2021 NAHRI LEADERSHIP COUNCIL RESEARCH:

Takeaways for Revenue Integrity Professionals

NAHRI National Association of Healthcare Revenue Integrity

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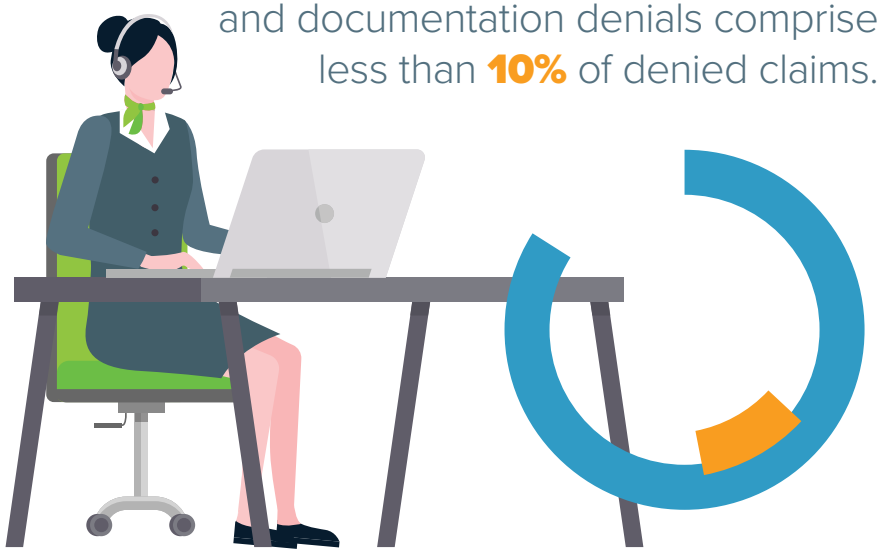
DENIALS MANAGEMENT CONTINUES TO BE A SIGNIFICANT CHALLENGE for healthcare organizations in 2021, made worse by the pandemic, which triggered a significant shift to virtual care services and many other changes that impacted billing, claims, and coding processes. As hospitals and provider organizations resume normal operations, they are looking to kick into high gear with a fresher perspective and approach to denials management. Revenue integrity, coding, and HIM leaders are doubling down to improve training and workflow processes, as well as turning to advanced technologies to reduce coding and documentation errors, speed up review and audit processes, and ultimately drive more clean claims out the door to minimize denials.

In collaboration with 3M Health Information Systems, NAHRI issued a survey in February 2021 to members of the NAHRI Leadership Council. Respondents revealed the coding and documentation issues with which they struggle most, the main reasons for denials, along with audit patterns and best practices for managing errors and denials, and ways technology can impact denial rates.

After conducting the survey, the NAHRI Leadership Council held two 90-minute panel sessions with Council members to review and interpret the survey results and share proven best practices from their own organizations. Following is a summary of the findings and highlights.

CODING AND DOCUMENTATION DENIALS

Surprisingly, **84%** of survey respondents say coding and documentation denials comprise less than **10%** of denied claims.



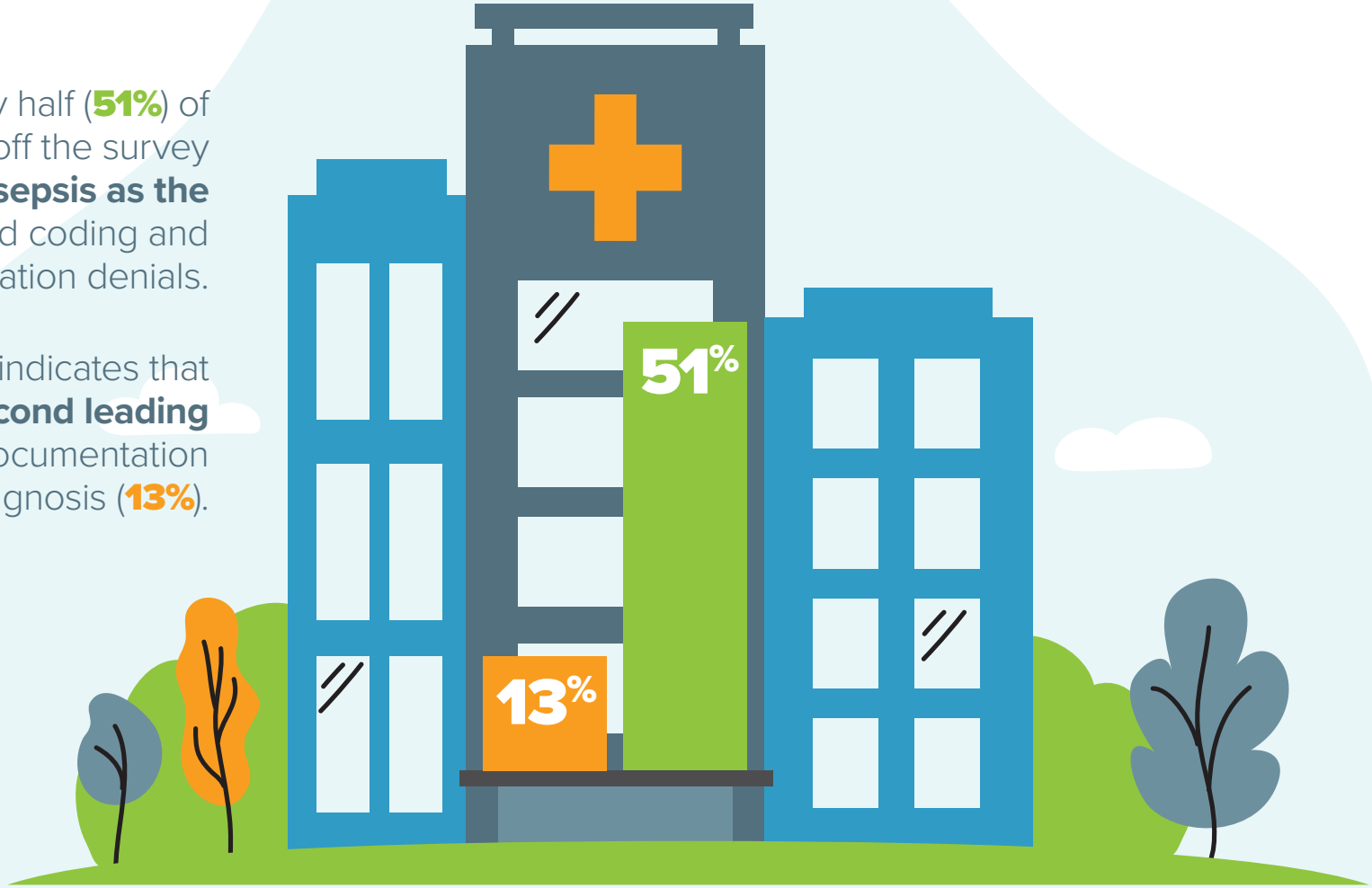
"Sepsis is our No. 1 denial from an inpatient perspective," says Katy Howard-Rife, director of revenue cycle support at Indianapolis-based Eskenazi Health. "All of our coding denials go back to our coding team for review, and they work the denials."

"Physicians will say sepsis in one progress note and never refer back to it. We look at it as an issue to handle before coding," says Karna Stroschein, director of coding at Prairie Lakes Healthcare System in Watertown, South Dakota. "We purchased a CDI product that helps with writing, and it has good documentation tips for the physician. We also use ACDIS information that helps us be more proactive with physicians," she adds.

CODING AND DOCUMENTATION DENIALS

Approximately half (**51%**) of respondents kicked off the survey by identifying **sepsis as the primary reason** behind coding and documentation denials.

The survey also indicates that **diabetes is the second leading cause** of coding and documentation denials by diagnosis (**13%**).



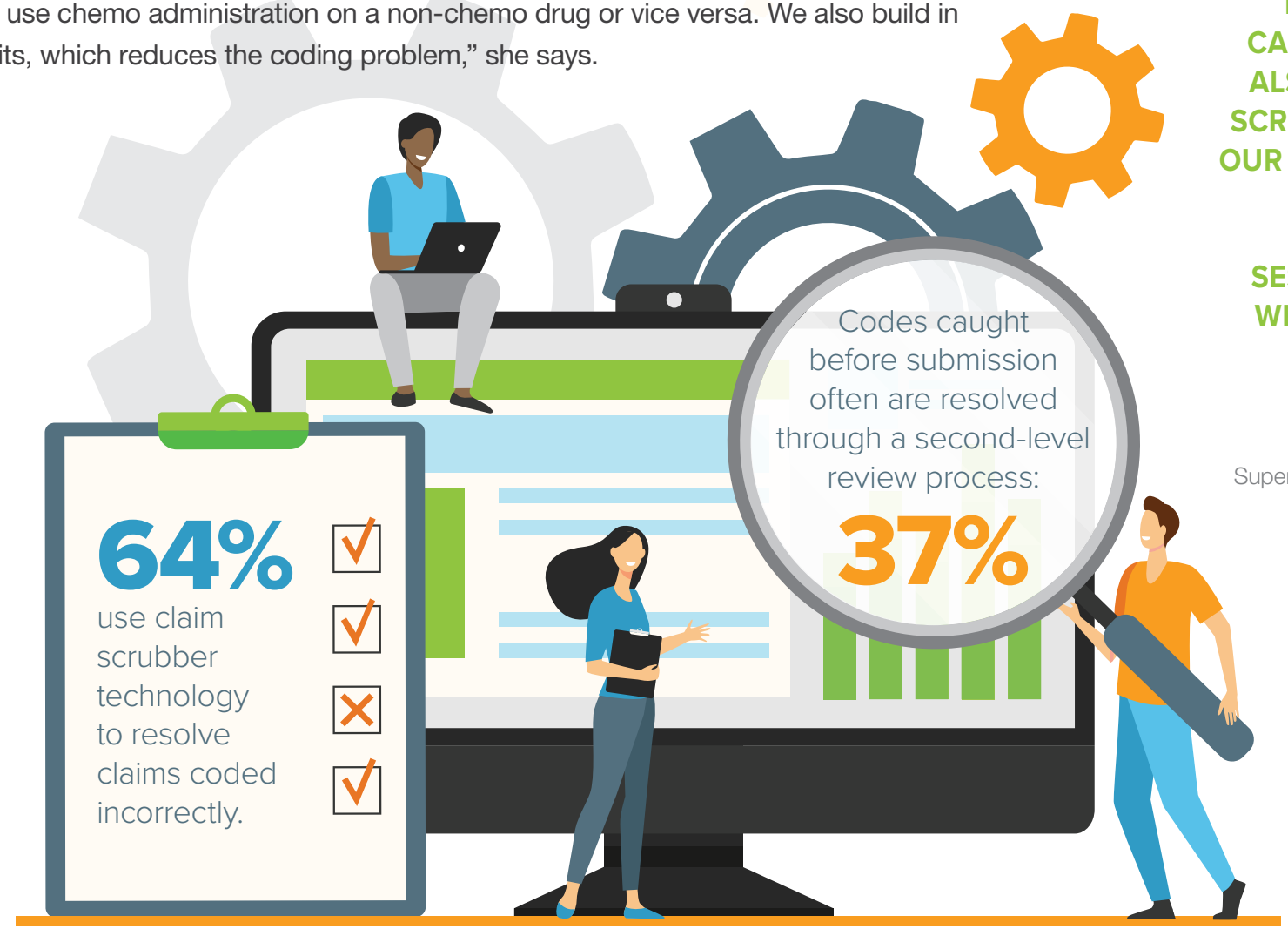
"We had a trend in which Type 1 diabetes and Type 2 diabetes were being documented on the same patient. The physicians knew what kind of diabetes the patients had, but the documentation templates were adding in both." says Jackie Woolnough, director of revenue integrity at MetroHealth System in Cleveland. Additionally, Woolnough says her department recognized an opportunity to better capture Hierarchical Condition Category codes for malnutrition by documenting and coding the patient's BMI.

RESOLVING CLAIMS

"We're small enough where if we find an edit on the 3M side or within the billing edit, we take it one step further and send it back to the department and make them responsible for the correction," says Karna Stroschein, director of coding at Prairie Lakes Healthcare System in Watertown, South Dakota. "We feel education is critical to changing processes, so we help them understand what they missed, why they're getting an edit for a device, or why they use chemo administration on a non-chemo drug or vice versa. We also build in those edits, which reduces the coding problem," she says.

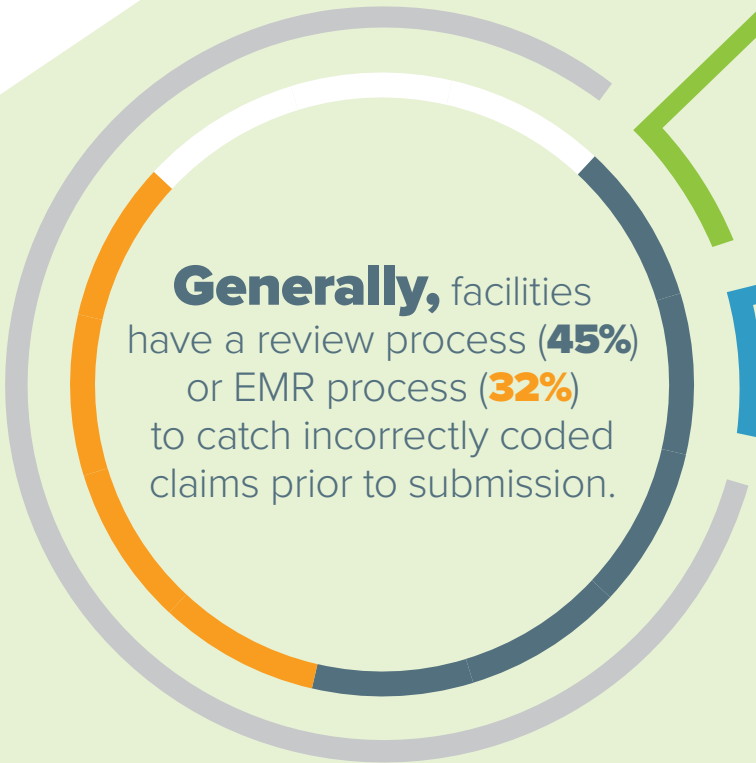
"FOR EXAMPLE, ONE SET OF EDITS MIGHT BE FOR REGISTRATION AND WOULD ADDRESS ERRORS SUCH AS A MISSING PRIMARY CARE PROVIDER. WE ALSO HAVE A CLAIM SCRUBBER THROUGH OUR CLEARINGHOUSE, AND WE ARE BIG ON WORKING SESSIONS IN WHICH WE TROUBLESHOOT CLAIM EDITS."

—Paula Twiss, MBA, CRCS-P, CRCS-I,
Supervisor of Revenue Integrity,
Monument Health,
Rapid City, North Dakota



"We are tasked to add the CDM, so we do not bring it back to our physicians. We have the opportunity and the security to review the documentation."

—KARLA GIBBS, COC-H,
Principal Analyst of Revenue Integrity,
UCLA Health System, Los Angeles



Generally, facilities have a review process (**45%**) or EMR process (**32%**) to catch incorrectly coded claims prior to submission.

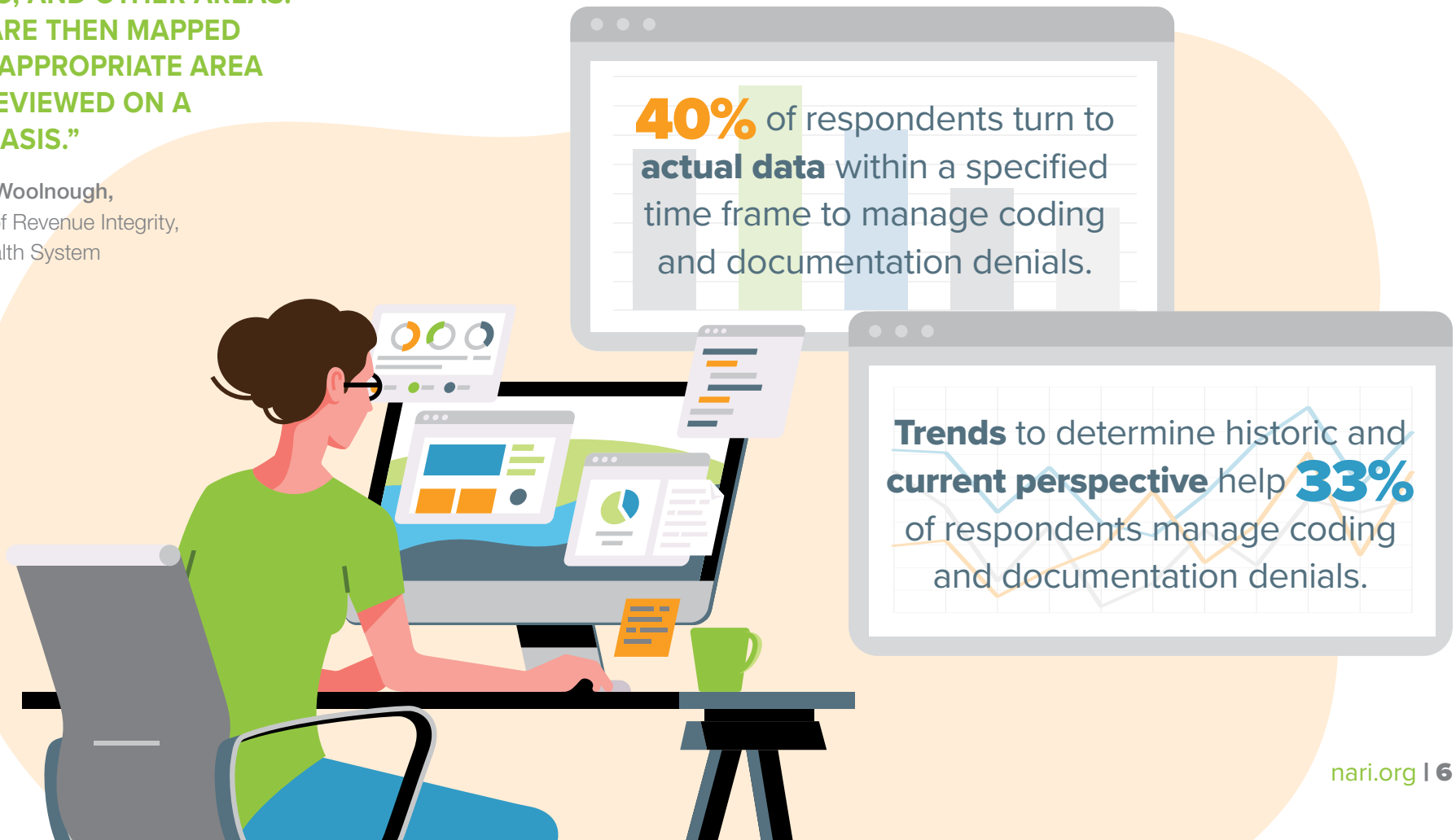
42% use **custom coding edit technology built into the EMR** to resolve claims coded incorrectly but caught before submission.

63% use **coding edits at the point of coding** to resolve claims coded incorrectly but caught before submission often.

"WHEN WE'RE LOOKING AT ACTUAL DATA, WE TAKE 100% OF THE REJECTIONS THAT COME IN WEEKLY AND USE AN INTERNAL MAPPING SYSTEM TO LINK REMIT AND REMARK CODES TO CODING, AUTHORIZATION, BILLING, AND OTHER AREAS. THEY ARE THEN MAPPED TO AN APPROPRIATE AREA AND REVIEWED ON A 100% BASIS."

—**Jackie Woolnough,**
Director of Revenue Integrity,
MetroHealth System

"In terms of metrics, we're looking at volumes of denials and dollars in denials," says Katy Howard-Rife, director of revenue cycle support, Eskenazi Health. She notes that a hospital denials committee meets biweekly to review denials by reason codes. "The top five denials are constantly being looked at and then added to as we address root cause issues." She adds that each department looks at its denials and places items back in its work queues. "We also look at denials from a coding and documentation perspective to ensure that 100% of the accounts are looked at before they were billed out, especially in the outpatient setting."



"We're doing a monthly audit, and one of the things that we discovered in doing this is that because our clinics are on a different EMR, their chargemaster has been causing many problems and not being updated. Now we have in place a special group that watches them as well."

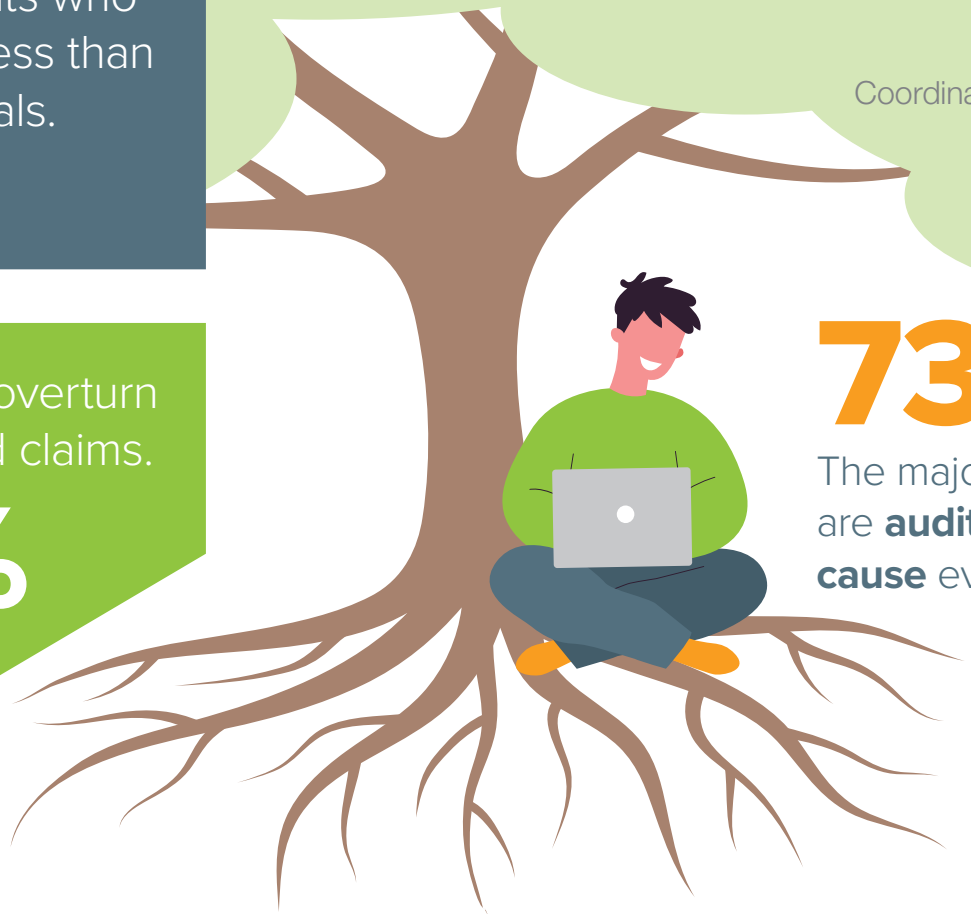
—**PRISCILLA FROST, AGS, CPC,**
Coordinator of Revenue/Compliance Auditor,
North Caddo Medical Center

68%

Survey respondents who say they overturn less than half of all denials.

Respondents who overturn 51%–75% of denied claims.

25%

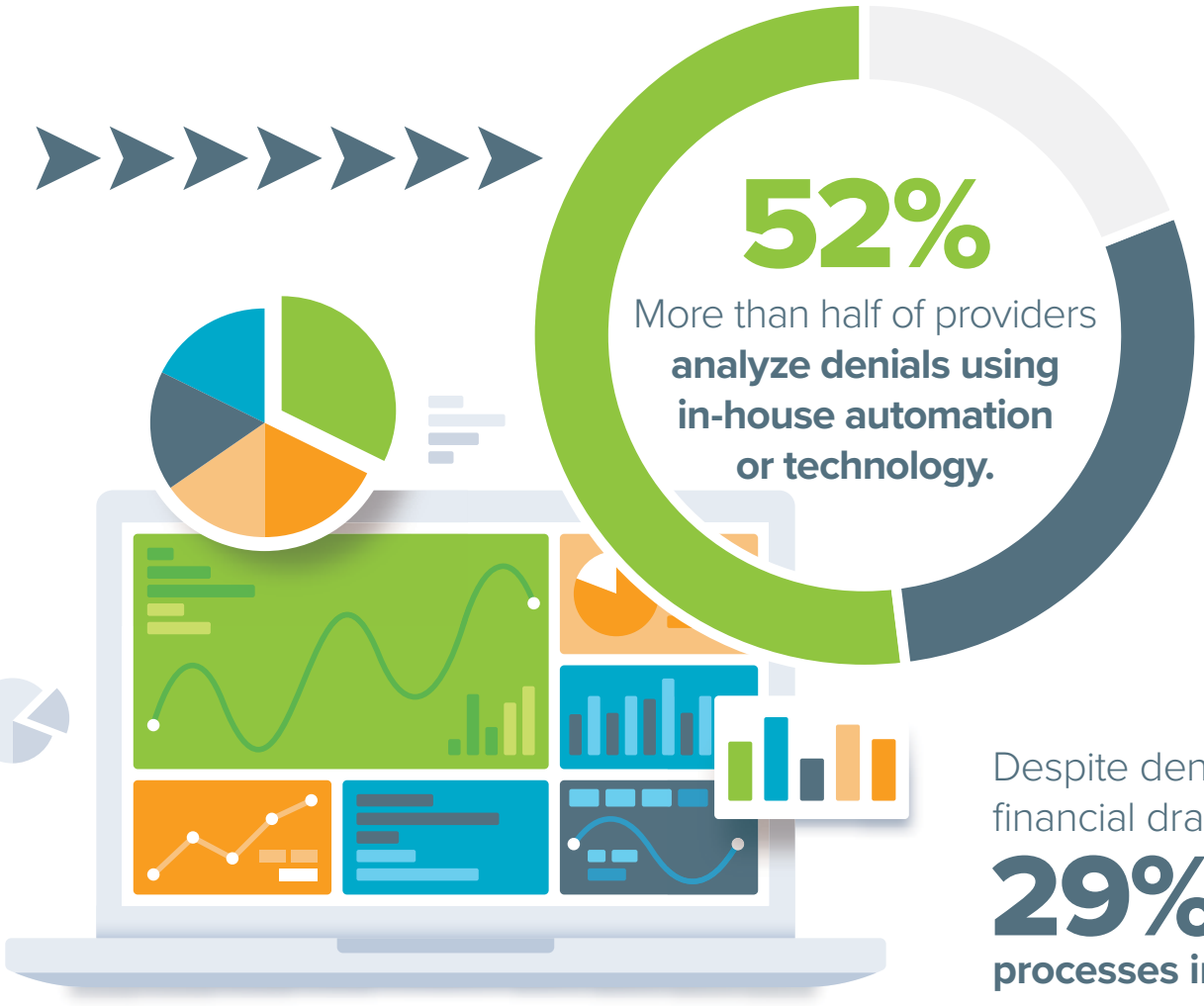


73%

The majority of survey respondents are **auditing denied claims for root cause** every month.

ANALYZING DENIALS TECHNOLOGY

"Denials are separated by CAS codes and fed through smart feeds/work queues in the vendor tool (Med-Metrix) to the applicable areas to work the denials. For example, a coding-related denial goes to the billing follow-up team through a Med-Metrix smart feed/work queue, who review and send multiple patients to HIM via an Excel® spreadsheet for review and recoding as applicable," says Vrinda Kosgi, Director of Revenue Integrity, Augusta University Medical Center.



"WE HIRED A CODER WHO REVIEWS THE AUTHORIZATIONS THAT ARE IN PLACE ON THE DAY OF THE PROCEDURE OR THE DAY AFTER SO THEY CAN GET A RETRO AUTH WITHIN 24 HOURS, WHICH IS WHAT SOME OF THE PROVIDERS REQUIRE. BY DOING THIS, WE'VE REDUCED OUR AUTHORIZATION ISSUES AND AUTHORIZATION DENIALS ... I THINK A LOT OF THE BUY-IN FROM OUR PROVIDERS HAS BEEN FROM BEING A PARTICIPANT IN THE PROCESS AND SEEING THE SUCCESS AND HOW VALUABLE THEIR PARTICIPATION HAS BEEN IN GETTING OUR DENIAL RATE REDUCED."

—Terresa F. Odum, MBA, PMP, CCS, CPC,
Cardiovascular Institute Revenue Operations Manager, Carilion Clinic

Despite denials being a substantial financial drain on healthcare systems, **29%** of participants **do not have technology or automation processes in place** to analyze denials.

TOP CAUSES FOR DENIALS

33% Inaccurate or incomplete provider documentation

17% Coding errors

16% Inaccurate patient demographic information

"We don't see a lot of denials due to our providers, and I think that's due to the work that our CDIs are doing … For the most part, our physicians are pretty good about working with our CDIs to resolve any knowledge deficits they have that are impacting our denials and causing write-offs," says Shawishi T. Haynes, Ed.D., MS, FACHE, director of revenue cycle operations at Valley Presbyterian Hospital in Van Nuys, California

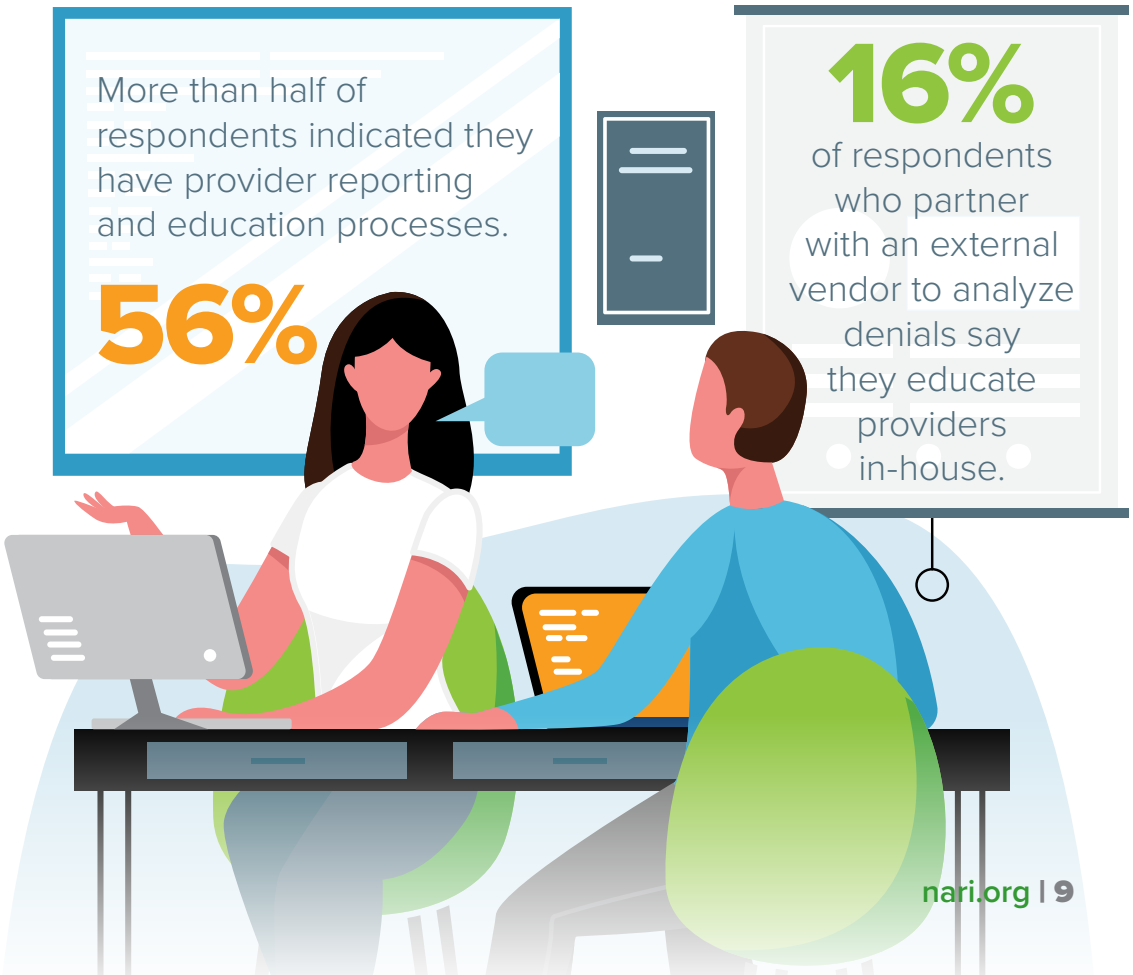
"WE HAVE OUR VENDOR THAT ANALYZES THE DATA AND PROVIDES US A MONTHLY REPORT OF OUR REMIT DENIALS … THE VARIOUS TEAMS MEET BEFORE THE BIG SUMMARY OF OUR DENIALS TO PREPARE FOR THAT MEETING AND FIGURE OUT ROOT CAUSE."

—Tracy Cahoon,
Director of Revenue Integrity,
Southwest General Health Center

More than half of respondents indicated they have provider reporting and education processes.

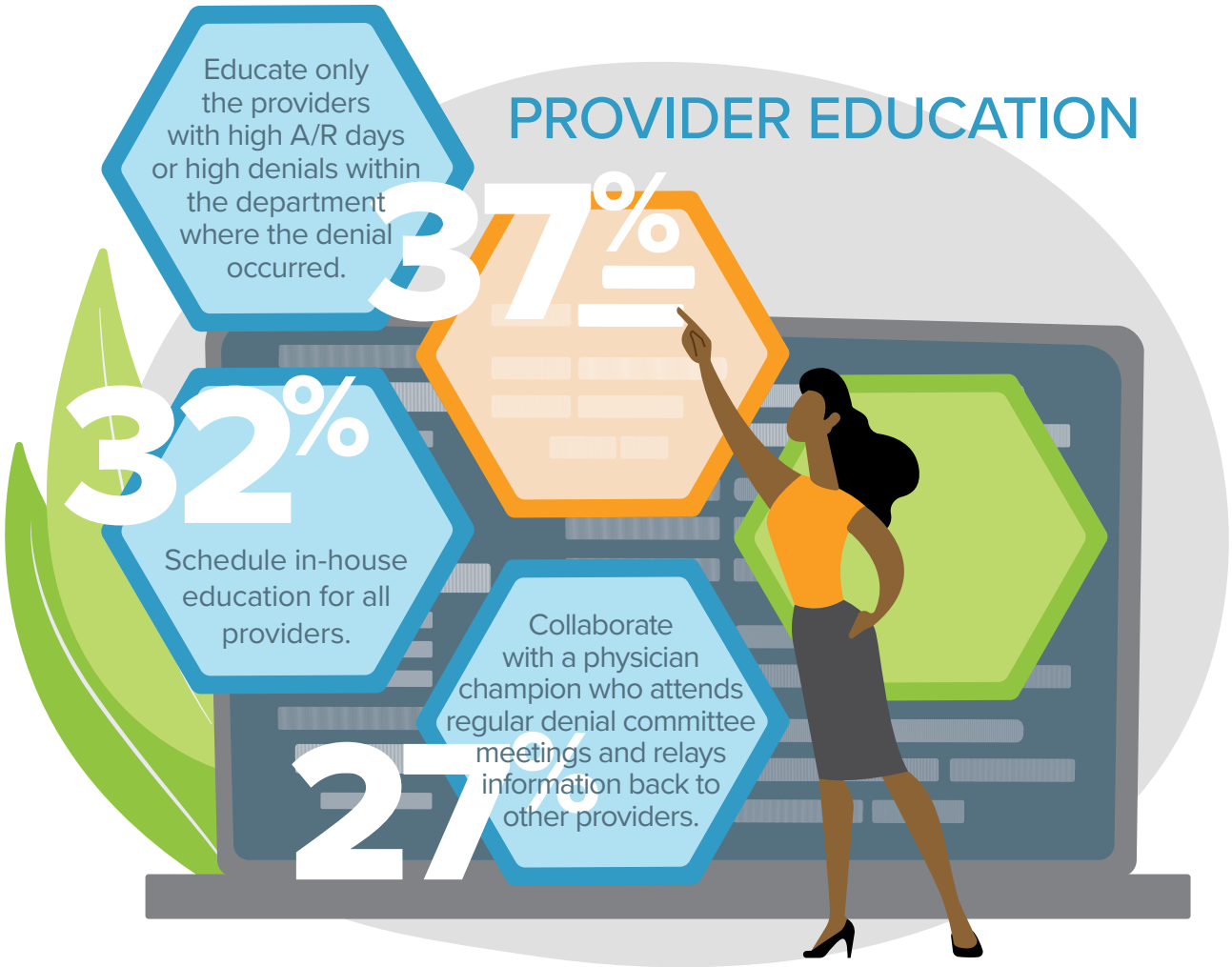
56%

16% of respondents who partner with an external vendor to analyze denials say they educate providers in-house.



PROVIDER PROCESSES AND EDUCATION

"Our bill hold days vary by patient type and have to meet certain criteria, beyond which it is deemed as a late charge. The expectation is for departments to get the charges ideally within 24–48 hours. But even with the 3–7-day bill hold, there are still a lot of late charges that drop after the bill has been processed. However, we are in the initial stages of developing an automated department-specific charge reconciliation process, which includes daily reconciliations and late charge compliance reporting at the CFO level," says Vrinda Kosgi, Director of Revenue Integrity, Augusta University Medical Center.



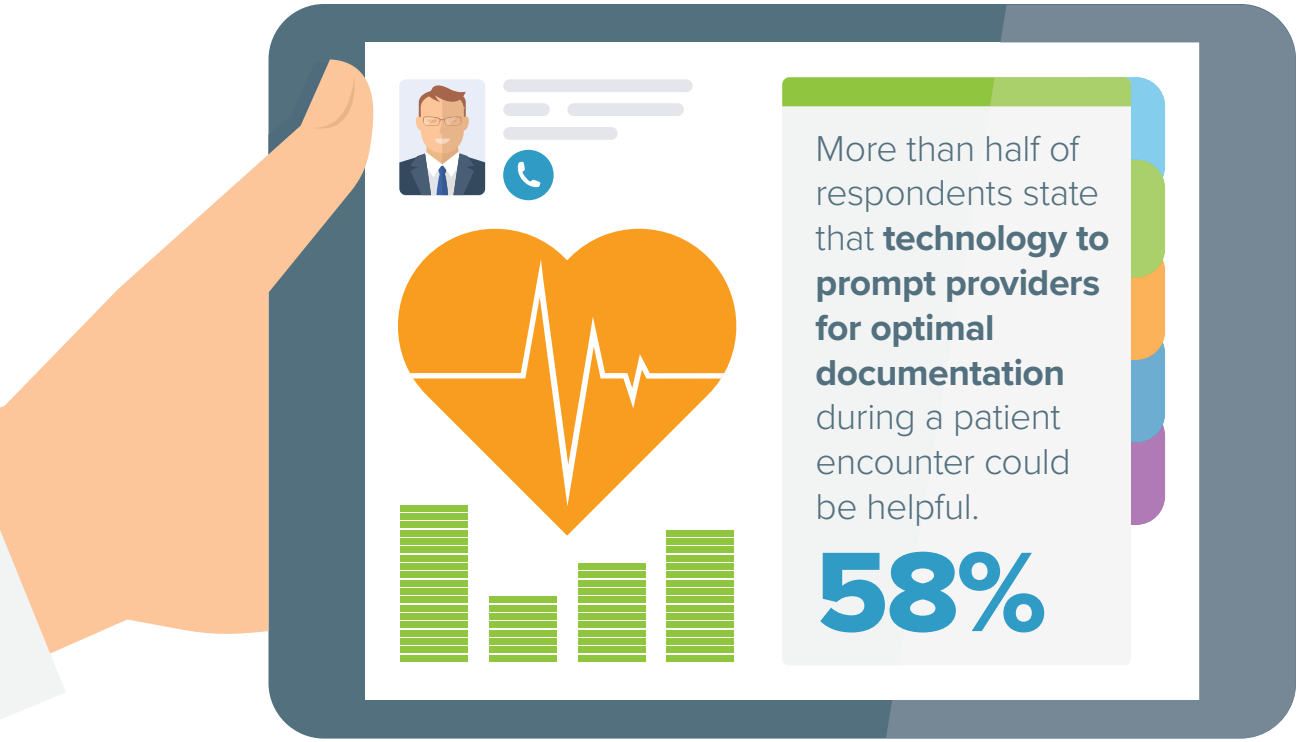
42% of respondents **give their providers more than 48 hours** from discharge to post charges.

35% of respondents **cap provider charge entry at 24–48 hours.**

"WE HAVE CHECKLISTS, DROP-DOWNS, AND RADIO BUTTONS TO HELP THEM CLICK THROUGH FASTER DURING THE PATIENT VISIT. HOWEVER, IF THERE IS A HARD STOP, THERE IS PUSHBACK FOR FEAR OF DELAY IN PATIENT CARE."

—VRINDA KOSGI,
Director of Revenue Integrity,
Augusta University Medical Center

PROVIDER PROCESSES AND EDUCATION



"WE HAVE TEMPLATES, DOT PHRASES IN THE NOTES, AND DROP-DOWN FIELDS WITH QUESTIONS SUCH AS START AND STOP TIMES, TYPE OF VISIT, AND FOR TELEHEALTH, WE MAKE SURE THEY SPECIFY THEIR PHYSICAL LOCATION VERSUS THE PATIENT'S LOCATION ... ADDITIONALLY, WE REMIND PROVIDERS TO ENTER NOTES ON COVERAGE DETERMINATION CATEGORIES SUCH AS THERAPY SERVICES. THERE ARE PROMPTS AND FIELDS FOR START AND STOP FOR TIMED THERAPY, SO THERAPISTS REMEMBER TO CAPTURE THAT INFORMATION."

—**Tracy Cahoon,** Director of Revenue Integrity, Southwest General Health Center

CONCLUSION

The survey results and roundtable discussion reveal that provider organizations are making significant progress in analyzing denials and decreasing denial rates. As revenue integrity leaders continue to optimize denial management processes, they remain committed to technology adoption, front-end to back-end provider engagement, and new workflows to drive down coding and documentation denial rates. Moving forward, technology, automation, and strategic physician engagement during critical stages in documenting, coding, and billing processes will continue to break down siloes, expose gaps, and drive meaningful change.

We hope you enjoyed this collaboration. We recommend you download and read the complete three-part series on **NAHRI.ORG**.