity supervisor
- Coordinator coding quality and education

In 2018 and 2019, the title of revenue integrity director was most common (18% in 2018 and 16% in 2019). Its prevalence continues to trend downward, though, as 10% of respondents this year held the job of revenue integrity director. The second most common job title was clinical documentation improvement/integrity specialist, which was part of the "other" category in 2018 and 2019. Revenue integrity directors and revenue integrity managers accounted for 25% of the responses in 2018 and 29% in 2019. This year, the two positions accounted for 20% of the responses.

"One possible reason for this trend is more non-director staff view revenue integrity as a profession and want to be part of their profession's association," says **Terri Rinker, MT (ASCP), MHA,** revenue cycle director at Community Hospital Anderson in Anderson, Indiana, and Emeritus NAHRI Advisory Board Member. "The other possibility is more organizations are formalizing the revenue integrity functions into a separately identifiable department, which, in turn, means there are more non-director level staff available."

In recent years, the revenue integrity profession has seen a spike in professionals with a coding background. When asked to select the field of healthcare that best aligns with their background in 2020, 34% of respondents checked off coding. This represents a dramatic increase from 2018 and 2019, when 7% and 14%, respectively, came from a coding background. The number of revenue integrity professionals with a background in clinical documentation improvement/integrity also experienced a sharp increase, moving from 4% in 2019 to 18% this

year. Figure 1 provides a full breakdown of the various backgrounds (note that respondents were able to select more than one category if they had experience in multiple backgrounds).

"As we acknowledge and celebrate Revenue Integrity Week, many of our revenue integrity professionals have migrated into this more specialized area of expertise from several other revenue cycle or compliance related fields. As our revenue integrity professionals continue to stay abreast and hone their skills, remember to ask questions no matter how trivial or simple or basic they may seem!" says **Diane G. Weiss, CPC, CPB, CCP,** vice president of reimbursement at RestorixHealth in Metairie, Louisiana, and Emeritus NAHRI Advisory Board Member. "This was the one way that I was able to learn so much from my colleagues in our organization. There's a wealth of information available just waiting for the questions to be asked!"

Revenue integrity professionals play critical roles in all healthcare settings. Acute care hospitals are still the most common setting for revenue integrity professionals, but by a smaller margin than in 2019. Last year, 63% of respondents reported working in acute care hospitals, followed by 11% in health systems, 6% in critical access hospitals, and 5% in consulting. This year's data shows a much more even distribution, with 34% of respondents working in acute care hospitals, 25% in health system corporate offices, and 14% in consulting roles.

While 33% of respondents indicated that they do not work in hospital settings, the majority of those who do work in hospitals reported that their facilities hold 500 beds or more. This accounted for 24% of all responses and 36% of those who work in a hospital. The number is in line with the results from past years; in 2018, 34% of respondents who worked in a hospital reported working in a facility with 500 beds or more, while in 2019 the figure was 38%.

Other common hospital settings in the 2020 survey included hospitals with 100–199 beds (11% of all responses), hospitals of 200–299 beds (9%), and hospitals of 400–499 beds (8%). Clearly, revenue integrity professionals are more likely to be employed by larger hospitals than by smaller hospitals. Only 10% of respondents reported working in hospitals of 100 beds or fewer.

Roles are constantly changing within the revenue integrity profession, as new positions are frequently created in response to current needs. As a result, revenue integrity professionals may not stay in the same role for an extended period. More than half of respondents (57%) indicated that they had been in their current roles for less than five years. The numbers are consistent with the results from last year, when 55% of respondents reported serving in their current roles for less than five years. The full breakdown of 2020's results can be found below:

- 3–5 years: 27%
- 1–2 years: 20%
- 6–10 years: 19%
- More than 10 years: 10%
- Less than 1 year: 10%
- 11–15 years: 7%
- 15–20 years: 7%

As organizations become increasingly aware of the value of revenue integrity professionals, the field continues to grow and earn recognition. The industry is still dominated by those with many years of experience, though. Fifty-five percent of respondents have worked in

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

Title	%
Clinical documentation improvement/integrity specialist	13%
Revenue integrity manager	10%
Revenue integrity director	10%
Coding manager or director	7%
Consultant	7%
Revenue integrity analyst	6%
HIM manager or director	4%
Revenue integrity coordinator	3%
Revenue cycle director	3%
Revenue integrity nurse	2%
Revenue cycle analyst or specialist	2%
Chargemaster coordinator or analyst	2%
Compliance manager or director	2%
Revenue integrity specialist	1%
President or vice president of revenue integrity	1%
Revenue cycle manager	1%
Compliance auditor or specialist	1%
CFO	1%
CEO	1%
Other	19%

Source: 2020 State of the Revenue Integrity Industry Survey

the industry for a minimum of 10 years. Additionally, 27% have worked in revenue integrity for more than 20 years, up from 24% a year ago. The number of respondents new to the revenue integrity field increased slightly this year; 17% reported having worked in the industry for less than two years. In 2019, only 13% had been in the field for less than two years.

Revenue integrity professionals are an accomplished group with expertise in diverse areas. Naturally, then, those working in revenue integrity hold a wide range of credentials.

Unsurprisingly, most respondents (82%) considered themselves revenue integrity professionals. Those who answered no provided some of the following explanations:

- "My role is connected to revenue integrity, but direct reports are not revenue integrity."
- "No, RI is a component of my duties."
- "My role is actually DRG coordinator and my department is finance. I work closely with other sections of finance/revenue."
- "It is part of my duties, but not the primary focus."

Revenue integrity professionals are an accomplished group with expertise in diverse areas. Naturally, then, those working in revenue integrity hold a wide range of credentials. Thirty percent of respondents hold CPC credentials, while 20% are RNs, 19% hold CCS credentials, and 14% are RHIT certified. Over 25% checked off "other" and listed MBA, JD, MD, CRCR, and CPO credentials, among others. Respondents were asked to check off all credentials that applied to them.

The number of respondents holding CPC credentials increased from 26% in 2019 to 30% this year. Similarly, there was a slight increase in those holding CCS credentials, bumping from 17% in 2019 to 19% in the most recent survey. The number of those holding RN credentials is trending downward, moving from 26% last year to 20%.

Primary and supporting functions of revenue integrity

To provide a clear picture of the structure of revenue integrity programs and departments, respondents were asked to describe the revenue integrity functions at their respective organizations. Sixty-eight percent of respondents reported having dedicated revenue integrity staff members. In addition, 57% of respondents said that their organization has a revenue integrity department, while 34% indicated that their organization has a revenue integrity program. Only 18% of respondents said that their organization has a revenue integrity committee. Also, 29% of respondents indicated that their organization has a budget for revenue integrity education.

"For smaller hospitals that don't have such a robust revenue integrity team, is there a good path to communicate issues to finance, to CFOs, etc.? Is there an understanding of what your CFO wants?" says **Kay Larsen, CRCR,** revenue integrity specialist, Adventist Health Glendale in Glendale, California, and NAHRI Advisory Board Member. "I had a CFO that required me to contact him whenever a department wanted to reduce the price of a charge. I had to provide justification for the reduction. Another CFO required contact any time charges were corrected that reached a certain dollar amount."

We asked respondents who stated that their organization has a revenue integrity department or program to identify the functions for which those departments or programs are responsible. Like the results from 2019, the responses to this question show the diverse number of ways revenue integrity departments can make an impact for an organization. Sixty-nine percent of respondents stated that revenue integrity programs or departments at their facilities were responsible for charge capture. This was the most common answer (respondents checked off more than one, if applicable), but the percentage of revenue integrity departments handling charge capture was down from 77% in 2019. The second most common response was chargemaster maintenance (68%). This figure also significantly decreased over the past year, as 80% of respondents in 2019 said their revenue integrity departments were responsible for chargemaster maintenance.

Other top responses were as follows:

- Chart auditing: 54%

- Charge reconciliation: 52%
- Education: 48%
- Correcting claim edits: 48%
- Denials management: 39%
- Internal audit/compliance: 38%
- Coding: 38%
- Clinical documentation integrity: 31%

Charge reconciliation, the fourth most common response, was not included in the 2018 or 2019 surveys. The number of revenue integrity departments responsible for coding has been on the rise, climbing from 27% in 2018 to 35% in 2019 to 38% this year. For a full list

Q&A: REVENUE INTEGRITY BACKGROUND AND EXPERIENCE

The following is a question and answer session with **Caroline Znaniec,** managing director of CohnReznick LLP's Healthcare Advisory Practice in Baltimore, on revenue integrity background and experience as reported in NAHRI's 2020 State of the Revenue Integrity Industry Survey. Znaniec is a NAHRI Advisory Board member.

Q: Nearly 85% of respondents hold one or more credentials. What value can credentials bring to revenue integrity professionals and the overall state of the industry?

A: Credentials are a great way to demonstrate proficiency and understanding that sets one apart from their peers. Adding a professional credential can especially aid the addition of more junior staff to a growing industry such as revenue integrity where their knowledge is obtained on the job more than a classroom. Adding a credential supports the knowledge obtained but also enforces how to translate that knowledge in a broader perspective.

Q: Approximately 27% of respondents have more than 20 years of industry experience. What knowledge and experience areas can new and veteran revenue integrity professionals seek education on to ensure they are well prepared for the future of the profession?

A: The outlook for improving performance across many industries and professions, not just healthcare or revenue integrity, will rely heavily on the ability to translate operations into technology. Education efforts should provide for the technical requirements, along with how to apply artificial intelligence into existing technology workflows. For example, implementing automated charge capture based on the completion of an order set and using predictive analysis to identify charge capture opportunities.

Q: Most respondents come from coding (34%) or chargemaster (22%) backgrounds. How can this experience prepare professionals for a career in revenue integrity?

A: The evolution of revenue integrity for many organizations began in coding or charge description master (CDM) roles. The foundation for ensuring the proper identification, capture, and reporting of items, services, and procedures is dependent on the CDM and coding functions. To be successful in either coding or CDM, the professional must also have holistic understanding of revenue cycle processes.

Q: What advice would you give to professionals who are new or looking to break into revenue integrity?

A: My advice to new revenue integrity professionals is to understand that the profession is ever changing. It takes much dedication to stay informed of the regular technical and operational changes. It can be exhausting. But if you have a passion for a higher-pace profession that can easily demonstrate results and performance, this is a great profession.

Q: What advice would you give to experienced revenue integrity professionals looking to further their careers?

A: My advice to experienced professionals looking to advance their career is to transfer your knowledge to the next generation. ■

of responses, and how they compared to those in years past, see Figure 2.

"What I find encouraging are the responses to what your revenue integrity department is responsible for and what functions your revenue integrity departments assists in. It highlights the broad reach and nature of revenue integrity," says Lamkin. "The areas identified such as charge capture, coding, denials management, and clinical documentation integrity all working together will advance the connection between clinical departments, revenue cycle, and financial departments. I think this list will grow as the C-suite puts more emphasis on retaining monies already earned."

We also asked respondents to select the functions that their revenue integrity departments assist with, act as a resource for, or support. Charge capture (55%) and coding (55%) were the most frequent responses. Other top responses included:

- Denials management: 53%
- Internal audit/compliance: 50%
- Education: 47%
- Chart auditing: 46%
- Correcting claim edits: 45%
- Chargemaster maintenance: 44%
- Compliance: 37%
- Quality: 35%

When compared to responses from a year ago, the responses for coding increased from 51% to 55%. The responses for charge capture, however, have decreased from 68% in 2018 to 63% in 2019 to 55% this year. Many of the responses have been consistent over the three-year period. Education was selected by 50% of respondents last year and 47% this year. Internal audit compliance was selected by 47% of respondents in 2018, 50% in 2019, and 50% this year.

Figure 2. If you have a revenue integrity department or program, what functions is the department or program responsible for at your organization?

	2020	2019	2018
Charge capture	69%	77%	73%
Chargemaster maintenance	68%	80%	79%
Chart auditing	54%	61%	60%
Correcting claim edits	48%	55%	49%
Education	48%	50%	62%
Denials management	39%	51%	46%
Claims auditing	38%	43%	42%
Internal audit/compliance	38%	42%	43%
Coding	38%	35%	27%
Clinical documentation integrity	31%	28%	32%
Compliance	26%	35%	43%
Quality	26%	29%	19%
Patient billing	25%	24%	10%
Claims/payment reconciliation	21%	34%	20%
Decision support functions	19%	23%	32%
Insurance verification	19%	18%	8%
Registration functions	12%	14%	6%
Financial counseling	12%	12%	7%
Other	13%	10%	14%

Source: 2020, 2019, and 2018 State of the Revenue Integrity Industry Survey

Figure 3. If you have a revenue integrity department or program, what functions do you assist with, act as a resource for, or support?

	2020	2019	2018
Charge capture	55%	63%	68%
Coding	55%	51%	59%
Denials management	53%	60%	60%
Internal audit/compliance	50%	50%	47%
Education	47%	50%	60%
Chart auditing	46%	56%	46%
Correcting claim edits	45%	56%	55%
Chargemaster maintenance	44%	54%	58%
Compliance	37%	44%	55%
Quality	35%	39%	30%
Clinical documentation integrity	34%	40%	46%
Claims auditing	33%	45%	43%
Patient billing	29%	38%	45%
Managed care/payer contract management	24%	N/A	N/A
Claims/payment reconciliation	24%	32%	32%
Decision support functions	21%	28%	38%
Insurance verification	16%	19%	11%
Registration functions	14%	18%	18%
Financial counseling	6%	15%	11%
Other (please specify)	10%	6%	9%

Source: 2020, 2019, and 2018 State of the Revenue Integrity Industry Survey

Figures 2 and 3 allow us to compare functions that are the responsibilities of revenue integrity departments versus functions that those departments assist with or support. Many of the responses were split evenly between the two categories. For example, 46% of respondents assist with chart auditing, compared to 54% of respondents marking it as a department responsibility; 50% assist with internal audit/compliance, while 38% consider it a department or program responsibility; and 53% assist with denials management, compared to 39% marking it as a department responsibility.

"In our current healthcare environment, separate departments cannot tackle the myriad of issues that erode revenue. It takes a team lead by a revenue integrity professional to understand and manage the entire continuum," says Lamkin.

Revenue integrity departments vary in size. We polled respondents on the number of full-time equivalent (FTE) positions in their departments. The responses are listed below:

- 5–7: 18%
- 2–4: 17%
- More than 20: 15%
- 16–20: 14%
- 11–15: 14%
- 0–1: 12%
- 8–10: 10%

The responses were more evenly distributed than they were a year ago, when 25% of respondents stated that their revenue integrity department contained 2–4 FTEs and 20% indicated that their department employed more than 20 FTEs.

In 2019, only 5% of respondents stated that their revenue integrity department employed 16–20 FTEs, but that figure rose to 14% this year. Similarly, the number of respondents working in departments of 11–15 FTEs rose from 12% to 14% over the past year.

Respondents were also asked about the reporting structure of their revenue integrity departments. Twenty-four percent said their department reports to the organization's VP or director of revenue cycle, while 22% indicated that their department reports to the chief financial officer. The remaining responses were as follows:

- VP or director of finance: 17%
- Other: 16%
- Patient financial services director: 7%
- Revenue cycle manager: 6%
- HIM director: 3%
- Compliance director: 2%

Although VP or director of revenue cycle was the most common response, its frequency declined from 48% a year ago to 24% this year. Those reporting to a VP or director of finance rose from 10% in 2019 to 17% this year. The respondents who selected "other" wrote in responses such as revenue integrity senior director, chief medical officer, and executive director of revenue integrity.

"In our current healthcare environment, separate departments cannot tackle the myriad of issues that erode revenue. It takes a team lead by a revenue integrity professional to understand and manage the entire continuum."

— Elizabeth Lamkin, MHA, CEO and partner at PACE Healthcare Consulting, LLC, in Bluffton, South Carolina

"In my experience, a successful revenue integrity team involves the entire scope of the revenue cycle. A collaborative approach bringing all revenue cycle disciplines together creates an environment of sharing perspectives and viewpoints, which creates a synergy to lift the organization to best practice," says **Donna Schneider, RN, MBA, CPHQ, CPC-P, CHC, CPCO, CHPC,** vice president of corporate compliance and internal audit for Lifespan in Providence, Rhode Island, and Emeritus NAHRI Advisory Board Member. "This type of collaboration also enhances the employee experience with everyone feeling like they have a voice in solving issues and a stake in the outcome."

Finally, we asked respondents to share the frequency with which their revenue integrity team, committee, department, or task force meets. Respondents indicated:

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Q&A: PRIMARY AND SUPPORTING FUNCTIONS OF REVENUE INTEGRITY

The following is a question and answer session with **Caroline Znaniec,** managing director of CohnReznick LLP's Healthcare Advisory Practice in Baltimore, on revenue integrity background and experience as reported in NAHRI's 2020 State of the Revenue Integrity Industry Survey. Znaniec is a NAHRI Advisory Board member.

Q: The percentage of respondents who have dedicated revenue integrity staff members has remained at 68% from our 2018 Industry Survey to our 2020 Industry Survey. Do you see a need for additional facilities to bring revenue integrity staff on board?

A: Yes, I am surprised that there has not been an overall increase. However, the amount of consolidation in the last two years could be why we haven't seen a shift at a facility level. For those facilities that do not have dedicated revenue integrity staff, it could be that the size, region, or culture of the facility is not conducive to a dedicated function or department. The staff may reside in other departments such as compliance, auditing, or billing, and may have additional "duties as assigned." These other duties cover the processes of what we consider to be revenue integrity, but the staff do not directly recognize themselves as working under revenue integrity. The survey may not reflect this occurrence as the survey may not reach these professionals.

I do continue to see the need for dedicated revenue integrity staffing. Recent experiences from the COVID-19 pandemic have shone a bright light on the need to be nimble, flexible, and timely in addressing operational changes. Facilities that are more likely to survive the pandemic financially have a foundation of revenue integrity and dedication to the objectives of the function.

Q: Chart auditing, charge capture, and chargemaster maintenance often top our respondents' list of primary functions of revenue integrity. How and why should revenue integrity be primarily responsible for these functions?

A: Revenue integrity focuses on those processes to properly identify, capture, and report the items, services, and procedures rendered by the facility and providers. The primary functions indicated directly contribute to the ability to ensure the processes are sound.

Q: In 2018, most respondents (25%) reported 2–4 full-time employees for their revenue integrity departments, a figure that increased to 5–7 for respondents (18%) in 2020. What can facilities do to gain buy-in for creating or expanding revenue integrity departments and programs?

A: The ability to create buy-in starts with the ability to clearly identify the objectives of the revenue integrity department: What are the goals of the department? How will you look to achieve those goals? What resources are needed? What is the expected benefit?

And as the department operates, the ability to demonstrate how the objectives are met will also validate across the organization the need for the department.

Q: Most respondents (35%) report that their revenue integrity department, committee, or task force meets monthly. What meeting frequency would you recommend? What topics are essential to cover at such meetings?

A: Meeting frequency can vary across organizations based on various factors, including revenue performance and level of payer and regulatory scrutiny. Regardless of the meeting frequency, the more important factor is the effectiveness of the meetings themselves. Frequency alone does not provide action, follow-up, or awareness. ■

- Monthly: 35% (37% in 2019)
- Weekly: 26% (24% in 2019)
- No regularly scheduled meetings: 23% (24% in 2019)
- Other: 9% (10% in 2019)
- Quarterly: 7% (10% in 2019)

Several respondents who selected “other” indicated that their departments hold biweekly meetings.

Chargemaster maintenance and price transparency

Chargemaster maintenance and price transparency have been top of mind for revenue integrity professionals for some time, but not more so than the last year or two.

The *2019 IPPS final rule* required facilities to begin publishing a list of charges for all items and services beginning January 1, 2019, a move that left many revenue integrity professionals concerned about patient perception of hospital charges and whether patients would compare prices and make the move to hospitals with lower posted charges. The price transparency debate waged on as the 2020 OPPS proposed rule introduced a requirement for hospitals to post payer-specific charges, a proposal that CMS pulled from the *2020 OPPS final rule* and vowed to address in separate, later rulemaking. Along came the *Price Transparency Requirements for Hospitals to Make Standard Charges Public final rule*, which required hospitals to publicly post charges in an easy-to-understand format by 2021, and the *Transparency in Coverage proposed rule*, which, if finalized, would require insurance companies and group health plans to provide patients with cost estimates prior to receiving care, as well as to list publicly available pricing information.

Despite the shakeups in price transparency requirements since 2018, which is also the first year we published NAHRI’s State of the Revenue Integrity Industry Survey, certain chargemaster responsibilities have remained the same. Nearly half of 2020 respondents (48%) still have a dedicated team responsible for overseeing chargemaster maintenance, a figure that is down just slightly from 2018 (56%) and 2019 (53%). Fewer than one-third of respondents put just one person in charge of this responsibility (26% in 2020 and 28% in 2019). A slight increase (9% in 2020 and 4% in 2019) was noted among respondents who opt to have the department director/representative responsible for the structure and codes with the line items entered by a data entry specialist. (See Figure 4.) Chargemaster approval processes are still largely managed by sending individual requests to one person (30% in 2020 and 2019, 25% in 2018). (See Figure 5.) Responsibility for making changes to chargemaster order sets mostly remained with revenue integrity departments from 2019 (42%) to 2020 (43%). In fewer instances, respondents stated this responsibility falls to

Figure 4. **How is your chargemaster maintenance structured?**

	2020	2019
A team is responsible for chargemaster maintenance	48%	53%
One person is responsible for chargemaster maintenance	26%	28%
The department director/representative is responsible for the structure and codes with the line items entered by a data entry specialist	9%	4%
A hybrid of internal staff and external consulting personnel	6%	6%
It is outsourced	1%	1%
Other	10%	8%

Source: 2020 and 2019 State of the Revenue Integrity Industry Survey

Figure 5. **How is your chargemaster approval process structured?**

	2020	2019	2018
Individual requests are sent to a central person	30%	30%	25%
A hybrid approach that uses chargemaster software and a central contact person	20%	14%	19%
Individual requests are routed to a team for approval (e.g., finance for pricing, HIM for coding)	13%	16%	22%
Automated approval process via chargemaster software	7%	9%	8%
All of the above	17%	16%	16%
Other	13%	15%	10%

Source: 2020, 2019, and 2018 State of the Revenue Integrity Industry Survey

the director of the department to which the charges are applicable (22% in 2020 and 15% in 2019), the IT department (16% in 2020 and 23% in 2019), clinical staff (4% for both years), or others (15% for both years).

Once CMS released the requirement for posting a public list of items and services, we began asking respondents whether they track who is downloading or viewing their list. In our 2019 survey, more than half of respondents (51%) stated they were not tracking views and downloads of their list of items and services, with 13% stating they were tracking and 36% stating although they were not tracking just yet, they had plans to do so. The percentage of respondents tracking views and downloads increased to 28% in 2020, indicating that some of those who said they were planning in 2019 had followed through.

"While this slight shift could simply indicate that curiosity took over, more likely it is due to improved efficiency in tracking as well as the anticipation of potential uses for such statistics in the future," says **Sarah L Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS,** president/CEO of SLG, Inc., in Raleigh, North Carolina, and NAHRI Advisory Board Member.

This year, we also asked whether respondents were checking the public lists of neighboring health systems or hospitals to compare them to their own. More than half of respondents (58%) had not adopted this practice.

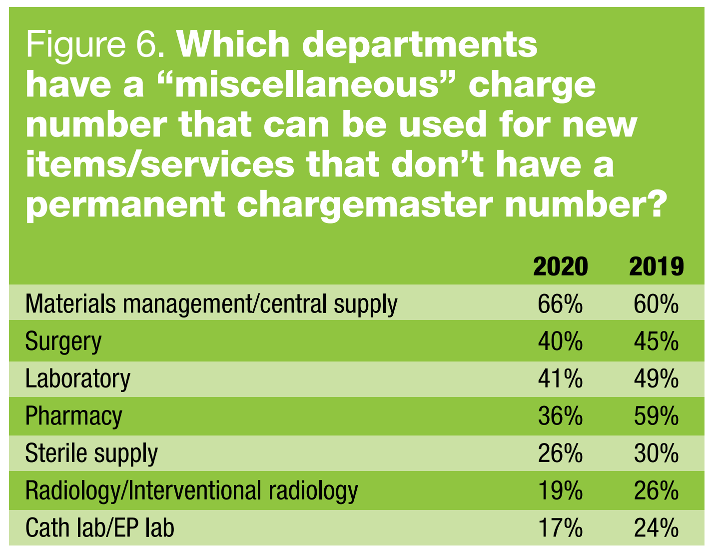

Figure 6. **Which departments have a "miscellaneous" charge number that can be used for new items/services that don't have a permanent chargemaster number?**

	2020	2019
Materials management/central supply	66%	60%
Surgery	40%	45%
Laboratory	41%	49%
Pharmacy	36%	59%
Sterile supply	26%	30%
Radiology/Interventional radiology	19%	26%
Cath lab/EP lab	17%	24%

Source: 2020 and 2019 State of the Revenue Integrity Industry Survey

In 2020 and 2019, we began looking into which departments have a "miscellaneous" charge number that can be used for new items and services that don't have a permanent chargemaster number.

Materials management and central supply topped this list each year (66% in 2020 and 60% in 2019). Pharmacy charges were a close second in 2019 at 59% but fell to 36% in 2020. (See Figure 6 for the full list of charges examined in this question.)

"The 23% decrease in miscellaneous pharmacy charges is fantastic news, but the increase in supplies being reported under a miscellaneous charge code is truly disappointing as accurate charge capture is undoubtedly compromised," says Goodman.

Larsen offered rationale for why some respondents may still report pharmacy charges as miscellaneous. "For pharmacy charges, often the miscellaneous charge represents the total dosage given and isn't set up so that the correct billing units are on the claim. This may also apply for skin substitute charges. Most Q-codes are reimbursed per square centimeter. A miscellaneous charge may drop a quantity of one instead of the total quantity of square centimeters used," says Larsen.

Along those same lines, we examined the time frame for using a miscellaneous number before requiring a permanent number. Nearly half of respondents selected "other" as an option in 2020 (45%) and 2019 (41%) with some writing in to clarify that they did not use miscellaneous numbers or they were unaware of the time frame for requiring a miscellaneous number to be changed to a permanent one. Of the other options available, the most common response was that the miscellaneous number is used until someone decides to review the activity (23% in 2020 and 33% in 2019).

"With miscellaneous charges, it is so important that they are reviewed daily. It could be that a miscellaneous charge is not created in the department's system but might be already in the chargemaster," says Larsen. "Miscellaneous charges may be set up with minimum information and money may be lost because the right information is missing."

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Q&A: CHARGEMASTER MAINTENANCE AND PRICE TRANSPARENCY

The following is a question and answer session with **Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS,** president/CEO of SLG, Inc., in Raleigh, North Carolina, on chargemaster maintenance and price transparency as reported in NAHRI's 2020 State of the Revenue Integrity Industry Survey. Goodman is a NAHRI Advisory Board member.

Q: Nearly half (48%) of respondents structure their chargemaster maintenance by assigning a team to this responsibility. What should teams be aware of when maintaining their chargemaster?

A: Chargemaster teams should have representation from various areas, including ancillary departments, compliance, coding/HIM, finance, physician leadership, if possible, and of course, revenue integrity. These teams should be cognizant of the changing healthcare landscape both internally and externally—this year especially due to COVID-19—and the impact this has had or may have on chargemaster structure, pricing, charge capture, and overall compliance. Moreover, they should be positioned to take a proactive rather than reactive approach to the constant barrage of data, new code sets, and shift to a "hospital without walls" mentality. Teams should focus on policy and procedure development to describe new or temporary chargemaster services during the public health emergency, strategies to address CMS' second round of sweeping changes released April 30, and the addition of statistical codes to the chargemaster to track services provided that are currently not separately billable. If these tracked services become eligible for reimbursement retroactively, the team will be able to easily identify the patients associated with them and can proceed accordingly.

Q: Most respondents (30%) have a chargemaster approval process that involves sending individual requests to a central person. What should this team member be aware of when approving chargemaster changes?

A: This team member should have familiarity with CPT®/HCPCS coding, UB-04 revenue coding, modifier assignment, pharmacy multipliers, facility pricing policies, and general reimbursement methodologies. Knowledge of how the charge description master (CDM) relates to the annual cost report is a definite plus.

Q: Most respondents (74%) assign HCPCS codes to all drugs and supplies if such a code exists. Is this a prudent practice? Why or why not?

A: With the advent of the -JW modifier requirements for reporting wastage of single-dose drugs and biologicals a few years ago, it is imperative that separately reimbursable drugs be HCPCS-coded and reported under UB-04 revenue code 0636 (drugs requiring detailed coding) with the appropriate units dispensed and discarded. However, non-separately payable drugs (i.e., those with status indicator of N under the OPPS) may be HCPCS-coded in the CDM but should be reported under a packaged revenue code such as 0250 (pharmacy—general) or 0258 (IV solutions), at least for Medicare. Other payers want the HCPCS and 0636 revenue code reported on all pharmaceuticals regardless of payment methodology.

Q: Most respondents (62%) use exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate. What recommendations do you have for using exploding charges, etc.? How often should these charges be reviewed and updated?

A: While exploding charges and other CDM triggers can be beneficial and simplify charge capture, they can also create some billing compliance nightmares if not established and maintained appropriately. These charging mechanisms should

be reviewed at least annually—or at any time when updating the chargemaster. Ensure also that there is a policy in place for crediting the entire panel or components of such panels should the services not be rendered in their entirety.

Q: Approximately 44% of respondents are not tracking who is viewing and/or downloading their public list of items and services and have no plans to do so. Should facilities track this? Why or why not?

A: The percentage of those not tracking is still surprisingly high but down 7% from last year. Thus, some of those who had no plans felt it was now important to do so. Perhaps curiosity took over or the facilities simply found a way to begin tracking in a cost-effective and efficient manner. In any event, while the collected data may not have an immediate, apparent benefit, it may prove useful during a survey or audit, or even in future marketing strategies. ■

For coding of drugs and supplies, most respondents (74% in 2020 and 87% in 2019) stated they assign a HCPCS code for all of these charges when such a code exists. A shift was noted in responses year over year, as the percentage of respondents stating they assign HCPCS codes to drugs and supplies only when the code generates separate payment increased from 14% in 2019 to 27% in 2020, presumably accounting for the decrease noted in the percentage of respondents who reported assigning HCPCS codes for all drugs and supplies when one exists.

Charge reconciliation is vital to ensuring that charge capture processes are properly operating and that charges are correct. This is one of revenue integrity's core functions.

"This trend could also be linked to the -JW modifier requirements for reporting wastage of single-dose drugs and biologicals, which are applicable to only to separately reimbursable HCPCS under the OPPS," says Goodman.

A decrease was also noted in the percentage of respondents who use exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate (62% in 2020 and 72% in 2019). However, more than half of respondents who use exploding charges, panel charges, or similar mechanisms (52% in 2020 and 60% in 2019) still list annual review of such charges as the primary method of determining appropriateness.

"Personally, I am glad to see this downward trend because while charge description master triggers can be beneficial and simplify charge capture, they can also create some billing compliance nightmares if not linked or maintained appropriately," says Goodman.

Charge reconciliation

Charge reconciliation is vital to ensuring that charge capture processes are properly operating and that charges are correct. This is one of revenue integrity's core functions, so it's no surprise that more than half (64%) of respondents reported some level of revenue integrity involvement in departments' charge reconciliation, according to the following responses:

- 35% indicated that operational departments are responsible for reconciling their own charges with regular support from revenue integrity
- 16% reported that some departments are responsible for reconciling their own charges, while others are centralized under revenue integrity
- 13% said that charge reconciliation is centralized under revenue integrity

The remainder indicated that operational departments are responsible for their own charges (30%) or that

the task does not apply to their organization (6%). See Figure 7 for a year-over-year comparison.

Charge entry is sometimes handled by clinical staff, but that process isn't practical for all clinical departments and situations. When that's the case, revenue integrity may be assigned more robust charge entry responsibility. Based on industry feedback, NAHRI looked into a broader range of charges that may be entered by nonclinical staff. According to respondents, clinical staff are typically not permitted to enter the following charges:

- Room and board (49%)
- Observation hours (42%)
- Emergency department (22%)
- Drug administration (19%)
- Laboratory (14%)
- Surgery (14%)
- Interventional radiology (11%)
- Clinic charges (e.g., wound care clinics, pain clinics, physician practices) (7%)
- Physical medicine (7%)
- Cardiac cath lab (6%)
- Respiratory therapy (3%)

Other respondents indicated that clinical staff enter all charges (8%) or that clinical staff do not enter any charges (7%). However, some (15%) selected "other" and commented to describe hybrid processes or automated systems such as:

- "Most charges interface from documentation and some are entered by clinical staff in all departments."
- "Quite a bit of our charging is entered by documentation of a process, so it is automated. Observation hours are automatically dropped by using times in a registration field, but coding figures the hours to subtract. Operating room and emergency department get soft coded."
- "[HIM codes] certain surgical and emergency services that are linked with charges from departments."

Considering that almost half of respondents reported that observation charges are not entered by clinical staff, it's no surprise that revenue integrity takes the lion's share of responsibility for carving out procedures that include active monitoring from observation hours. More than one-quarter (27%) of respondents indicated that revenue integrity is responsible for this process. Almost as many (22%) reported that HIM/coding takes the lead.

Time is an important factor in charge reconciliation. Charges should be verified and errors should be corrected before the claim is billed. To help us dig into the process, respondents were asked to indicate their time frame for reconciling charges. More than half (61%) of respondents reported that their time frame is one to three days, up from 44% in 2018 and 45% in 2019. However, 18% reported that they have a charge reconciliation process but don't know the time frame for reconciling charges. See Figure 8 for a full breakdown of responses.

Figure 7. **Who is responsible for charge reconciliation?**

	2020	2019
Operational departments are responsible for reconciling their own charges with regular support from revenue integrity	35%	30%
Operational departments are responsible for their own charges	30%	50%
Some departments are responsible for reconciling their own charges, while others are centralized under revenue integrity	16%	14%
Charge reconciliation is centralized under revenue integrity	13%	6%
We do not have a charge reconciliation process in place	0%	N/A
N/A—this task does not apply to my organization	6%	N/A

Source: 2020 and 2019 State of the Revenue Integrity Industry Survey

Figure 8. **What is your time frame for reconciling and correcting charges?**

Response	%
1–3 business days	61%
4–5 business days	5%
6–7 business days	8%
More than seven business days	4%
We have a charge reconciliation process, but I don't know what our time frame is for reconciling charges	18%
N/A—we do not reconcile charges and/or this task does not apply to my organization	4%

Source: 2020 State of the Revenue Integrity Industry Survey

Simply having a charge reconciliation process in place doesn't guarantee that it's working. Like any other process, charge reconciliation works best when it is regularly monitored to catch technical or human errors before they snowball.

"Even with automated programs to assist charge reconciliation, it's so important to monitor that these programs are working as expected," says Larsen. "Does the person creating these automations understand your facility? Are updates getting to the creators on a timely basis? A simple break in the system can have a big impact. If you're on a multiple hospital system, are changes to one hospital—but not required by all—limited to that one hospital?"

For the first time, NAHRI asked respondents how their organizations incorporate technology into charge reconciliation monitoring. Fewer than half (45%) of respondents reported that their organization uses automation or technology to monitor charge reconciliation practices for consistency and appropriateness. Some respondents wrote in with additional information on their monitoring processes:

- "[The] charge description manager supervisor is responsible [for reviewing] daily reports of charge rejections and charge exceptions for follow up with clinical departments as needed."
- "We have Epic reports but there needs to be enforcement of accountability for reconciliation."
- "We have a third-party system that is fabulous. Home-grown system that is just now growing to other systems."

Figure 9. **Does your organization have a process for identifying and/or preventing revenue leaks?**

Response	%
We have a process for identifying and preventing revenue leaks	41%
We have a process for identifying revenue leaks but do not have a process for preventing them	15%
I don't know	24%
No	11%
N/A—this task does not apply to my organization	9%

Source: 2020 State of the Revenue Integrity Industry Survey

- "[We] use a report to monitor departments that are/aren't running their reconciliation reports."
- "We use technology to pull data and [manually] review."

Revenue monitoring

"Hospital executives should have zero tolerance for payers underpaying claims. However, without a contract surveillance program, it's possible hospitals may be getting underpaid, causing them to lose valuable revenue. A payer contract surveillance program works best when it's coupled with payer contract experts and software technology. When payer experts leveraging software technology can compare payer contract terms with actual paid claims, a variety of underpayments are typically discovered. Once the information and data is discovered, it can be used to support a settlement negotiation with the payers."

—Chris Fowler, President, TruBridge

Without appropriate monitoring and controls, an organization can lose earned revenue through a multitude of leaks—small-dollar edits, an outdated chargemaster, and open encounters that linger in accounts receivable, to name a few. Finding and fixing revenue leaks is critical to protecting the organization's bottom line and identifying potential process improvements or even compliance risks. But if an organization doesn't already have processes in place, it can be challenging to get a program off the ground and demonstrate that it will offer a strong return on investment—particularly without industry standards and benchmarks to use as support.

"When you think of the impact any of these leaks can have on an organization, revenue integrity professionals should be very proud of the work they do each day to help their organization remain financially viable," says Rinker.

To learn whether standard approaches to revenue monitoring and addressing leaks are emerging in the industry, NAHRI asked respondents about their processes. Almost half (41%) of respondents reported that they have a process for identifying and preventing revenue leaks. Although that leaves more than half without an established leak prevention process in place, some respondents said that it's on their to-do list. (See Figure 9.)

"We are working on tightening this. Would love more ideas/processes," a respondent wrote.

Q&A: CHARGE RECONCILIATION

The following is a question and answer session with **Lisa Kanivetsky, BA, CPC, CHRI,** operations director at Guidehouse, on charge reconciliation practices as reported in NAHRI's 2020 State of the Revenue Integrity Industry Survey. Kanivetsky is a NAHRI Advisory Board member.

Q: Most respondents (35%) stated that operational departments are responsible for reconciling their own charges with regular support from revenue integrity. What recommendations do you have for revenue integrity team members and operational departments involved in the charge reconciliation process?

A: I think 35% is a great start; however, I would encourage all revenue integrity teams to work directly with the operational leaders to design and support charge reconciliation at the cost center or department level for 100% of revenue-producing departments.

Q: Approximately 60% of respondents have a turnaround time of 1–3 days for reconciling charges. What should revenue integrity look for during this time frame?

A: I would suggest looking at gross charges and comparing those to budgeted gross charges and doing a "gut" test. For example, if you have a budget of $100,000 of daily gross charges and you show $500,000 on your revenue and usage report, you need to figure out why—regardless of whether your volumes were way up for the day—there is such a large discrepancy. Conversely, if only $5,000 shows up on your revenue and usage—with a gross budget of $100,000—then you're on another hunt for charges. But if your gross and actual charges are within a comfortable range as defined by your revenue integrity and operations leaders, then it's a match.

Q: CMS tasks facilities to have a policy for "carving out" procedures that include active monitoring so that observation hours are not reported for the same time frame. Approximately 27% of respondents say revenue integrity is responsible for this process. What recommendations do you have for carve-outs?

A: Wow! If I'm reading this correctly, 27% of respondents are performing manual carve-outs. This percentage is extremely high, and this method is time consuming and prone to errors. I would recommend coming up with a standard—CMS has provided a couple of options—and working with IT to automate the carve-out time.

Q: Nearly half (45%) of respondents use automation or technology to monitor charge reconciliation practices for consistency and appropriateness. What should revenue integrity look for when using technology for this purpose?

A: I love the idea of using technology for charge reconciliation. However, I would caution that it can only be used at a high level (e.g., general check of $100,000 projected, $101,000 generated, volumes are within projected standard). When one needs to troubleshoot—what I like to call the fun part—it is always driven by an individual expert. You must understand volumes, schedules, clinical services provided, chargemaster and charging rules, and EHR configuration. ■

Another respondent wrote that their revenue integrity staff are planning to review and implement a process this year.

Some organizations give their revenue monitoring activities a boost by using tools to flag revenue leaks—but how this is accomplished can vary widely. To gain more insight into practices across the industry, we asked respondents to share their organization's approach to using technology to identify revenue leaks. Almost half (42%) of respondents reported that their organization uses technology to help monitor revenue leaks. Those respondents are taking the following approaches to integrating technology:

- We use a vendor-built tool integrated into our EHR (19%)
- We use vendor software that interfaces with our EHR but is not integrated with it (16%)
- We use a homegrown tool integrated into our EHR (5%)
- We use homegrown software that interfaces with our EHR but is not integrated with it (1%)

For some respondents, applying technology is part of a long-term plan to address revenue leaks. (See Figure 10.) "We are working on a program that will take a deep dive into each department and look at all practices from appointment scheduling, check-in, documentation, and through to billing and denials to identify revenue leakage," one respondent wrote. "We then look at system optimization, break-fix, education, and workflow optimization to mitigate any revenue leakage we find."

Some organizations give their revenue monitoring activities a boost by using tools to flag revenue leaks—but how this is accomplished can vary widely.

Revenue integrity professionals looking to implement or refine their revenue monitoring processes might choose to prioritize departments more prone to leaks. Respondents identified the following as the top three areas in which revenue leaks are most likely to occur:

- Drug administration (38%)
- Emergency department (36%)
- Clinics (e.g., wound care clinics, pain clinics, physician practices) (33%)

See Figure 11 for the full list of responses.

Figure 10. **Which of the following best describes your organization's approach to using technology to identify revenue leaks?**

Response	%
We use a vendor-built tool integrating into our EHR	19%
We use a homegrown tool integrated into our EHR	5%
We use vendor software that interfaces with our EHR but is not integrated with it	16%
We use homegrown software that interfaces with our EHR but is not integrated with it	1%
I don't know	27%
We do not use technology to identify revenue leaks	16%
We do not have tools or a process to identify revenue leaks	1%
N/A—this task does not apply to my organization	10%

Source: 2020 State of the Revenue Integrity Industry Survey

Figure 11. **What are the areas in which revenue leaks occur?**

Area	%
Drug administration	38%
Emergency department	36%
Clinics (i.e., wound clinics, pain clinics, physician practices)	33%
Pharmacy	32%
Surgery	32%
Clinical nursing areas	30%
Observation	24%
Cardiac cath lab	24%
Interventional radiology	23%
N/A—this task does not apply to my organization	21%
Other	15%

Source: 2020 State of the Revenue Integrity Industry Survey

LOWER A/R DAYS, FEWER DENIALS, AND INCREASED PAID CLAIMS

MARK ST. DENNIS,
Adirondack Health Patient Financial Services Analyst

Adirondack Health came to TruBridge after discovering they could save money over their previous clearinghouse. "We had a new director come in who'd been using a few of the revenue cycle management (RCM) product modules from TruBridge in his previous hospital," says Adirondack Health Patient Financial Services Analyst Mark St. Dennis. "The cost savings was the main reason we decided to switch to TruBridge." However, due to the seamless integration to Meditech as well as other product capabilities, the following benefits revealed themselves:

- 20% decrease in A/R days
- 40% reduction in denial rates
- $125,000 recovered in underpaid claims
- 22% increase in paid claims

The solution

Adirondack Health uses the full suite of integrated TruBridge RCM product modules, including claim scrubbing and submission, ERA retrieval, remittance management, denial and audit management, eligibility verification, and contract management. "We've also incorporated the Medicare Navigator module, which is really easy—one login, one system," says Kathy Bauer, director of patient financial services at Adirondack Health. "And it costs less than what we were using prior."

According to St. Dennis, it has been a good experience from the start. "With the help of the TruBridge experts and our dedicated staff, the overall improvement in key areas of the revenue cycle has exceeded our expectations."

The results

Decrease in A/R days. A quality RCM solution plays an important role in ensuring healthcare facilities get paid every dollar they deserve from both patients and payers. Since implementation, the TruBridge RCM product, including its integration to Meditech, has helped steadily decrease Adirondack Health's gross A/R days. The bottom line is that TruBridge RCM has helped Adirondack Health get paid faster while improving efficiencies across many areas of the revenue cycle.

Increase in paid claims and reduction in denials. With the TruBridge RCM product and additional process changes, Adirondack Health has experienced a 22% increase in paid claims. "We've found tremendous efficiency gains in the audit management module. Essentially, we have one individual who is our appeals and audit coordinator," says St. Dennis. "She's been incredibly impressed with the ability to track and manage claim appeals and, as such, we've seen significant improvements in our auditing, tracking, and appealing of denied claims."

While the increase in paid claims has been great, the best way to increase efficiency while still getting paid is to reduce the percentage of claim denials and the related effort to manage them. The TruBridge RCM suite has endless flexibility and customization on a payer-by-payer basis. This capability has enabled a 97% first pass clean claim rate, which specifically relates to the 40% reduction in denied claims. Simply put, "the TruBridge RCM suite has allowed us to operate more efficiently, saving us valuable time and money managing the ever-increasing complexity of healthcare billing," says St. Dennis.

Recovery of contract underpayments. Once live on the core TruBridge RCM modules, Adirondack Health added the contract management module. Since the mod¬ule can compare payer contract terms to actual paid claims, Adirondack Health was able to identify a variety of underpay¬ments. In fact, in the first 10 months, they identified one payer that had been underpaying claims by 2% for more than two years, and a second that was underpaying by 3% over a six-month period. With information and data to support their case, Adirondack Health successfully negotiated a settlement payment of $125,000 for the underpaid claims.

St. Dennis shares that the TruBridge contract management module provided a nice mix of technology and data that allowed Adirondack Health to compare contract terms against actual paid claims. "Having better tools to manage contracts and the related leverage to hold payers accountable will continue to help us get paid every dollar we deserve from our payers. ■

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Q&A: REVENUE MONITORING

The following is a question and answer session with **Anna Santoro, MBA, CCS, CCS-P, RCC,** system director of revenue integrity/CDM at Hartford Healthcare in Newington, Connecticut, on revenue monitoring as reported in NAHRI's 2020 State of the Revenue Integrity Industry Survey. Santoro is a NAHRI Advisory Board member.

Q: Nearly 20% of respondents use a vendor-built tool integrated with their EHR to identify revenue leaks. What kind of revenue leakage should revenue integrity aim to identify through the use of this technology?

A: Vendor-built tools can help identify revenue leakage in multiple clinical areas. When starting with a new tool, create a plan to address your hospital's high-dollar or high-volume areas, as well as specific areas of known concern. Focus on one or two areas at first. This will provide a good sense of how to use the tool and allow time to develop and create standard work. Standard work should include root cause resolution and a monitoring process. Create a plan with a list of focus areas based on dollar value, highest volume, or areas of concern so you can map out your objectives. Establish a monitoring process for previously identified and resolved revenue leakage, and be sure to track subsequent issues in those areas.

Q: What guidance do you have for revenue integrity teams looking to reduce revenue leakage in the emergency department (ED)?

A: In the ED, revenue leakage often occurs in the form of missing charges for supplies and bedside procedures. To ensure chargeable supplies are accounted for, work with the hospital supply chain department to develop a list of chargeable supplies used in the ED and link those supply items to the ED chargemaster. Once you have generated a complete list, develop a standard workflow process to capture those charges. As part of your process, enter charges into the billing system for each patient and perform daily reconciliation.

ED practitioners/physicians, consulting physicians, or physicians called from other areas in the hospital can all perform bedside procedures. It is key to have HIM coders thoroughly review the medical record and capture the technical component of those procedures. If coders are entering a CPT® code for bedside procedures, be sure there is an established workflow for linking these codes to the chargemaster.

Q: What guidance do you have for revenue integrity teams looking to reduce revenue leakage related to drug administration?

A: Drug administration revenue leakage is frequently related to the CPT code assignment for the administration. Retrospective coding reviews for CPT code assignment would verify whether the administration codes were assigned correctly. Review the assignment of the administration CPT codes to ensure modifiers are not used to incorrectly bypass National Correct Coding Initiative edits. In addition, review the documentation to ensure the start and stop times are included in the medical record. If times are missing, coders cannot assign the CPT administration codes. Educate clinical teams on appropriate documentation of start and stop times.

Q: What guidance do you have for revenue integrity teams looking to reduce revenue leakage in pharmacy charges?

A: Pharmacy revenue leakage is frequently related to incorrectly assigning drug units on claims. Work with your pharmacy department to verify they have the correct drug HCPCS code descriptions. Focus on the unit descriptions in the HCPCS code descriptor. Review current claims with high-dollar drugs. Calculate the units that should be reported on the claim by verifying the units provided to the patient based on the medical record documentation. If the calculation is correct, that is good news. If the calculation is not correct, there might be an issue with the pharmacy multiplier.

Q: What areas would you recommend facilities look to for revenue leakage after identifying and mitigating all low-hanging fruit?

A: Revenue opportunities may vary from one hospital to the next. The individual department revenue and usage reports can help gauge sudden or gradual declines in the expected average number of services. These declines may indicate there are missing charges or that a procedure requires a different CPT code. Ask the clinical department whether they have performed a new procedure. If the answer is yes, verify that the procedure is set up in the chargemaster and that charges are captured in the billing system.

Each department should perform a daily reconciliation of charges to ensure all patients who received services have been charged. Reviewing charge reconciliation reports can assist in identifying any missing charges.

Also consider reviewing outpatient procedures associated with multiple implants. Ensure all implants used for a procedure are captured and billed on the claim. ■