2023 STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY REPORT

NAHRI

MEET OUR ROUNDTABLE

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2023 STATE OF THE REVENUE INTEGRITY INDUSTRY SURVEY REPORT

NAHRI is celebrating the sixth annual Revenue Integrity Week (June 5–9) to acknowledge and raise awareness of the invaluable contributions of revenue integrity professionals in the healthcare industry. With the *2023 State of the Revenue Integrity Industry Survey Report,* NAHRI is taking an in-depth look at standards and trends across the industry to help shine a light on the work revenue integrity professionals do. The report highlights revenue integrity functions and areas of opportunity, program design, and more.

Revenue integrity is a data-driven profession. The report analyzes data on key topics, such as chargemaster maintenance and primary and supporting functions, to highlight standards and change and how revenue integrity programs are evolving to adapt to organizations' current needs.

REVENUE INTEGRITY DEPARTMENTS ARE MADE UP OF A VARIETY OF POSITIONS THAT REQUIRE PROFESSIONALS WITH DIVERSE BACKGROUNDS AND SKILLSETS.

Background and experience

Revenue integrity departments are made up of a variety of positions that require professionals with diverse backgrounds and skil sets. NAHRI asked survey respondents to report their specific job titles to better understand how departments are structured.

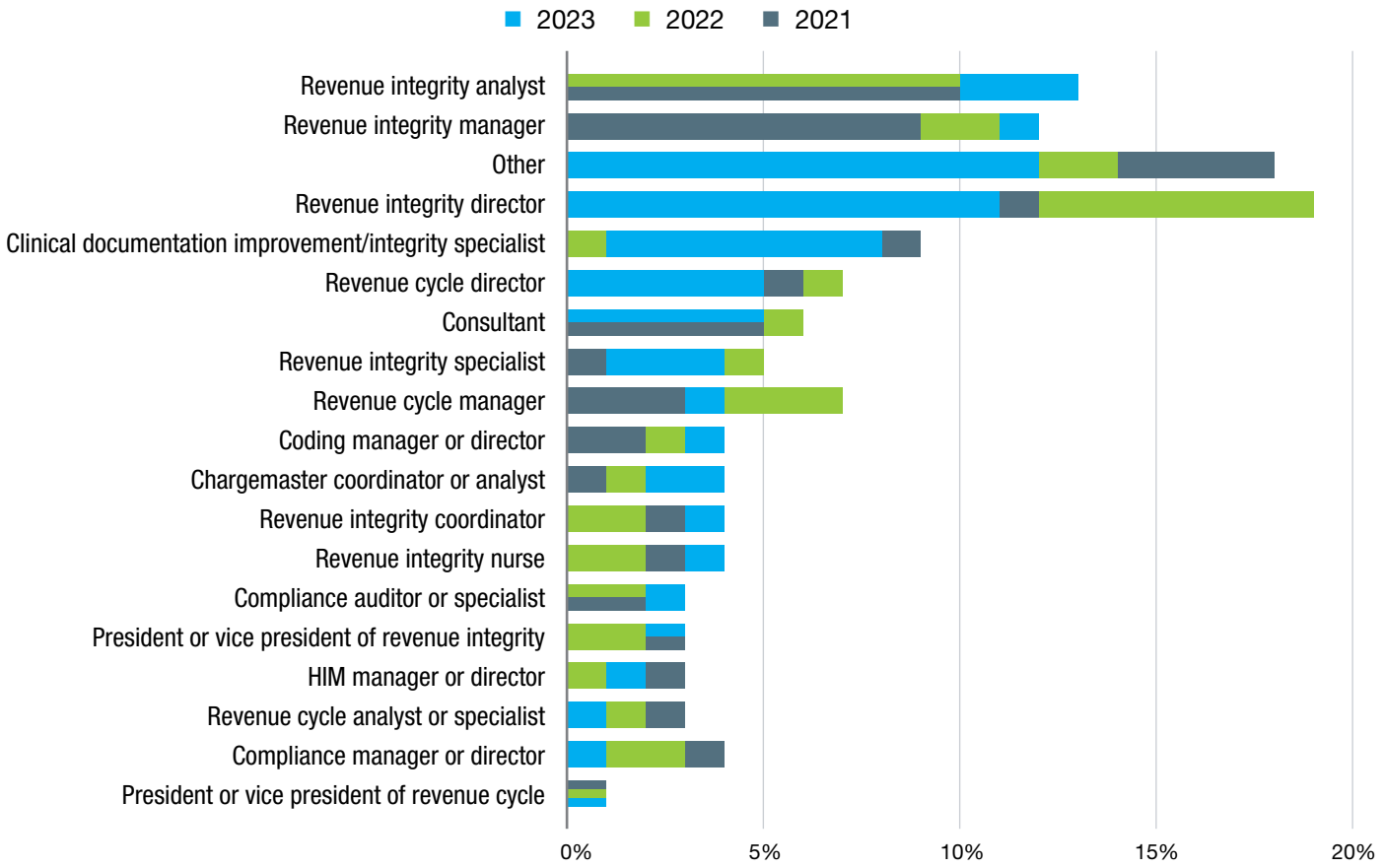
Similar to previous years, most survey respondents reported having revenue integrity-specific titles. The most common title was revenue integrity analyst (13%), followed closely by revenue integrity manager (12%). Several options were not chosen, such as utilization director, manager, and committee member.

Respondents who selected "other" (12%) listed their job titles, and their answers included the following:

- Billing specialist
- Director of payer enrollment and contracting
- Internal auditor
- Quality and training manager

See Figure 1 for more information on job titles.

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



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey

Nearly three-quarters of respondents (73%) reported that they work for an acute care hospital or health system, and 41% stated that their organization has at least 500 beds.

Primary and supporting revenue integrity functions

Although certain core functions tend to be common among revenue integrity programs, many programs are fine-tuned to their organization's specific needs. To gain insight into these trends and what skills and knowledge revenue integrity professionals need, survey respondents were asked about their revenue integrity program's level of involvement in various functions.

Respondents were asked to specify whether each function is a primary part of their program, something that the program plays a supporting but not leading role in, or something that does not fall under their program's purview at all.

The top primary revenue integrity functions, according to survey respondents, were as follows:

- Chargemaster maintenance (82%)
- Correcting claim edits (55%)
- Charge capture (54%)
- Chart auditing (47%)
- Charge reconciliation (46%)

Even when revenue integrity professionals don't own various functions, they play critical supporting roles. The following were most commonly reported:

- Charge reconciliation (49%)
- Denials management (45%)
- Charge capture (43%)
- Decision-support functions (42%)
- Claims auditing (37%)

In terms of functions that revenue integrity program are not involved in, the most commonly reported were as follows:

- Financial counseling (71%)
- Insurance verification (70%)
- Registration functions (69%)
- Patient admission status (52%)
- Managed care/payer contracting (52%)

Although chargemaster maintenance falls squarely in the revenue integrity wheelhouse, it makes sense that revenue integrity plays a supporting rather than primary role in charge capture and charge reconciliation, says NAHRI Advisory Board member **Tracy Cahoon, MBA, CHRI,** director of revenue integrity at Southwest General Health Center in Middleburg Heights, Ohio.

Defining your revenue integrity department's or program's scope is important, but it's also essential to stay alert for areas of opportunity. For example, revenue integrity professionals should familiarize themselves with their organization's insurance verification process, says **Tina Bui,** reimbursement integrity manager at Children's Hospital Colorado in Aurora, Colorado. If an incorrect insurance plan is attached to an account it will impact reimbursement and payment received. Other registration and insurance verification functions may also dovetail with revenue integrity functions, she adds. For example, in many behavioral health encounters, a patient's primary

Figure 2: **This is a primary function of our revenue integrity department/ program**

	2023	2022	2021
Chargemaster maintenance	82%	71%	66%
Correcting claim edits	55%	53%	52%
Charge capture	54%	52%	58%
Chart auditing	47%	41%	47%
Charge reconciliation	46%	44%	41%
Price strategies/methodologies	44%	N/A	N/A
Education	43%	48%	48%
Price transparency compliance	43%	N/A	N/A
Claims auditing	40%	36%	34%
Denials management	38%	39%	39%
Claims/payment reconciliation	29%	28%	31%
Decision-support functions	27%	30%	27%
Clinical documentation integrity	26%	23%	22%
Coding	25%	18%	33%
Internal audit	25%	31%	32%
Quality	19%	22%	22%
No Surprises Act compliance	18%	N/A	N/A
Patient billing	18%	21%	25%
Insurance verification	16%	16%	18%
Managed care/payer contract management	14%	14%	20%
Registration functions	13%	12%	14%
Patient admission status	13%	N/A	N/A
Financial counseling	8%	17%	17%

Figure 3. **Our revenue integrity department/program provides support, but it's not a primary function**

	2023	2022	2021
Charge reconciliation	49%	45%	43%
Denials management	45%	38%	53%
Charge capture	43%	40%	31%
Decision-support functions	42%	44%	36%
No Surprises Act compliance	37%	N/A	N/A
Claims auditing	37%	40%	47%
Coding	35%	40%	34%
Price strategies/methodologies	35%	N/A	N/A
Education	34%	37%	33%
Internal audit	34%	36%	37%
Quality	33%	33%	30%
Correcting claim edits	33%	30%	25%
Clinical documentation integrity	29%	32%	38%
Price transparency compliance	29%	N/A	N/A
Managed care/payer contract management	28%	33%	29%
Patient billing	27%	21%	23%
Claims/payment reconciliation	27%	32%	34%
Chart auditing	27%	30%	28%
Patient admission status	24%	N/A	N/A
Financial counseling	12%	8%	15%
Registration functions	9%	16%	18%
Chargemaster maintenance	8%	18%	17%
Insurance verification	7%	12%	16%

Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey

diagnosis can determine which health plan should be billed. Without clear guidelines on charging and billing from payer policies or a job aid on the expected workflow that spans the entire revenue cycle for these scenarios, the patient's coverage can be changed multiple times by different team members. This delays the billing process and creates follow up work after the claim is submitted, Bui explains.

In these cases, revenue integrity may be in a unique position to take the lead on spotting issues, identifying root causes, and setting solutions in motion, according to Bui. "Because our main focuses are to ensure appropriate charging, optimize reimbursement, and minimize risk, we need to have the full revenue cycle perspective. We often partner not only with our revenue cycle counterparts, but also with our managed care and clinical teams," she says.

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

Chargemaster maintenance

A well-maintained chargemaster is the keystone of revenue integrity. Even as the profession has evolved over the years, core revenue integrity responsibilities remain focused on managing the chargemaster and reviewing chargemaster updates.

In 2023, 52% of respondents indicated that a team is responsible for chargemaster maintenance, roughly in line with previous years. And while the number of respondents who reported they outsource this function has always been low, this year it bottomed out at 0%. See Figure 4 for more details on chargemaster maintenance strategies over the years.

Q&A: IDENTIFYING OPPORTUNITIES FOR REVENUE INTEGRITY

Q: What are some areas of opportunity for revenue integrity?

Tracy Cahoon, MBA, CHRI, director of revenue integrity at Southwest General Health Center in Middleburg Heights, Ohio:

I think managed care is an area of opportunity. I think when you're doing chargemaster maintenance, pricing strategy, and chargemaster strategy in general, being looped in with the managed care team to understand what your contracts are saying vs. how you are building things on the chargemaster is important. I think that there's a risk if you don't understand what your contracts are saying and what's being expected from a contracting point. Also, recently I've gotten more involved with our financial counselling and team that does the patient estimates. I think this is another area where there's an opportunity to make sure the team understands what should be incorporated into a quote for a patient estimate and [to make sure] they're using the right kind of logic to put together that patient estimate. We've found some areas where we were misquoting because of some wrong billing/charging assumptions when looking at an individual CPT/HCPCS code vs. quoting for the encounter level. So getting involved from that standpoint has been helpful and we're becoming a little more accurate how we're putting those quotes together now.

Andrew Reiten, managed care coordinator at Trinity Health in Minot, North Dakota:

Insurance verification is [an opportunity]. To me the easiest way to make money is to take a three or four month old self-pay account and find some insurance to add on to it. [There are] patients that are not responding to letters, they're not letting us know if they have insurance, but you can see they had a different visit where they had insurance or the eligibility systems will return an insurance. [With changes to Medicaid eligibility related to the end of the public health emergency], I think it's going to be rough in that we're going to have patients that we think have coverage, but then the eligibility systems are going to be retroactively updated and they're going to be self-pay. ■

The optimal way to structure this function may depend on the size of the organization, how many individual facilities it includes, and what EHR it uses.

MERGER AND ACQUISITION ACTIVITY, AS WELL AS STAFFING SHORTAGES AND CHANGES IN BUDGETS THAT MAY AFFECT TECHNOLOGY, COULD INFLUENCE CHANGES IN PROCESSES SUCH AS REQUESTS FOR CHANGES TO THE CHARGEMASTER.

At Southwest General Health Center, two people are responsible for chargemaster maintenance, Cahoon says. A chargemaster supervisor handles routine maintenance while Cahoon manages tasks such as the overall chargemaster strategy, pricing, and larger projects related to new departments or service lines.

Although depending on the EHR used it's possible for person to manage the chargemaster at multifacility organizations, generally assigning at least two people to chargemaster maintenance makes sense, says **Maureen Sloane, RHIT, COC,** chargemaster manager at Northside Hospital in Atlanta, Georgia.

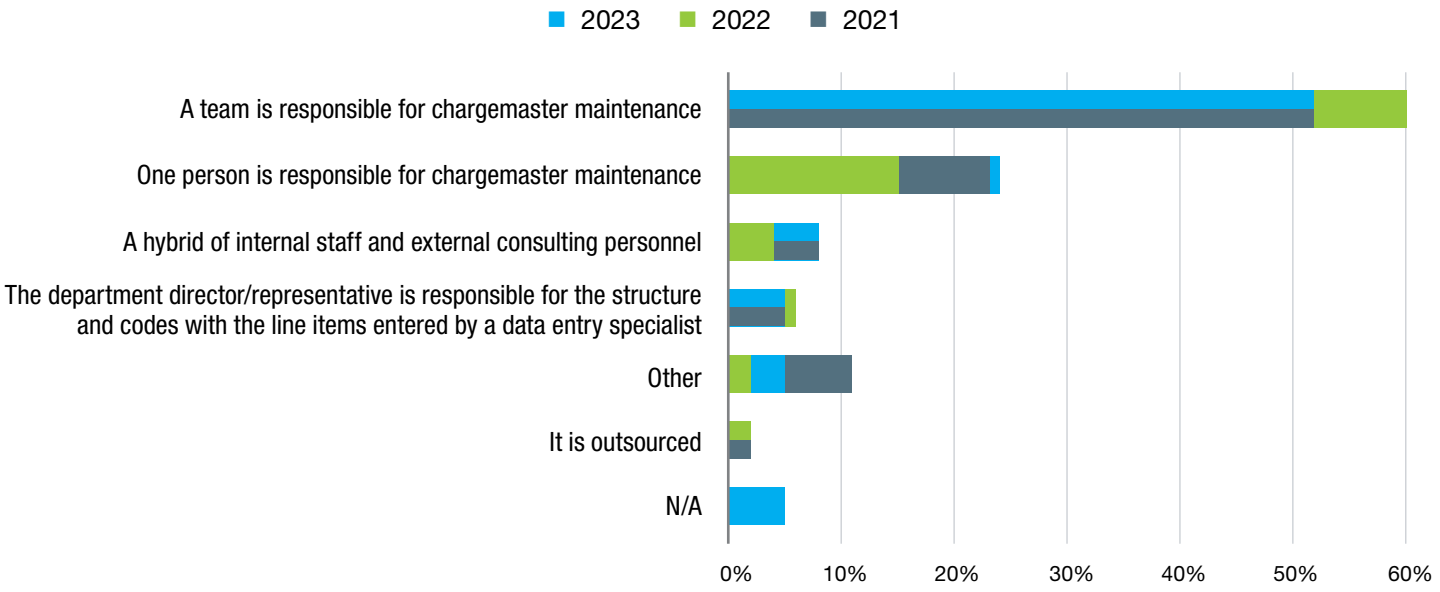
But even at a sole facility organization, it may be prudent to assign an additional person exclusively to manage the pharmacy chargemaster, says **Andrew Reiten,** managed care coordinator at Trinity Health in Minot, North Dakota.

This year saw some changes in chargemaster approval processes. In 2023, 30% of respondents reported that individual requests are routed to a team for approval (e.g., finance for pricing, HIM for coding), compared to 20% in 2022 and 18% in 2021.

Different approval processes may be better suited for different types of organizations—as well as various configurations of staffing and technology. Merger and acquisition activity, as well as staffing shortages and changes in budgets that may affect technology, could influence changes in processes such as requests for changes to the chargemaster.

"We have a SharePoint site for departments to request items, but most of the time they send emails to either [the revenue integrity supervisor] or myself," Cahoon

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



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey

says. "Then [we have to go] into the SharePoint site so we can try to track it. I'm in the process now of implementing Craneware and their new chargemaster maintenance workflow, so I'm hopeful that in the future we will have a more streamlined request process."

Northside Hospital in Atlanta, Georgia, eventually moved away from its team approach, according to Sloane.

"We started originally with a team approach but the requests would be hung up by so many people that it just wasn't working. [Now] we discuss it with the department and then the revenue integrity team does everything else," Sloane says.

See Figure 5 for more information on chargemaster approval processes.

EXPLODING CHARGES, PANEL CHARGES, AND OTHER MECHANISMS TO ENSURE A SINGLE CHARGEMASTER NUMBER TRIGGERS MULTIPLE CHARGES CAN BE CHALLENGING TO MAINTAIN.

Processes for handling Healthcare Common Procedure Coding System (HCPCS) code assignment to drugs and supplies are relatively unchanged year over year. A majority (74%) of respondents said that they assign HCPCS codes to all drugs and supplies when such a code exists. See Figure 6 for more details and a comparison to previous years.

Exploding charges, panel charges, and other mechanisms to ensure a single chargemaster number triggers multiple charges can be challenging to maintain—even though they are useful in circumstances such as charging lab panels. Some organizations opt to avoid them altogether to cut out the risks. When they are used, regular reviews are key to ensuring these types of charges are functioning as intended.

Continued on page 10. ▶

Figure 5. How is your chargemaster approval process structured?

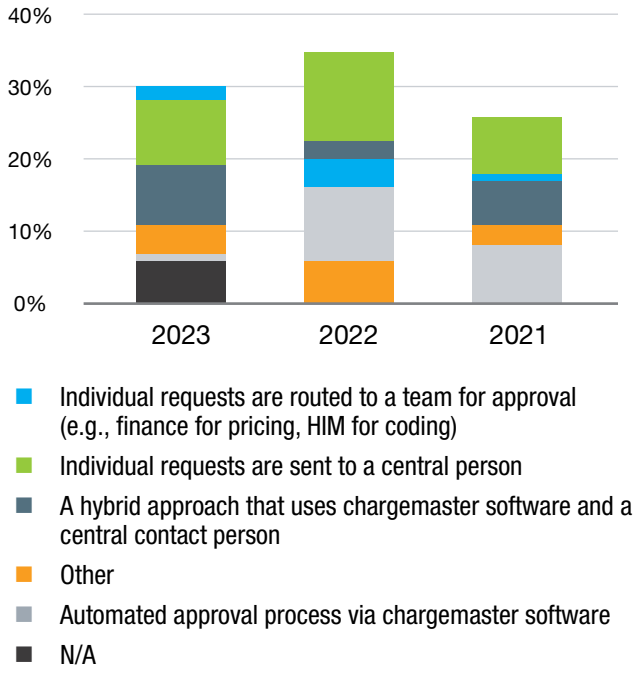
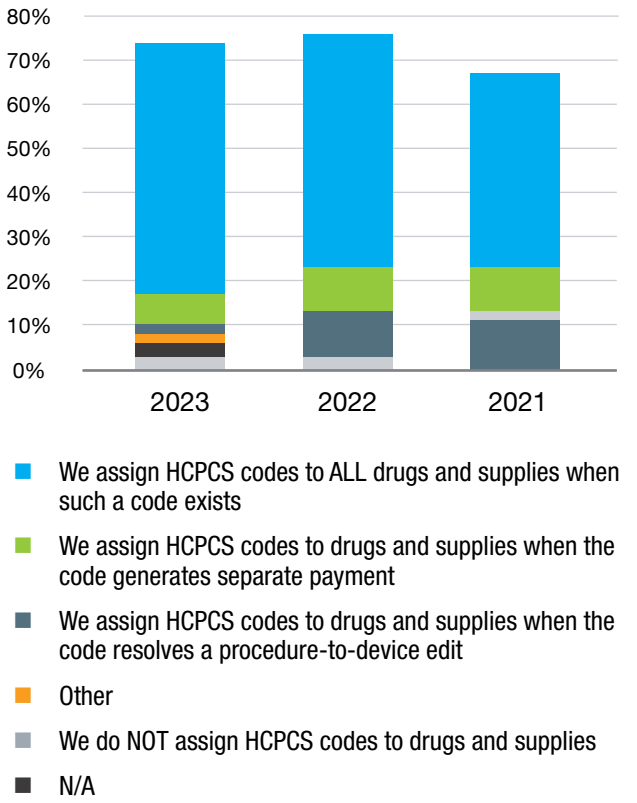


Figure 6. When do you assign HCPCS codes to drugs and supplies?



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey.

END OF COVID-19 PUBLIC HEALTH EMERGENCY Q&A

PROPEL Medicare

Please note: This information is accurate as of 5/12/2023, but guidance may have changed since that point. Please check the CMS website for the most up-to-date information.

Telehealth Terms

Distant Site: where the physician or other authorized practitioner is located when providing a service on the approved list of Telehealth Services.

Authorized Practitioners: Physicians, physician assistants, clinical nurse specialists, nurse practitioners, certified registered nurse anesthetist, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

Through December 31, 2024: also includes physical therapists (PT), occupational therapists (OT), speech-language pathologists (SLP), audiologists, RHCs and FQHCs.

Originating Site: where the patient is when the service is rendered, billed with Q3014.

May be a hospital, CAH, REH, physician office, RHC, FQHC, SNF, CMHC, renal dialysis facility, located in a rural area as defined in the statute.

Through December 31, 2024: Any site in the US, including the patient's home.

CAA of 2023: Consolidated Appropriations Act of 2023, enacted by Congress December 29, 2022, extending many flexibilities applicable during the PHE, most notably the rural and patient's home exception for the originating site and the addition of PT/OT/SLP providers as distant site providers.

Questions

1. May a hospital bill Q3014 after the PHE ends when the patient is located in their home?

No, Q3014 may only be billed by a hospital for originating site fee services provided in a hospital department (i.e., a hospital service). The patient's home may no longer be considered a department of the hospital after the PHE ends May 11.

Note: a hospital may still bill the originating site fee (Q3014) if the patient is in a hospital department, even if that hospital department is not in a rural area (through the end of December 31, 2024), provided the physician is at a distant site. (CAA of 2023)

2. May a physician provide telehealth distant site services after the PHE ends when the patient is located in their home?

Yes, the patient's home, including in a non-rural location, is considered an appropriate originating site through December 31, 2024. This would include calling out from a hospital outpatient department to a patient in their home. (CAA of 2023)

3. If a physician in the hospital department provides telehealth to a patient in their home, what POS is used?

Until December 31, 2023, use the POS where the service would have been furnished in-person (e.g., POS 19 for off-campus outpatient hospital departments or 22 for on-campus outpatient hospital departments). (2023 MPFS Final Rule; 87 Fed. Reg. 69466)

4. What services may the hospital bill when the patient is in their home?

- Remote mental health services billed with C7900 – C7902 may be provided to patients in their home when there is no associated professional service billable

END OF COVID-19 PUBLIC HEALTH EMERGENCY Q&A (CONT.)

- Chronic care management, billed with 99490, is a non-face-to-face service that may be provided to a patient not located in the hospital
- Remote monitoring services for patients with a monitoring device that transmits data to hospital staff

Additionally, CMS clarified in FAQs released May 12 (question #21), that PT, OT, SLP, DSMT, and MNT may be provided remotely through the end of CY2023 and hospitals are to bill "in the same way they have been during the PHE." The FAQ appears to include DSMT provided by RNs, even though they are not on the list of approved distant site providers as extended in the CAA of 2023. Additionally, the FAQ appears to limit PT, OT, and SLP to the end of 2023, even though they were added to the list of eligible distant site provider through the end of 2024 in the CAA of 2023. Finally, nutritionists employed by hospitals were approved telehealth distant site providers to provide MNT prior to the PHE, so it is unclear if the limitation to the end of 2023 applies to these services. Presumably, it does not.

The May 12 FAQ instructs hospitals to continue to bill in the same way they did before the end of the PHE, which presumably would be as a remote outpatient service for DSMT provided by an RN, but as either a remote outpatient service or as telehealth with the modifier -95 for PT/OT/SLP and nutritionists providing MNT. The FFS FAQs, Section MM Q1 and the second Q2 (misnumbered, following Q4) discuss these two billing options.

5. Is G0463 billable after the PHE when the patient is located in their home?

No, outpatient hospital clinic visits billed with G0463 are only billable when provided in a hospital outpatient department. The patient's home may no longer be considered a department of the hospital after the PHE ends May 11.

6. Will the position of the COVID diagnosis change?

Since COVID is inclusive in the Official Guidelines, there should be no changes in sequencing directives. However, the final changes for 2024 have not been released so there is a chance they could create a new code in another chapter of the manual since U07.1 is in the Emergency Use codes, which were not intended to be a permanent home for COVID. But one would assume even if moved out of the U codes to another section (infectious or respiratory codes), that it wouldn't revise the issues that are addressed surrounding COVID itself.

7. Is C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), any specimen) reportable after the end of the PHE?

It is unclear if this code will be reportable after the PHE. In the CY2023 OPPS Final Rule, CMS stated that the code was only for use during the PHE and discussed excluding data about the code from rate setting data. The FAQs on the expiration of various waivers and flexibilities does not specifically state if it is continuing or not, simply stating it was for use during the PHE and that it was a temporary code. Additionally, the COVID specimen collection codes for laboratory use and the flexibility for physician offices to bill 99211 for COVID specimen collection will end at the end of the PHE.

However, on a stakeholder's call on 4/25, a CMS representative stated C9803 would be continued through December 31, 2023. Further, it is not included in the mid-quarter termination edits for codes ending with the PHE in the Integrated Outpatient Code Editor. Providers should retain a copy of the transcript of the stakeholders call on file if they continue to bill the specimen collection code.

Additionally, note that the code is packaged to other services, such as visits, major or minor surgical procedures, diagnostic tests, drug administration services, etc., and not paid separately. It is paid separately if the only other services billed are laboratory tests. ■

This Q&A was provided following a PROPEL all-member quarterly call. If you'd like to learn more about PROPEL, visit our website.

▸ Continued from page 7.

Generally, organizations opt to review these charges annually (40%), similar to previous years.

Also in line with previous years, 22% chose not to use these mechanisms. See Figure 7 for more details.

IT GENERALLY TAKES THE LEAD WHEN IT COMES TO MAKING CHANGES TO CHARGEMASTER ORDER SETS, ACCORDING TO SURVEY RESPONDENTS.

"We started getting away from them because people set up panels and then you have personnel changes and then people don't remember why we set that up and what it was for. So, we try to get away from them as much as possible, but the ones we have left we review at least annually," Sloane says.

IT generally takes the lead when it comes to making changes to chargemaster order sets, according to survey respondents. Almost one-third of respondents (31%) indicated that IT is responsible for this task, while 27% reported the responsibility falls to revenue integrity. This tracks with trends seen in previous years that showed IT increasingly taking responsibility for changes to chargemaster order sets. See Figure 8 for more details.

"We have RNs in the IT department doing [that] for the clinical knowledge. It's a subdepartment inside the IT department called clinical informatics, and it's all RNs and other [staff with clinical backgrounds]. They have educational roles in terms of teaching clinical staff how to use order sets and document," Reiten says.

At Sutter Health in Sacramento, California, IT collaborates with revenue integrity to update order sets, which are primarily used in the radiology department. "Whenever a change needs to be made, our IT department works with our revenue integrity service line specialist for radiology to review those order sets to ensure they're accurate and that the coding is correct. Then [the revenue integrity service line specialist] works the ticket with IT and IT completes the request. The revenue integrity service line specialist works with the ordering physicians to make sure that everything is correct before it even gets to IT, so all IT has to do is make the changes," says **Crystal Tobin, COC, CHRI, ROCC,** revenue integrity service line specialist/subject matter expert at Sutter Health in Sacramento, California.

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

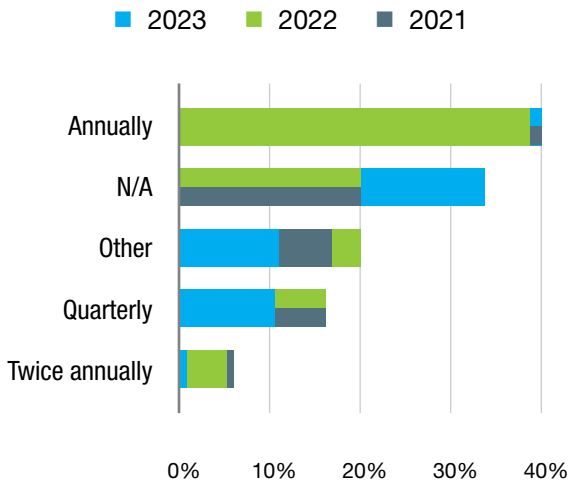
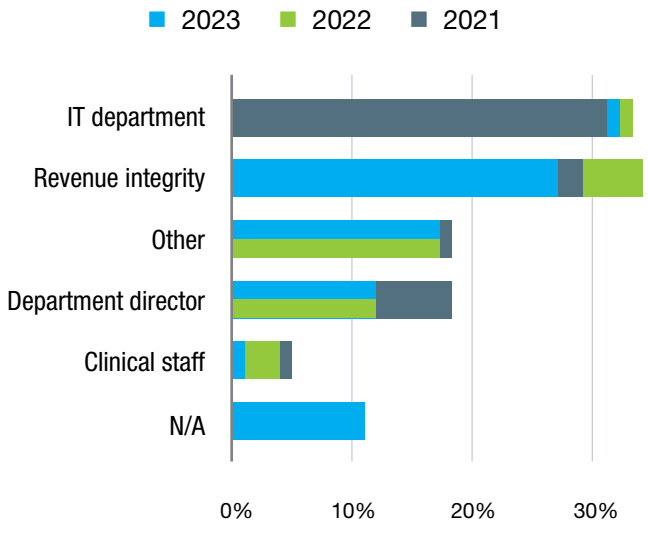
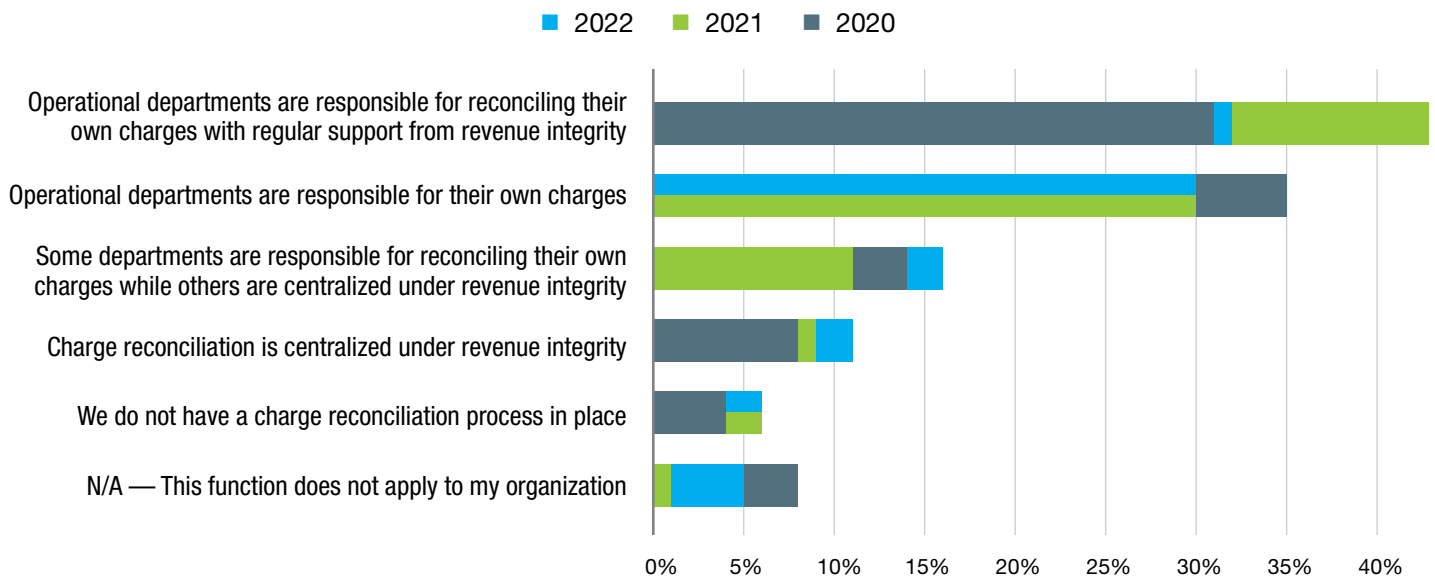


Figure 8. Who is responsible for making changes to chargemaster order sets?



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey

Figure 9. **Who is responsible for charge reconciliation?**



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey

Charge reconciliation practices

Regular charge reconciliation is an essential part of ensuring correct reimbursement. Although revenue integrity typically plays a supporting rather than a primary role in this function (see p. 4), it's still a major area of focus.

Thirty-two percent of respondents said that operational departments are responsible for reconciling their own charges with regular support from revenue integrity. At other organizations, operational departments are expected to be more independent: 30% of respondents reported that operational departments are responsible for their own charges. See Figure 9 for more information and a comparison of changes over the years.

Q&A: WORKING WITH OTHER DEPARTMENTS ON CHARGEMASTER APPROVALS

Q: How do you work with other departments when approving requests for changes to the chargemaster?

Tracy Cahoon, MBA, CHRI, director of revenue integrity at Southwest General Health Center in Middleburg Heights, Ohio:

We have a SharePoint site for departments to request items, but most of the time they send emails to either [the revenue integrity supervisor] or myself. Then [we have to go] into the SharePoint site so we can try to track it. I'm in the process now of implementing Craneware and their new chargemaster maintenance workflow, so I'm hopeful that in the future we will have a more streamlined request process.

Maureen Sloane, RHIT, COC, chargemaster manager at Northside Hospital in Atlanta, Georgia:

We started originally with a team approach but the requests would be hung up by so many people that it just wasn't working. [Now] we discuss it with the department and then the revenue integrity team does everything else. ■

Almost half (44%) of respondents said their organization's time for reconciling and correcting charges is one to three business days. However, the number of respondents reporting a time frame of four to five days increased slightly to 20% in 2023, compared to 16% in 2022.

Organizations may be making changes to acknowledge the reality of errors and what it costs to fix them further downstream. "I think there might also be a recognition of the costs of not allowing that extra day or two when there are errors and you don't get your proper reimbursement or denials or the cost of working late claims," Reiten says.

CMS REQUIRES HOSPITALS TO HAVE A POLICY FOR CARVING OUT PROCEDURES THAT INCLUDE ACTIVE MONITORING TO ENSURE THAT OBSERVATION HOURS AREN'T REPORTED FOR THE SAME TIME FRAME.

Survey respondents were also asked what types of charges are not entered by clinical staff. Observation hours (44%), emergency department (ED) (43%), and room and board (39%) were the most frequently reported. See Figure 10 for more information on charges not entered by clinical staff.

CMS requires hospitals to have a policy for carving out procedures that include active monitoring to ensure that observation hours aren't reported for the same time frame. When this responsibility is fulfilled manually, revenue integrity (23%) most likely handles it, followed by HIM/coding (17%), according to respondents. However, of the 26% who selected the "other" option many wrote that this function is automated in their EHR, removing the need to assign staff to it.

Even if a process is automated, though, staff should be assigned to review it to ensure it's functioning properly and be ready to intervene if they spot a system or operational issue. **Tracy Smith,** clinical operations at Pomerene Hospital in Millersburg, Ohio,

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

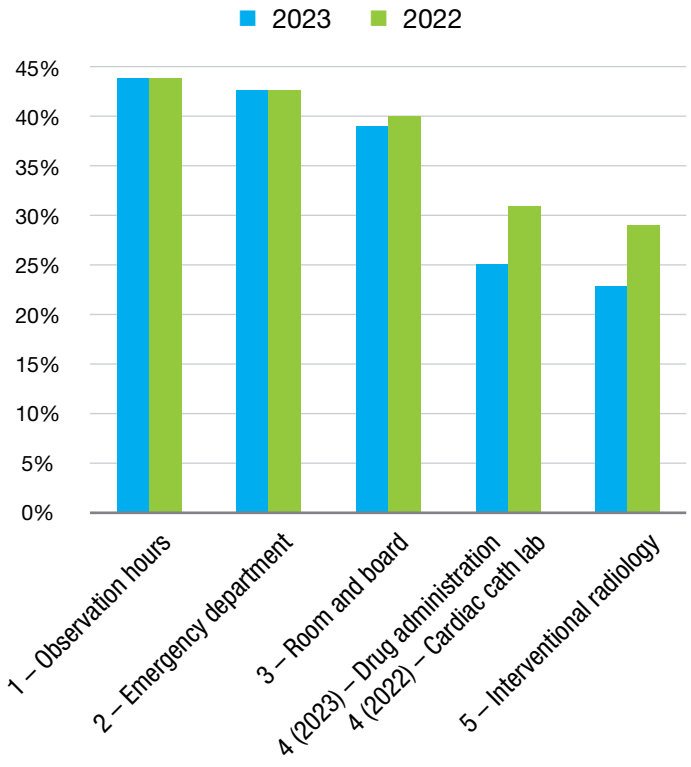
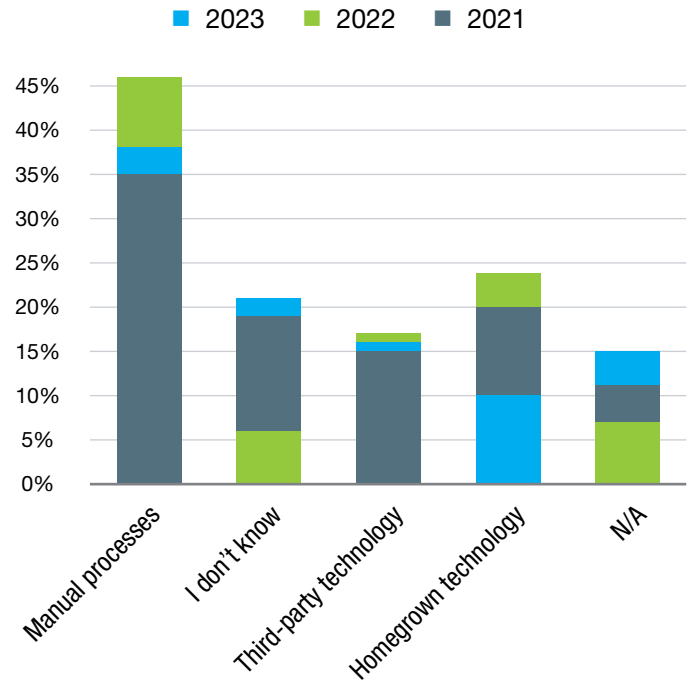


Figure 11. **How does your organization monitor charge reconciliation practices for consistency and appropriateness?**



Source: 2023, 2022, and 2021 State of the Revenue Integrity Industry Survey.

says her organization switched to an automated process that dropped ED charges based on a form filled out by ED nursing staff. However, due to the nature of that clinical area, clinical staff were not ideally positioned to own the function, and Smith had the task moved back to the revenue cycle.

AS PAYERS ISSUE DENIALS AT AN INCREASING RATE, REVENUE INTEGRITY PROFESSIONALS MUST ENSURE THEIR ORGANIZATION IS WELL EQUIPPED TO HANDLE WHATEVER COMES THEIR WAY.

When it comes to monitoring charge reconciliation practices for consistency and appropriateness, 38% said their organization relies on manual processes. Of those who use technology to support this task, 16% use third-party automation or other technology and 10% use homegrown automation or other technology. See Figure 11 for details.

Denials management

As payers issue denials at an increasing rate, revenue integrity professionals must ensure their organization is well equipped to handle whatever comes their way. It is imperative that they have systems in place that help manage—and prevent—denials. However, there is no one-size-fits-all approach. While some facilities have departments dedicated solely to denials management, others bring together people from a variety of teams.

NAHRI asked survey respondents to detail which departments are responsible for denials management at their organization. A majority of survey respondents (55%) reported that their patient financial services/business office department is responsible for denials management. In 2022, a majority of respondents (57%) said they have a dedicated denials management department. This year, 54% of survey respondents reported the same thing.

See Figure 12 for more information on denials management by departments.

Sutter Health has a dedicated resolution team for denials management, Tobin says. In addition, she tracks all revenue integrity-related denials and compiles the

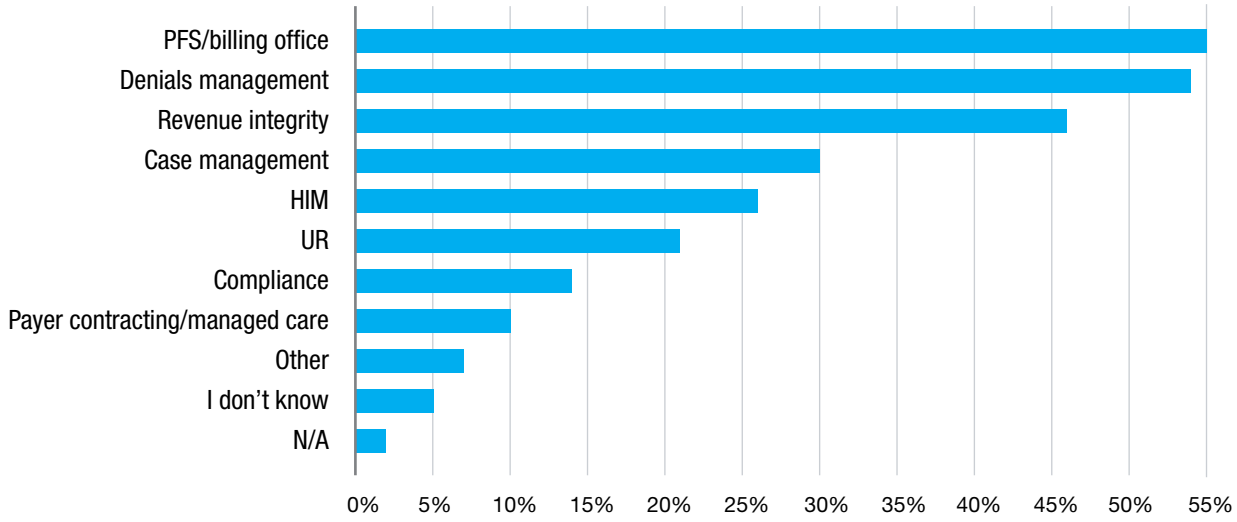
Q&A: ASSIGNING RESPONSIBILITY FOR CHARGE ENTRY

Q: If a clinical department does not enter their own charges, what staff member holds that responsibility?

Tracy Cahoon, MBA, CHRI, director of revenue integrity at Southwest General Health Center in Middleburg Heights, Ohio:
I have an observation charge capture specialist that reports to me. She is responsible for reviewing of all of our Medicare and Medicaid and managed care observation cases for accurate reporting of observation hours, which includes backing out the active monitoring time for the Medicare cases. The ED is charged out by our HIM department. Room and board automatically charges based on accommodation code and patient type. We have a charge capture specialist who does the manual charging for our cath lab and our interventional radiology as well.

Crystal Tobin, COC, CHRI, ROCC, revenue integrity service line specialist/subject matter expert at Sutter Health in Sacramento, California:
We have a team that does 100% review for observation hours for all of our patients. We have an ED charging team as well and they enter the ED charges. Room and board, the charge is automatically populated. For cardiac cath lab and interventional radiology, the departments are actually responsible for entering those charges but we do have a specialized coder who does 100% review of those to ensure that those are being sent out appropriately. ■

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



Source: 2023 State of the Revenue Integrity Industry Survey.

information in a monthly report. There is a lot of collaboration across her organization when it comes to denials management. "If I see that a payer doesn't like a particular modifier and there's a huge spike in denials, I will reach out to a service line specialist and our revenue integrity manager to let them know the issue," she says. "That way, we can nip it in the bud as soon as possible."

Tracking denials allows revenue integrity professionals to identify trends and take preventive measures. Every facility should document their denials in some way, shape, or form as it provides valuable information. NAHRI asked survey respondents how they track denials at their organization. Over three-quarters of respondents (77%)

TRACKING DENIALS ALLOWS REVENUE INTEGRITY PROFESSIONALS TO IDENTIFY TRENDS AND TAKE PREVENTIVE MEASURES. EVERY FACILITY SHOULD DOCUMENT THEIR DENIALS IN SOME WAY, SHAPE, OR FORM AS IT PROVIDES VALUABLE INFORMATION.

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

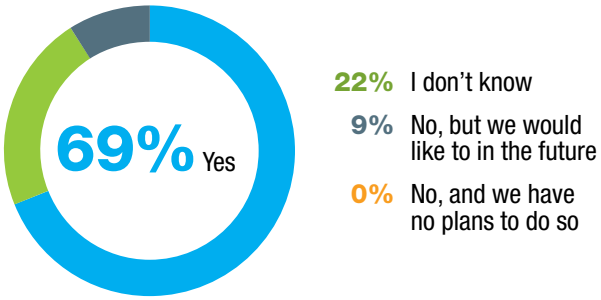
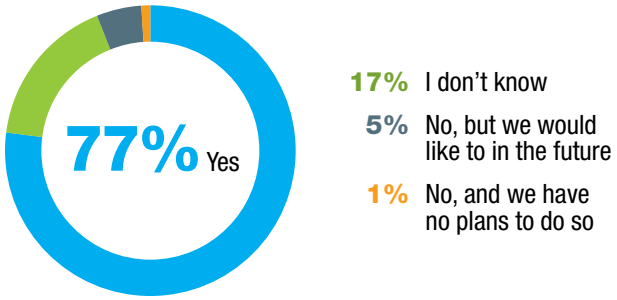


Figure 14. **Do you track denials by payer?**



Source: 2023 State of the Revenue Integrity Industry Survey.

reported tracking denials by payer, and 69% stated that they track them by reason/type.

See Figures 13 and 14 for more information on tracking denials.

Claim edits

Suspense periods are a valuable tool in ensuring claims are accurately coded and billed. Also known as pre-billing holds, suspense periods can help revenue integrity professionals make sure charges are correct and complete before submitting them. Organizations must clearly define these holds and make sure they are appropriate for their facility.

NAHRI asked survey respondents to detail their current suspense periods. Over three-fifths of respondents (66%) reported that their organization has a hold to review encounters/accounts. While 53% of respondents stated that they have holds targeted for specific scenarios (e.g., inpatient-only procedures), 13% said theirs is a random selection.

Thirty-nine percent of respondents said their suspense period is between three and four days, which is standard across the industry. However, Reiten wishes his organization's suspense period of three midnights was longer. "There are potential issues any time there's a federal holiday, blizzard, or anything of that nature," he says.

See Figures 15 and 16 for more information on pre-billing holds.

ALSO KNOWN AS PRE-BILLING HOLDS, SUSPENSE PERIODS CAN HELP REVENUE INTEGRITY PROFESSIONALS MAKE SURE CHARGES ARE CORRECT AND COMPLETE BEFORE SUBMITTING THEM.

NAHRI asked survey respondents to detail which departments resolve coding claim edits at their facility. Nearly three-quarters of respondents (71%) reported that HIM/coding and revenue integrity departments are involved. In 2022, only 58% of respondents indicated that their revenue integrity department participated in resolving coding claim edits.

Tobin says that the division of labor between HIM and revenue integrity is a fair representation of her

Q&A: IDENTIFYING PROCESSES FOR DENIALS MANAGEMENT

Q: What processes or systems do you have in place for managing denials?

Maureen Sloane, RHIT, COC, chargemaster manager at Northside Hospital in Atlanta, Georgia:
Our denials management department is ultimately responsible, but they certainly reach out to us in revenue integrity and ask for assistance. A lot of times they ask us why payers are denying certain claims and want to know more about the type of issue they're dealing with (e.g., charge, coding).

Tina Bui, reimbursement integrity manager at Children's Hospital Colorado in Aurora, Colorado:
At Children's Hospital, when we receive a denial, a follow-up record is created in Epic automatically and sent to the designated revenue cycle department that owns that denial reason. Each revenue cycle area is responsible for the initial review. If the denial requires an appeal, the team can route the account back to the billing office since they have a dedicated denials team to coordinate the appeals process to write the letters and follow up with the payer. If we identify a trend or pattern, it is escalated to a weekly joint call we have our billing office to validate the root cause and develop an action plan to prevent future denials. Most recently, Children's developed a multidisciplinary review of top denials that happens monthly. ■

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

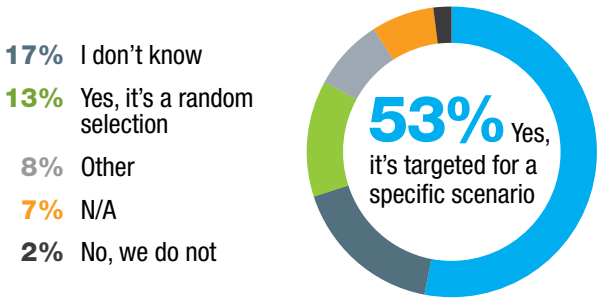
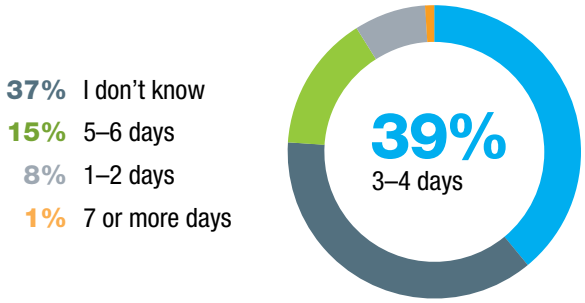


Figure 16. How long is your billing hold/suspense period?



Source: 2023 State of the Revenue Integrity Industry Survey.

organization. "If it was coded by HIM (e.g., diagnosis codes, surgical codes), they would resolve those claim edits," she says. "If it was charge related, or something entered by a department, we would send it to revenue integrity and our charge edit team of coders."

The answers were similar when NAHRI asked which departments review claim edit patterns for root cause analysis. Most respondents (71%) said that their revenue integrity department is involved, and over one-quarter of respondents reported that their patient financial services/business office (38%) and HIM/coding (31%) departments are involved.

See Figures 17 and 18 for more information on claim edits.

Challenges and benefits

Hospitals faced a tough financial situation over the past year, even as the COVID-19 pandemic slowly wound down. Ongoing financial difficulties often led to departmental budget cuts, which strained departments that were already grappling with staffing shortages. With fewer resources available to hire new staff, train existing staff, or implement technology to fill staffing gaps, revenue integrity departments and programs found themselves

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

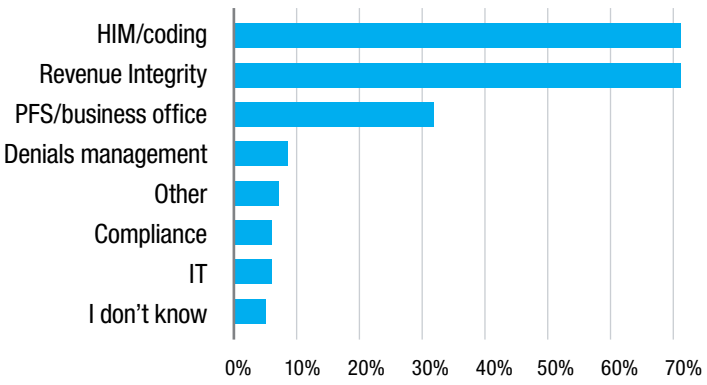
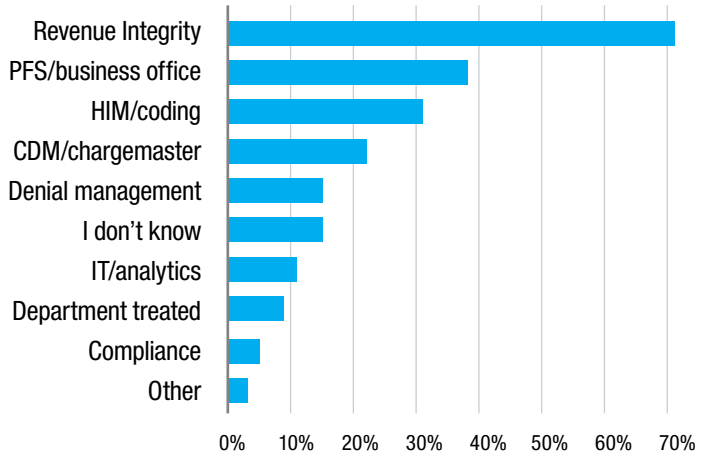


Figure 18. What departments are involved in reviewing claim edit patterns for root cause analysis?



Source: 2023 State of the Revenue Integrity Industry Survey.

asked to do more and more with less and less. To stay effective, revenue integrity professionals needed to think outside the box and focus on their strengths.

So, what's helping revenue integrity departments stay on track? It's the people who make the difference, according to survey respondents. Over 80% percent said their relationships with clinical departments had a positive effect on their department's or program's effectiveness over the past 12 months. Many revenue integrity responsibilities, from chargemaster and charging functions to denials management, depend on relationships with clinical departments. When interdepartmental connections are strong and everyone understands how their work supports the organization's overall mission, problems can be solved through cooperation and shared resources.

Meanwhile, what's derailing revenue integrity from achieving its goals? Here, 67% said that lack of qualified staff has had a negative effect on their department or program's effectiveness. Budget cuts make it harder to get approval to hire new staff—or even replace staff who've moved to a new role or organization. Qualified job

FACING REVENUE INTEGRITY CHALLENGES

What are revenue integrity's current top challenges? NAHRI asked respondents of the 2023 State of the Revenue Integrity Industry Survey to identify the biggest revenue integrity challenges facing their organizations. Here's what some of them told us:

- Accurate charge capture, particularly with provider-based billing.
- Inability to post positions due to finances, [how to] quantify denials from audits vs. claims vs. requests for medical records.
- Other departments' (patient financial services, coding, HIM) non-willingness to own their workflows and education.
- Coding compliance and quality is an issue, [as is] price transparency. Right now, we are also implementing a new chargemaster tool so that is a challenge.
- Consistency and recognition across all clinical departments. Being brought to the table when decisions are being made that impact revenue and denials.
- Departments working in silos (central business office, denials management, managed care contracts) and not communicating issues.
- Health system growth without staff, No Surprises Act, price transparency, denials management.
- Charge capture accuracy, coding compliance, denials management.
- Traditional revenue integrity functions are spread among multiple departments.
- Archaic, rigid system, staff leaving without training anyone to do work, short staffed, clinical departments not held responsible for errors.
- At this moment, our main challenge is staffing. We are currently under a hiring freeze and we are not able to backfill any positions if a staff member leaves; however, our system keeps growing. We are expected to do more work with less staff.
- Lack of understanding for revenue integrity's work and functions.
- Departments' ability to understand their role in the revenue cycle with the criticality of timely charges. With the turnover of clinical staff due to COVID, trying to find a way to effectively communicate charge reconciliation efforts.
- Enforcing standardized charge and reconciliation processes, telehealth, various payer-specific edits and programming related in the chargemaster or billing editor to avoid denials.
- Medicare Advantage plans not following Medicare guidelines. Commercial payers circumventing National Correct Coding Initiative edits by establishing payer policies.
- Defining an industry best practice revenue integrity department and allocating work to the correct teams. ■

seekers may have the advantage. To meet candidates expectations, and to retain existing staff, employers need to take stock of whether their compensation and benefits are truly competitive. It may be beneficial to consider augmenting monetary benefits with intangible benefits such as remote and hybrid work options.

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

What changes and challenges are on the horizon for revenue integrity? To learn more, NAHRI asked survey respondents to share the biggest challenges they're facing.

For many survey respondents, staffing is their biggest hurdle.

"At this moment, our main challenge is staffing. We are currently under a hiring freeze, and we are not able to backfill any positions if a staff member leaves; however, our system keeps growing. We are expected to do more work with less staff," one respondent said.

"[We have] more work with less staff and no new automation/IT options to assist in work functions," another respondent said.

Other respondents cited issues related to properly defining revenue integrity functions, best practices, and scope of work.

"No one understands what we do, so we are asked to do everything," a respondent said.

In some cases, these issues can be traced back to a lack of visibility in the organization or a lack of clarity at the C-suite level. To turn this around, revenue integrity leadership should take steps to raise their department's profile.

"My personal challenge this year is to be more visible and make revenue integrity more visible in the departments. [I plan to] work with them about how all of the different parts of the revenue cycle impact various areas of the organization," one respondent said.

Other common challenges include denials, payer audits, changing payer regulations, providing education to staff, and charge capture.

See the sidebar on p. 17 for more on revenue integrity challenges.

As we hit the halfway point of 2023, what projects and goals are revenue integrity professionals working

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

	Positive effect	Negative effect	No effect	N/A
Use of automation (e.g., automation charges, edit management)	**73%**	5%	9%	13%
Resolving claim edits	**73%**	5%	15%	6%
Managing denials	**62%**	9%	21%	8%
Conducting internal audits	**51%**	4%	24%	21%
Lack of qualified staff	8%	**67%**	10%	15%
Use of productivity measures	**39%**	16%	23%	22%
Relationship with IT/analytics	**67%**	13%	17%	4%
Relationship with other middle revenue cycle departments	**70%**	4%	16%	10%
Relationship with clinical departments	**81%**	5%	10%	4%
Expansion of duties to non-revenue integrity related functions	**33%**	24%	24%	18%

Source: 2023 State of the Revenue Integrity Industry Survey.

toward? To find out, we asked survey respondents what changes they're looking to implement.

"More up-to-date systems and more support from leadership to educate and then make departments accountable and responsible for the revenue functions from the clinical systems," one respondent said.

"I would like to see revenue integrity return to a wholistic approach for each facility in our organization to provide true revenue integrity service rather than just resolution of billing edits," another respondent said.

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

PLANNING FOR CHANGES AND IMPROVEMENTS

Revenue integrity is constantly evolving to keep up with the healthcare industry. To find out what new goals revenue integrity professionals have set, NAHRI asked respondents of the 2023 State of the Revenue Integrity Industry Survey what changes they'd like to implement. Here's some of what they told us:

- Redesign and reporting enhancement of audit and appeal denial management. Utilizing missing charge capture tool for education. Review of all orderables and supplies to determine charge capture compliance.
- Implement a charge reconciliation program and begin department-specific monitoring.
- I'd like to see subject matter experts for edits who could work those accounts to ensure accurate charging. I would like to see more staff educated in chargemaster maintenance. I would like to see more staff assigned to be the primary contact for a facility instead of just working through random queues of billing edits.
- More automation, more root cause analysis, more hospital and payer interaction.
- Remove coding edit resolution from revenue integrity and place under coding.
- More team members, cleaner definitions of what is required of my team.
- More staff, enhanced KPIs/metrics, more proactive education to clinical teams.
- More up-to-date systems and more support from leadership to educate and then make departments accountable and responsible for the revenue functions from the clinical systems.
- I would like to see revenue integrity return to a wholistic approach for each facility in our organization to provide true revenue integrity service rather than just resolution of billing edits.
- Establish workflows/processes, set and reach goal for cleaning up chargemaster according to industry standard best practice and CMS guidelines, pull together a denials management team, decide on workflows/processes and communicate them.
- Create a denial management team to streamline our denials processes, find solutions to the root cause of the denials and build teamwork between registration, business office and HIM. Create an education program to build confidence with our coders and billers and help them to be more successful in their roles.
- Implement more auditing and less error correction.
- I would like to have an outpatient CDI program and bring coding under revenue integrity.
- Developing a denial review committee based on root cause analysis. Comprehensive charge reconciliation program Increasing use of automation.
- More automation of repetitive tasks that allow more time for complex tasks that require human intervention.
- Additional full-time employees to do prospective auditing; receive more information on denials and write-offs. ■