2024

State of the Revenue Integrity Industry Survey Report

NAHRI

MEET OUR ROUNDTABLE

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2024 STATE OF THE REVENUE INTEGRITY INDUSTRY REPORT

NAHRI is celebrating the seventh annual Revenue Integrity Week (June 3–7) to acknowledge and raise awareness of revenue integrity professionals' incredible contributions to the healthcare industry. As part of this effort, NAHRI is releasing the *2024 State of the Revenue Integrity Industry Survey Report,* taking a deep dive into standards and trends across the industry to highlight the work revenue integrity professionals do. The report analyzes trends in revenue integrity functions and areas of opportunity, program design, and more.

ALMOST THREE-QUARTERS (74%) OF RESPONDENTS ARE EMPLOYED BY ACUTE CARE HOSPITALS/HEALTH SYSTEMS, AND 50% WORK AT LARGE ORGANIZATIONS WITH 500 OR MORE BEDS.

Background and experience

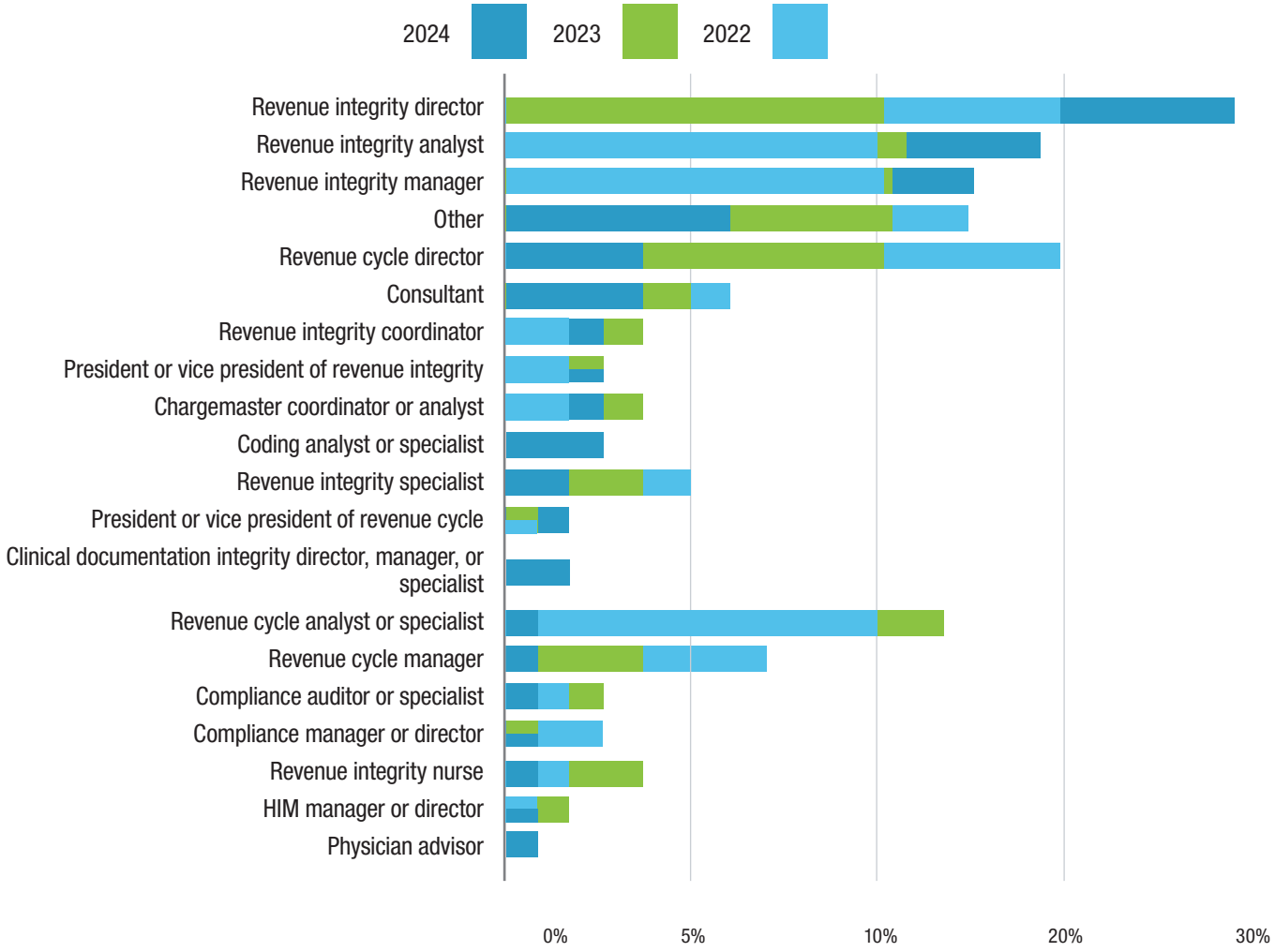
Revenue integrity programs often include professionals representing a broad range of backgrounds and experiences—and job titles. A team's collection of skill sets and job titles is likely to emerge from the specific structure and focus of a revenue integrity program, as well as how the program has evolved organically at the organization. While some organizations have standalone revenue integrity departments with defined revenue integrity job titles, others opt for committees or initiatives supported by individuals from several departments, such as HIM, patient financial services (PFS), or clinical documentation integrity.

In 2024, 69% of survey respondents indicated they hold revenue integrity–specific job titles. Of that group, the most commonly reported job title was revenue integrity director (28%), followed by revenue integrity analyst (17%) and revenue integrity manager (15%). Other revenue integrity titles represented included revenue integrity coordinator (3%), president or vice president of revenue integrity (3%), revenue integrity specialist (2%), and revenue integrity nurse (1%).

Among titles not specific to revenue integrity, the most commonly reported was revenue cycle director (4%).

Almost three-quarters (74%) of respondents are employed by acute care hospitals/health systems, and 50% work at large organizations with 500 or more beds.

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



Source: 2024, 2023, and 2022 State of the Revenue Integrity Industry Surveys

The majority (76%) reported that their organization has a standalone revenue integrity department. Those with standalone revenue integrity departments tend to have more dedicated revenue integrity staff. Almost half (44%) of standalone revenue integrity departments are supported by 20 or more full-time employees, compared to only 25% of those who have revenue integrity committees, initiatives, or other types of revenue integrity programs.

Having a standalone revenue integrity department supported by dedicated staff gives organizations an edge, says **Kelly Bowley, RN, MBA, CRCE,** senior director of healthcare business transformation, revenue cycle, at FTI Consulting in Washington, D.C. "It allows you to make sure that [resolutions] are being applied consistently across the organization, as opposed to having certain functions be dispersed across the organization, maybe even sitting with individuals who may not report through the revenue integrity department."

Kelly Henneman, vice president of revenue integrity at the University of Maryland Medical System in Baltimore, Maryland, a 12-hospital health system, says her organization has a dedicated revenue integrity department supported by 60 full-time revenue integrity staff members. The department is responsible for hospital and professional fee billing and is structured by service line. Each service line, such as radiology or labor and delivery, has a dedicated revenue integrity data analyst who is responsible for educating and working with the departments.

"From my perspective, revenue integrity is like a hub-and-spoke model. We are the hub, the liaison that works with many different departments, whether it's coding, clinical departments, physicians, the central business office, IT, compliance, or legal" Henneman says. "The primary purpose of our team is to promote proactive billing compliance with all federal, state, and HSCRC regulations, improve operational efficiencies, and reduce compliance risk through charge capture monitoring, assessments, interventions, education, and clinical department collaboration. We would not be successful in our role if were not for the integrated relationships we have built with administrative and clinical departments across the medical system."

IT'S REALLY IMPORTANT TO HAVE AN ADVANCED REVENUE INTEGRITY TEAM TO MOVE FORWARD WITH THE TECHNOLOGY

-HEATHER DUBOIS

As technology has advanced, including AI and EHRs, it's become critical to have professionals with keen analytical skills who can perform high-level monitoring of revenue cycle functions such as charging, says **Heather Dubois,** director of revenue integrity at Lifespan in Providence, Rhode Island, a nonprofit health system comprising four hospitals and a large physician group that includes primary care physicians and specialists.

"It's really important to have an advanced revenue integrity team to move forward with the technology," Dubois says.

Angela Cummings, MHA, BSN, RN, ACM-RN, director of revenue and documentation integrity at Duke University Health System in Durham, North Carolina, a three-hospital system that also includes physician practices, hospice care, and other services, says her organization's revenue integrity department is supported by more than 60 full-time staff members. Duke's revenue management staff are assigned by service line. Each service line–specific team is responsible for monitoring charges, receipts, write-offs, avoidables, and adjustments made by other departments. They also serve as quasi-project managers to help departments resolve issues they've uncovered or stand up new processes and procedures.

"If [for example] we were having problems with compliance with left atrial appendage closures, we work with cardiology to develop a workflow for making sure that all the components of those requirements are met," Cummings says. "It's an interesting group of professionals. They are professional revenue managers. They're ones that focus on professional billing or supporting professional services, and then there are ones that are focused on hospital and some that do double duty."

See Figures 1–3 for more details on job titles, staffing, and program structures.

Figure 2: **Does your organization have a revenue integrity department, program, committee, or initiative?**

We have a standalone revenue integrity department	76%
We have a revenue integrity program	10%
No, we do not have a standalone revenue integrity department or a revenue integrity program, committee, etc.	7%
We have a revenue integrity committee	5%
We have a revenue integrity initiative	3%

Source: 2024 State of the Revenue Integrity Industry Survey

Figure 3: **How many full-time employees support your organization's revenue integrity department/program?**

More than 20	40%
2–4	14%
5–7	14%
8–10	12%
11–15	9%
16–20	8%
0–1	3%

Source: 2024 State of the Revenue Integrity Industry Survey

Q&A: IDENTIFYING THE VALUE OF A REVENUE INTEGRITY DEPARTMENT

Q: What is the value of a dedicated revenue integrity department?

Kelly Bowley, RN, MBA, CRCE, senior director of healthcare business transformation, revenue cycle, at FTI Consulting in Washington, D.C.:

Having a dedicated revenue integrity department allows you to create standardization and consistency so that the processes and policies, and even how you address situations, whether it be edits or other things, permits you to have more control. It allows you to make sure that [resolutions] are being applied consistently across the organization, as opposed to having certain functions be dispersed across the organization, maybe sitting with individuals who may not report through the revenue integrity department.

Loretta Hefley, MHA, COC, CHFP system director of revenue integrity at Baptist Health System in Little Rock, Arkansas:

Our revenue integrity department is small, but we're growing. We do audits. We do [charge] reconciliation. We do a lot of training with departments on reconciliation and appropriate charge capture. We are moving towards adding outpatient clinical documentation integrity to my team, which is something new for us. It is definitely a value finding missing charges and adding revenue for the health system

Primary and supporting functions

Most revenue integrity programs include common core functions, despite the diversity of program structures. These primary functions represent the day-to-day work and main goals of a revenue integrity program.

The five most common primary functions, according to survey respondents, are as follows:

1. Chargemaster maintenance (81%)
2. Price strategies/methodologies (59%)
3. Charge edits (56%)
4. Charge capture (55%)
5. Price transparency compliance (48%)

Along with their core primary functions, revenue integrity programs typically play key supporting roles across a range of tasks. These roles leverage the revenue integrity program's strengths in service of the organization's mission and goals, as well as the goals of the program itself.

The five most common secondary functions are:

1. Educating revenue cycle/nonclinical staff (55%)
2. Charge reconciliation (52%)
3. Denials management (52%)
4. Claim edits (50%)
5. Coding edits (hospital and/or professional fee) (46%)

When it comes to charge reconciliation, the level of support revenue integrity programs offer to clinical departments can vary. However, even when it's classified as a secondary function, revenue integrity must take its role seriously.

"Since we work with departments on appropriate charge capture, we also train them on how to reconcile on a daily basis. So I think revenue integrity does need to own that one, too," says **Loretta Hefley, MHA, COC, CHFP** system director of revenue integrity at Baptist Health System in Little Rock, Arkansas, a nonprofit, 11-hospital health system that also includes urgent care centers, a senior living community, and more than 100 primary and specialty clinics.

However, there are some revenue cycle functions that revenue integrity programs play minimal or no part in. According to survey respondents, these functions include:

1. Financial counseling (78%)
2. Insurance verification (78%)
3. Credentialing (76%)
4. Registration (76%)
5. Patient admission status (63%)

Although it's important to guard against scope creep and prioritize core responsibilities, stay alert for opportunities to advance essential revenue integrity goals by strengthening partnerships with other departments, such as patient access. Many issues that later end up on revenue integrity's plate start with process errors in front-end functions. Solving these root causes may call for more robust support.

Clearly defining and prioritizing revenue integrity functions can be a challenge within one organization, never mind across the industry. Even as revenue integrity has become more of a focus for organizations and leadership, inconsistencies in program structure and function remain common.

"If you go to every system, you're going to see a little different version of revenue integrity, which is exciting, but it also can be somewhat confusing at times," Cummings says.

This lack of consensus also makes it difficult for organizations to determine how their revenue integrity programs should look and how to staff them, Dubois adds. With so much variation, it's difficult to define the skills and qualifications a revenue integrity professional should have.

"Oftentimes when we're doing assessments, you're comparing one organization to what's considered leading best practice. And if there's not a consensus on what falls into revenue integrity, how do you compare yourself? How do you recruit? And then even more so, how do you use those as arguments and business cases to expand the revenue integrity department within an organization because it's critical to have?" Dubois says.

Industry standards would provide leverage, she adds, and lead to staffing models that are optimized to minimize revenue leakage and support core functions.

Setting and promoting industry standards around core functions would also allow revenue integrity leaders to create meaningful career ladders and establish guidance for new hires, Dubois says. In turn, this would make the revenue integrity field more attractive and ensure that professionals entering it, and hiring managers, have appropriate expectations that can apply across organizations.

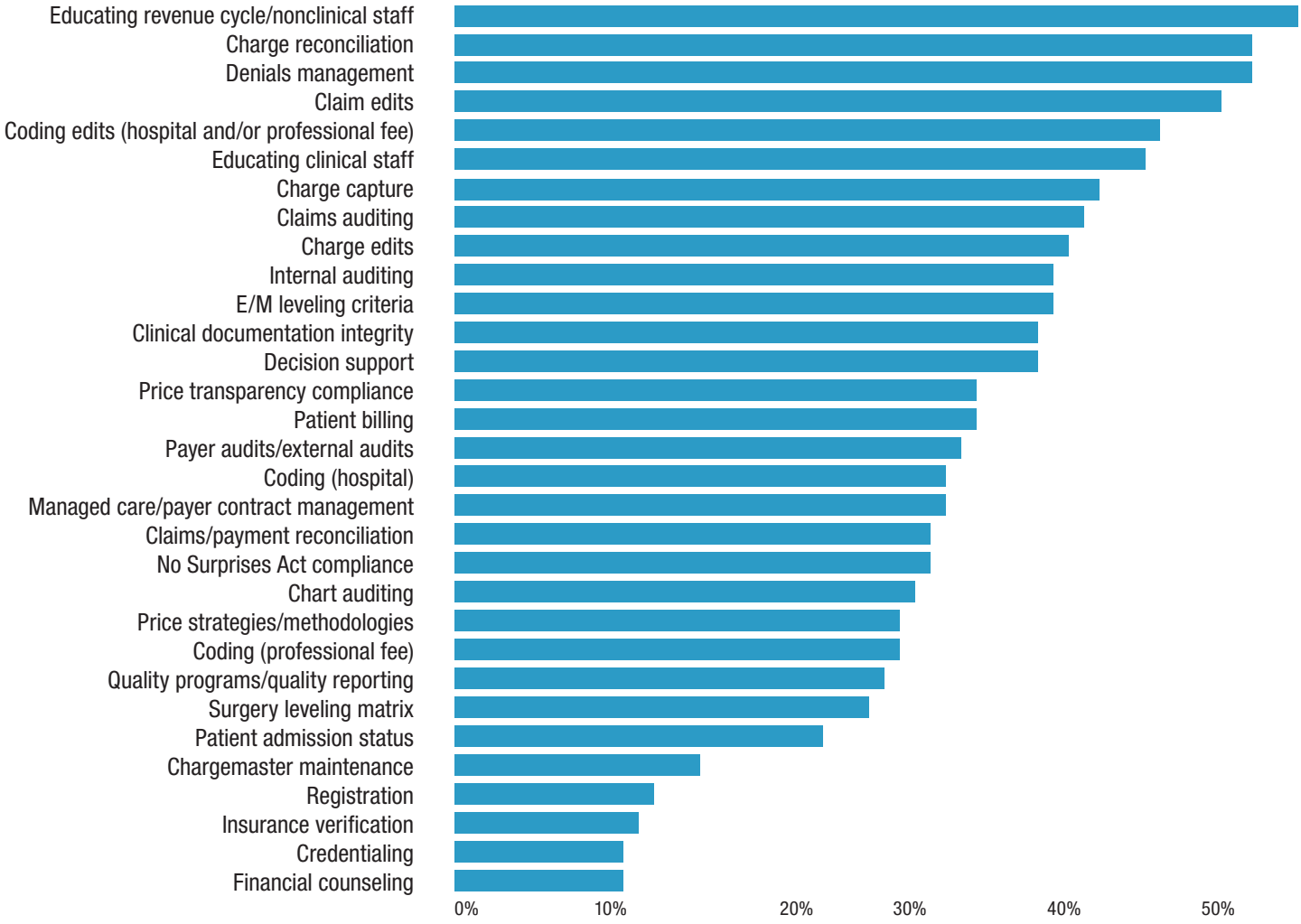
See Figures 4 and 5 for more information on primary and secondary revenue integrity functions.

Figure 4: **Primary functions of revenue integrity**

Chargemaster maintenance	81%
Price strategies/methodologies	59%
Charge edits	56%
Charge capture	55%
Price transparency compliance	48%
Chart auditing	46%
Charge reconciliation	40%
Payer audits/external audits	39%
Educating clinical staff	39%
Educating revenue cycle/nonclinical staff	38%
Correcting claim edits	35%
Claim edits	35%
Denials management	31%
Claims auditing	27%
E/M leveling criteria	22%
Internal auditing	21%
Coding edits (hospital and/or professional fee)	20%
Clinical documentation integrity	20%
Claims/payment reconciliation	18%
Surgery leveling matrix	18%
Decision support	18%
No Surprises Act compliance	15%
Coding (professional fee)	12%
Quality programs/quality reporting	12%
Managed care/payer contract management	12%
Patient billing	11%
Coding (hospital)	11%
Credentialing	8%
Patient admission status	7%
Insurance verification	7%
Financial counseling	6%
Registration	6%

Source: 2024 State of the Revenue Integrity Industry Survey

Figure 5: **Secondary functions of revenue integrity**



Source: 2024 State of the Revenue Integrity Industry Survey

Q&A: DEFINING CORE FUNCTIONS FOR REVENUE INTEGRITY

Q: How should revenue integrity's core functions be defined?

Angela Cummings, MHA, BSN, RN, ACM-RN, director of revenue and documentation integrity at Duke University Health System in Durham, North Carolina:

Definitely a robust chargemaster that also monitors the missing charges, such as with Revenue Guardian or whichever charge capture audit tool that you're using. And then I think revenue management by service lines. It's really important that someone has that bird's-eye view of what's going on with charges, receipts, adjustments, write-offs, and really digging into everything that we're adjusting off behind the scenes.

Kelly Henneman, vice president of revenue integrity at University of Maryland Medical System in Baltimore, Maryland:

As it relates to any clinical and financial system build, maintenance, testing, and support, revenue integrity has to be integral in those meetings, planning discussions, etc. Because if it's touching charges, if it's mapping revenue to the ledger, if it's making sure things are captured properly, that has to be a revenue integrity concern. There has to be [revenue integrity involvement] related to that integration with clinical and system financial builds.

Chargemaster maintenance

Even as revenue integrity has evolved and expanded over the years to suit a variety of settings, the chargemaster remains foundational. Managing and maintaining the chargemaster is at the heart of revenue integrity's mission.

Despite changes in the industry, chargemaster maintenance practices have remained relatively unchanged over the years. In 2024, 62% of respondents reported that a team is responsible for chargemaster maintenance. Other strategies include assigning the responsibility to one person (26%) and making the department director/representative responsible for the structure and codes with the line items entered by a data specialist (4%).

Determining what roles should be part of the chargemaster maintenance team isn't always cut and dried. As EHRs have become more sophisticated, IT may play a larger and more hands-on role.

"[We] have one chargemaster analyst and we have a separate pricing analyst under revenue integrity that handles all the pricing related to the chargemaster. But they're both essentially telling IT what to do and what to build in the system," Dubois says.

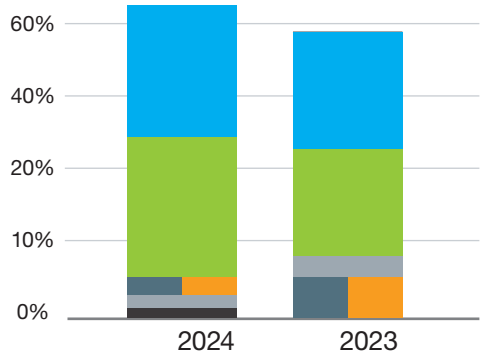
The chargemaster analyst and pricing analyst have very limited system access, she explains. When changes need to be made to the chargemaster, the analysts document them in a spreadsheet that they send to the IT department, which is then responsible for implementing the changes.

"It's interesting because it requires a lot more IT support than we did prior to Epic, but also they're working very closely with IT all the time," Dubois adds.

Henneman says that because of Maryland's unique and frequently changing reimbursement model, her team builds and maintains the fee schedules in Epic. These staff members hold Epic certifications. The University of Maryland's reimbursement team, however, handles pricing.

Organizations are leaning into technology more to handle chargemaster approval processes. In 2024, 29% of respondents indicated that their organization uses a hybrid approach that relies on chargemaster software and a central contact person.

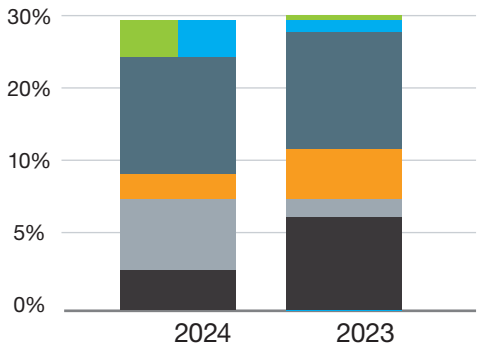
Figure 6: How is your chargemaster maintenance structured?



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

Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Figure 7: How is your chargemaster approval process structured?



- A hybrid approach that uses chargemaster software and a central contact person
- Individual requests are routed to a team for approval (e.g., finance for pricing, HIM for coding)
- Individual requests are sent to a central person
- Other
- Automated approval process via chargemaster software
- N/A

Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Different processes may be better suited for different organization types and structures, and the right processes may be informed by an organization's service lines, its EHR and other software, and its budget. Mergers and acquisitions, staffing, and enterprise-wide technology management goals also affect the processes used.

See Figures 6 and 7 for more on chargemaster maintenance and approval processes.

Similarly, respondents noted few changes in policies for assigning Healthcare Common Procedure Coding System (HCPCS) codes to drugs and supplies. Most (79%) assign HCPCS codes to all drugs and supplies when such a code exists. See Figure 8 for more responses and a comparison to 2023.

Although exploding charges, panel charges, and other mechanisms to ensure a single chargemaster number triggers the charging of multiple components can be challenging to maintain, they remain useful in specific circumstances. To make sure these mechanisms are functioning as intended, it's necessary to keep them on a regular review schedule. In 2024, the plurality (49%) of organizations opt to review these charges annually, as has been the case in previous years (see Figure 9 for more information).

When it comes to making changes to chargemaster order sets, IT is generally the go-to, similar to previous years. In 2024, 51% said IT holds the responsibility for making changes, followed by revenue integrity (44%). Over the years of conducting this survey, NAHRI has tracked a steady shift of this responsibility to IT. Figure 10 shows more information and a comparison to previous years.

Although it makes sense for IT to handle implementing changes to chargemaster order sets, revenue integrity can't simply leave the task to IT and the clinical departments, Bowley cautions. "Any time those changes are being made, it's important for revenue integrity to have a seat at the table," she says.

Charge reconciliation

Correct reimbursement depends on regular, accurate charge reconciliation. Although, as noted earlier in this report, charge reconciliation typically isn't a primary

Figure 8: When do you assign HCPCS codes to drugs and supplies?

	2024	2023
We assign HCPCS codes to ALL drugs and supplies when such a code exists	79%	74%
We assign HCPCS codes to drugs and supplies when the code generates separate payment	13%	17%
We assign HCPCS codes to drugs and supplies when the code resolves a procedure-to-device edit	9%	10%
N/A	8%	6%
We do NOT assign HCPCS codes to drugs and supplies	6%	3%
Other	4%	8%

Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Figure 9: How often do you review exploding charges, panel charges, or other mechanisms to ensure a single chargemaster number triggers the charging of multiple components when appropriate?

	2024	2023
Annually	49%	40%
We don't use these mechanisms	17%	22%
Other	13%	12%
Quarterly	10%	11%
N/A	8%	N/A
Twice annually	4%	1%

Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Figure 10: Who is responsible for making changes to chargemaster order sets?

	2024	2023	2022
IT department	51%	31%	31%
Revenue integrity	44%	27%	34%
The director of the department to which the charges are applicable	25%	12%	12%
Other	15%	17%	17%
Clinical staff	12%	1%	4%
N/A	6%	11%	N/A

Source: 2024, 2023, and 2022 State of the Revenue Integrity Industry Surveys

Q&A: MANAGING CHANGES TO CHARGEMASTER ORDER SETS

Q: What role does revenue integrity play in managing changes to chargemaster order sets?

Kelly Bowley, RN, MBA, CRCE, senior director of healthcare business transformation, revenue cycle, at FTI Consulting in Washington, D.C.:

The majority of my experience with order sets has been as a registered nurse before moving into the revenue integrity space. I think they're very much geared towards standardizing for patient care. But regardless, any time those changes are being made, it's important for revenue integrity to have a seat at the table. What, if any, of those actions can be billable? Revenue integrity needs to be at the table, as well as IT because they will be making those changes, getting them into the system, and then tested and pushed through.

Kelly Henneman, vice president of revenue integrity at University of Maryland Medical System in Baltimore, Maryland:

We do integrity checks and then give feedback to the IT teams making changes and checking for mistakes. Even when we're involved at the beginning, we will do annual or other types of routine checks, too.

revenue integrity responsibility, it's nevertheless an essential revenue integrity task and one revenue integrity teams play a strong supporting role in.

Almost half (45%) of respondents said operational departments are responsible for reconciling their own charges with regular support from revenue integrity. Fewer organizations expect departments to handle it more independently: Only 28% said operational departments are responsible for reconciling their own charges. Meanwhile, a smaller minority reported some level of centralization: 12% said some departments are responsible for reconciling their own charges while others are centralized under revenue integrity, and 7% said charge reconciliation is centralized under revenue integrity.

Similar to previous years, most (52%) said their organization's time frame for reconciling and correcting charges is one to three business days.

Hefley says her organization expects charge reconciliation to happen the day after. For departments that aren't open on weekends, Friday's charges are reconciled on Mondays.

Although some organizations may extend their time frame beyond three days, Hefley says that the sooner charges are reconciled, the better.

"If you reconcile too far out and you realize something is missing, the staff that should have dropped the charge by that time is not going to remember every patient, every charge," she says.

Holding clinical departments accountable for charge reconciliation is an ongoing challenge for many organizations. The issue was exacerbated by the COVID-19 pandemic and the exodus of seasoned clinical staff that followed, according to Hefley.

> **IF YOU RECONCILE TOO FAR OUT AND YOU REALIZE SOMETHING IS MISSING, THE STAFF THAT SHOULD HAVE DROPPED THE CHARGE BY THAT TIME IS NOT GOING TO REMEMBER EVERY PATIENT, EVERY CHARGE**
> -LORETTA HEFLEY, MHA, COC, CHFP

"There was a huge turnover; a lot of people that were close enough to retire did. So holding people accountable has been an issue because so many of our managers that are now expected to reconcile also wear the clinical hat and have to work as a clinical person in that department," she says.

Henneman says her department sends late charge reports to the organization's leadership team. She's also working on developing more robust reporting.

"Part of our dilemma right now is, how do we track that everyone is reconciled when they're supposed to? We're creating a manual process that'll be tracked in Smartsheet®," she says.

Henneman's goal is to use the report to more accurately monitor charge reconciliation and provide actionable data that can be leveraged for support when necessary.

"If, for example, the cath lab always says they reconcile, yet the cath lab has tons of late charges and denials or other types of issues, then we have something that gives us a leg to stand on," Henneman says. "We need to create more robust metrics to share with management so they understand what it means, and then they can help us hold others accountable when you have really delinquent departments."

See Figures 11 and 12 for more information on charge reconciliation responsibilities and time frames.

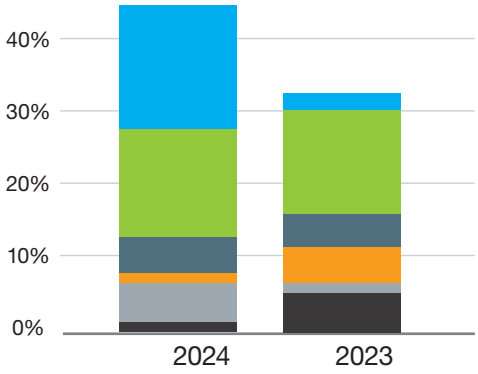
Even when charge entry isn't centralized, handing that responsibility to certain clinical departments may not be ideal. Similar to previous years, charges for emergency/trauma department (48%), observation hours (48%), and room and board (41%) are typically not entered by clinical staff. See Figure 13 for more details.

Per CMS requirements, hospitals must have a policy for carving out procedures that include active monitoring to ensure that observation hours aren't reported for the same period. Generally, this task falls to HIM/coding (26%) or revenue integrity (22%), according to survey respondents.

Almost half (45%) of respondents said their organization relies on manual processes to monitor charge reconciliation for consistency and appropriateness. Of those who employ automation or other technology for this function, 17% use homegrown solutions, and 16% turn to tools from third-party vendors.

Dubois says her organization uses Epic's Revenue Guardian report to monitor charge reconciliation. Using the report, clinical departments are able to view the full picture of an encounter and indicate whether an encounter was reviewed. Then revenue integrity pulls

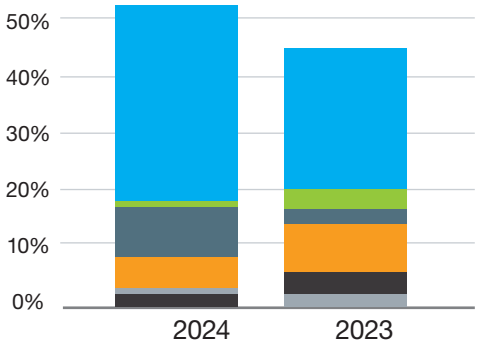
Figure 11: **Who is responsible for charge reconciliation?**



- Operational departments are responsible for reconciling their own charges with regular support from revenue integrity
- Operational departments are responsible for their own charges
- Some departments are responsible for reconciling their own charges while others are centralized under revenue integrity
- Charge reconciliation is centralized under revenue integrity
- We do not have a charge reconciliation process in place
- N/A

Source:2024and 2023 State of the Revenue Integrity Industry Surveys

Figure 12: **What is your time frame for reconciling and correcting charges?**



- 1–3 business days
- 4–5 business days
- We have a charge reconciliation process, but I don't know what our time frame is for reconciling charges
- N/A
- More than 7 business days
- 6–7 business days

Source: 2024and 2023 State of the Revenue Integrity Industry Surveys

the data from Revenue Guardian and generates a report in Crystal, which is sent to all stakeholders.

The reporting system is working well for some departments, such as radiology, but others are still lagging, according to Dubois. Nevertheless, the reports provide solid data that leaders can act on.

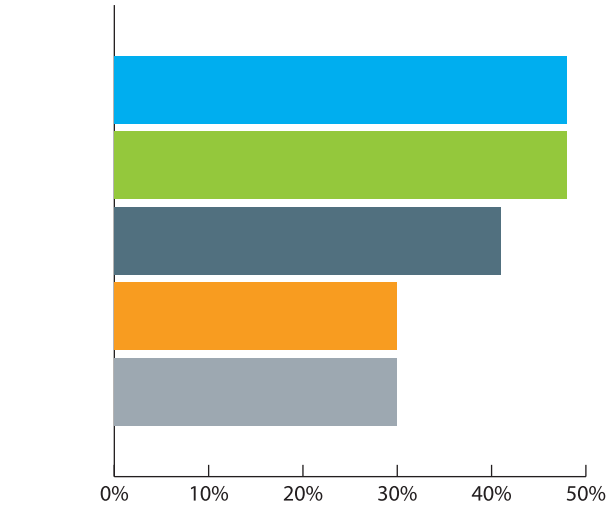
"The reports are great because we—revenue integrity—don't hold departments accountable for their charge reconciliation," Dubois says. "We expect their VPs to hold their directors and managers accountable for charge reconciliation. So it gives us a way to let them know who's doing what and where things are being missed."

See Figure 14 for more on how organizations are monitoring charge reconciliation processes.

Denials management

Managing and addressing denials continues to be a major, and growing, concern for hospitals. Even when helmed by dedicated denials management departments, a successful strategy calls for interdepartmental support and coordination to identify and resolve the sources of denials. With their holistic view

Figure 13: **What types of charges are not entered by clinical staff? (Top five)**



Source: 2024 State of the Revenue Integrity Industry Survey

Q&A: SUPPORTING ACCOUNTABILITY FOR CHARGE RECONCILIATION

Q: How can revenue integrity help clinical departments be accountable for charge reconciliation?

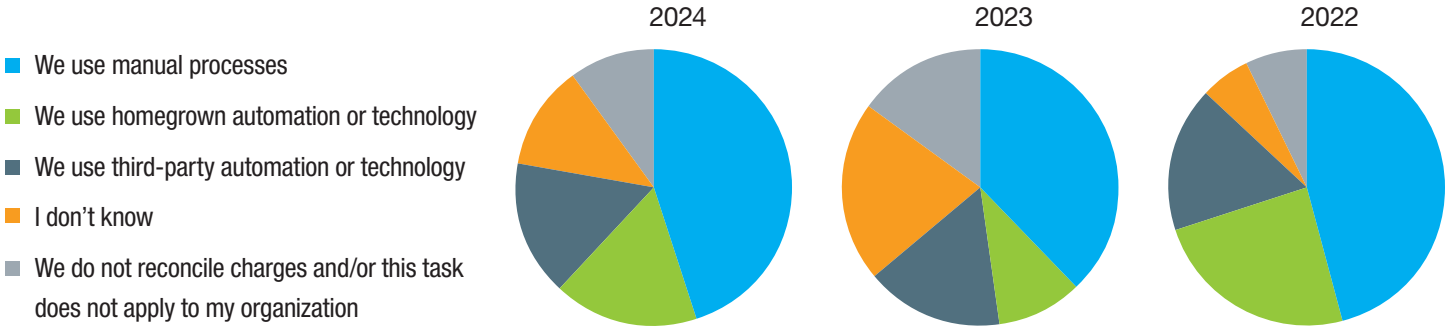
Angela Cummings, MHA, BSN, RN, ACM-RN, director of revenue and documentation integrity at Duke University Health System in Durham, North Carolina:

We do send out late charge reports, but holding them accountable to timely and accurate charge reconciliation is a huge challenge. Here, the late charge reports go to the VPs, and they are very engaged and having those conversations. I think that the tide has turned a little bit and people are more interested in revenue than they have been in the past. The culture is changing. People are more interested in trying to go after their dollars and maintain what they're supposed to have, so they're much more interested in enforcing those changes.

Heather Dubois, director of revenue integrity at Lifespan in Providence, Rhode Island:

We use a Revenue Guardian report. We require departments to go in and review accounts and then they have to indicate if they did review the account or not. Then we have a report, built in Crystal, that pulls in all that information from Epic and then we send it to everybody. It works for some departments, radiology clinics and areas like that, but we're still lacking in areas like the OR and cath labs. The report's great because we—revenue integrity—don't hold departments accountable for their charge reconciliation. We expect their VP to hold their directors and managers accountable for charge reconciliation. So it gives us the chance to let them know who's doing what and where things are being missed.

Figure 14: How does your organization monitor charge reconciliation practices for consistency and appropriateness?



Source: 2024, 2023, and 2022 State of the Revenue Integrity Industry Surveys

of the revenue cycle and strong analytical and problem-solving skills, it's not surprising that many revenue integrity professionals play a supporting role in denials management.

In 2024, 62% of respondents reported that PFS or the billing office is responsible for denials management, with revenue integrity (59%) and denials management (58%) rounding out the top three.

Tracking and analyzing data is key to managing denials, giving provider organizations insight into trends and opportunities. Fortunately, most hospitals are already keeping tabs on denials data, according to survey respondents.

The majority (84%) said their organization tracks denials by reason/type, and 89% track them by payer. Compared to 2023, these significant gains show that hospitals are catching up with payer organizations when it comes to understanding the power of data.

Enforcing proper and timely charge capture and reconciliation can mitigate denials, Dubois points out. Organizations typically won't hold a claim if a charge for a small dollar amount (such as $25) is missing, and will instead write it off. Payers may be using these types of scenarios to their advantage to increase denials.

"We're finding that they're really increasing device-to-procedure edits. So those $25 charges really are contributing to denials of entire claims now," Dubois says. "That $5 lidocaine drug that we used to consider inherent in other charges is now the reason they're not paying a cancer claim. I suspect that payers are taking advantage of our efforts to streamline workflows by requiring more billing itemization; charge capture for those low dollar charges becomes important again."

Payers have become more likely to issue denials, Henneman agrees. She notes that her organization has seen a significant increase in denials for emergency department claims.

Although it's important for organizations to conduct internal audits and address errors in their own processes that lead to denials, they must also ensure that payers are playing by the rules. Inappropriate denials drain hospital resources and drive up administrative costs. The Maryland Hospital Association is working with Maryland hospitals to meet with payers and address payer practices that are in violation of laws and regulations, Henneman notes.

"We take all this time to fight and then we end up overturning [the denial]," Henneman says. "But the amount of work that goes into this and [the payers'] reasoning for some of the denials, it's just unbelievable."

See Figures 15–17 for more on denials management processes.

Claim edits

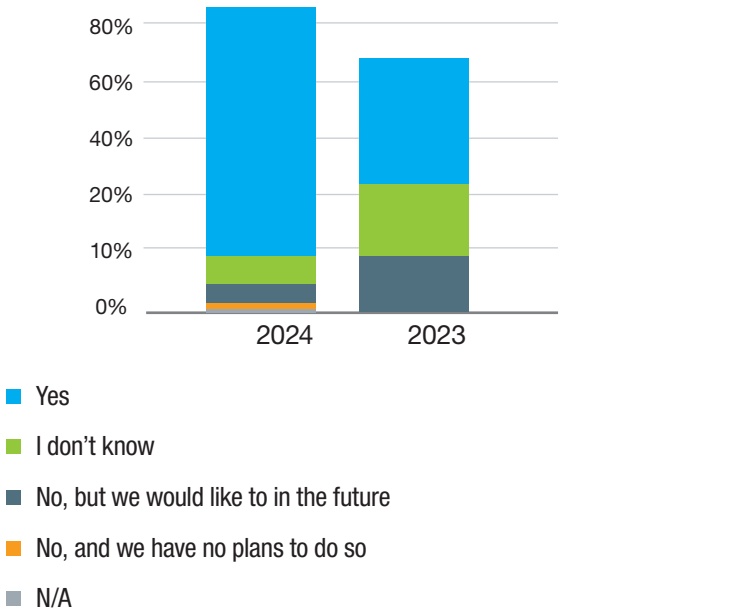
Billing holds, or suspense periods can help ensure claims are accurately coded and billed by giving revenue integrity professionals time to make sure charges are correct and

complete before submitting them. However, organizations must clearly define these holds and develop them to be appropriate for their unique needs.

Figure 15: **Which departments are responsible for denials management at your organization?**

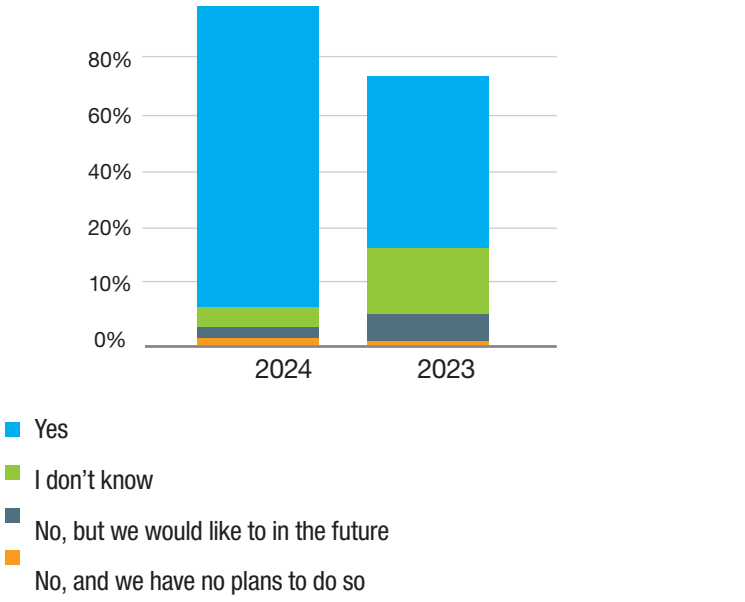
Source: 2024 State of the Revenue Integrity Industry Survey

Figure 16: **Do you track denials by reason/type?**



Source: 2024 and 2023 State of the Revenue Integrity Industry Surveys

Figure 17: **Do you track denials by payer?**



Source: 2024, and 2023 State of the Revenue Integrity Industry Surveys

Q&A: STRUCTURING DENIALS MANAGEMEN

Q: How does your organization structure denials management?

Angela Cummings, MHA, BSN, RN, ACM-RN, director of revenue and documentation integrity at Duke University Health System in Durham, North Carolina:

Prebuilt concurrent denials are managed by utilization management (UM). Once the claim bills, any kind of denials from that point on, medical necessity or authorization related, go to the denials management team. UM reports up through nursing, and denials management reports up through billing and collections. Revenue integrity [handles] any kind of denials that are the result of an audit—so any postpayment audit that results in a denial—and we manage those appeals. Clinical validation coding–type audits also fall under revenue integrity.

Kelly Henneman, vice president of revenue integrity at University of Maryland Medical System in Baltimore, Maryland:

Denials is managed by a team separate from revenue integrity, but we're very involved. We have a biweekly denials dashboard meeting. Our denials team has created teams—we call them tiger teams—at each member organization specific to the highest types of denials at that organization, whether it's medical necessity or another type.

Seventy-one percent of respondents said their organization has some type of billing hold/suspense period. More than half (57%) reported their hold is targeted for specific scenarios (e.g., inpatient-only procedures).

Almost half (48%) said their suspense period is three to four business days, which has long been the industry standard.

See Figures 18 and 19 for more details on billing holds.

As in previous years, coding claim edits are typically resolved by HIM/coding. In 2024, 80% of respondents said HIM/coding handles this task, while 60% indicated that revenue integrity is involved.

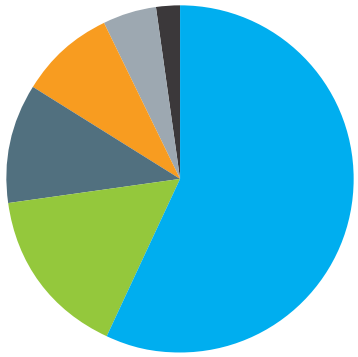
However, when it comes to reviewing claim edit patterns for root cause analysis, revenue integrity's strengths shine. Sixty-nine percent said revenue integrity is involved, followed by PFS/business office (55%) and HIM/coding (31%).

See Figures 20 and 21 for more information.

Challenges and benefits

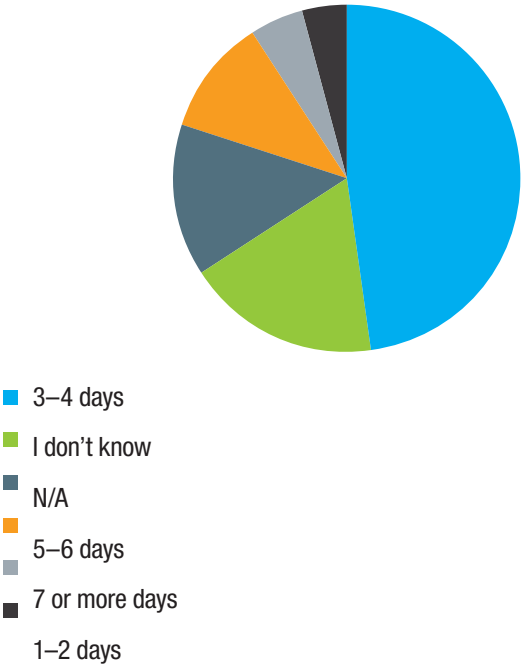
Hospitals have weathered several major challenges in recent years, including the COVID-19 pandemic and widespread staffing shortages. Changes in the payer landscape, including the growth of Medicare Advantage,

Figure 18: Does your organization have a billing hold/suspense period to review encounters/accounts?



Source: 2024 State of the Revenue Integrity Industry Survey

Figure 19: **How long is your billing hold/ suspense period?**



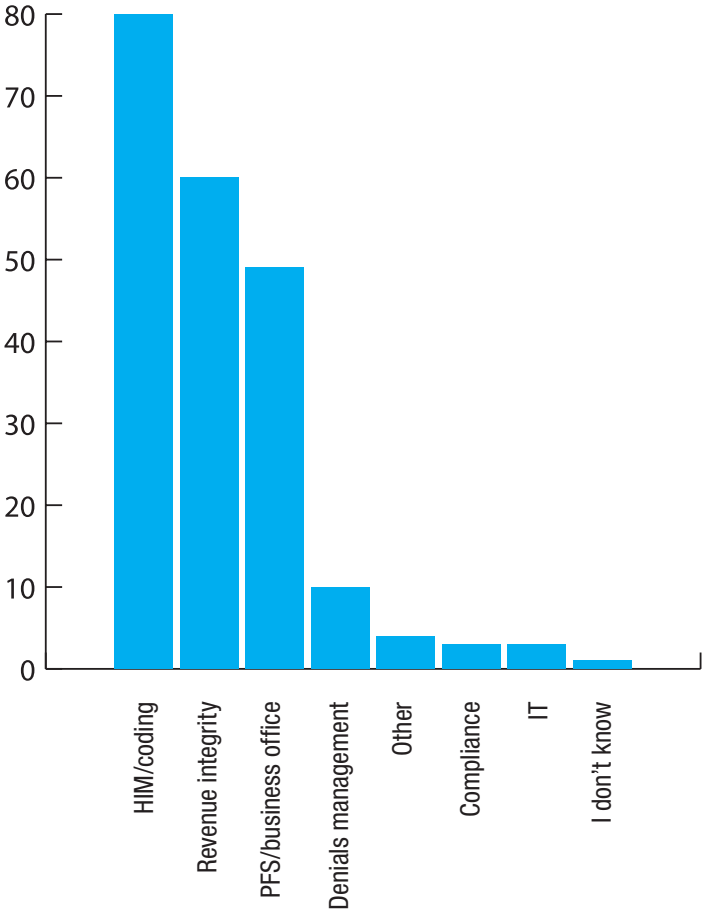
Source: 2024 State of the Revenue Integrity Industry Survey

have increased the financial pressure on hospitals and further reduced margins. Recently, the Change Healthcare cyberattack left many provider organizations unable to submit claims and, therefore, receive reimbursement for an extended period of time.

AT UMMS, REVENUE INTEGRITY GETS PULLED IN MANY DIRECTIONS, BECAUSE IF IT'S RELATED TO REVENUE I CAN›T JUST LET IT GO.
-KELLY HENNEMAN

These ongoing pressures have hampered revenue integrity efforts. In recent years, revenue integrity departments have reported budget cuts and problems finding and retaining staff even as their departments' responsibilities grow.

Figure 20: **What departments are responsible for resolving coding claim edits at your facility?**



Source: 2024 State of the Revenue Integrity Industry Survey

Figure 21: **What departments are involved in reviewing claim edit patterns for root cause analysis?**

Revenue integrity	69%
PFS/business office	55%
HIM/coding	31%
CDM/chargemaster	28%
Denials management	26%
Compliance	13%
IT/analytics	13%
Clinical department where the patient was treated	9%
I don't know	5%
Other	3%
N/A	2%

Source: 2024 State of the Revenue Integrity Industry Survey

However, revenue integrity professionals have also found ways to thrive and capitalize on opportunities to improve processes and protect compliant reimbursement. For many, the key to success lies in building and maintaining strong relationships with colleagues across their organizations.

More than 80% of respondents said their relationship with clinical departments has had a positive effect on their revenue integrity program's effectiveness. Relationships with other departments are also an essential part of revenue integrity's success: 87% said relationships with other middle revenue cycle departments have positively impacted effectiveness, and 79% credited their relationship with IT/analytics as having a positive effect on revenue integrity.

A positive, professional attitude goes a long way toward maintaining relationships with other departments, Hefley says. For example, if issues are uncovered during an internal audit, take a constructive approach when discussing them with the department. If the department perceives the audit findings as a "gotcha" moment, that hurts the department and the organization. Instead, present it as a learning experience.

"Don't ever be negative, because once you're negative with the department they're less likely to work for you or work with you to help resolve issues. We try to be collaborative, but never come across as being negative or we've caught them doing something wrong," she says.

On the other hand, it comes as no surprise that staffing woes are the biggest obstacle to revenue integrity success, with 58% saying a lack of qualified staff has a negative impact on revenue integrity's effectiveness. Expansion of duties to functions unrelated to revenue integrity (35%) and payer audits (24%) round out the top three negative impacts.

Henneman says her organization has worked around shortages of more seasoned staff by hiring and training recent college graduates for revenue integrity data analyst roles. These new professionals receive on-the-job training and are partnered up with more experienced colleagues to guide them through the technical aspects of revenue integrity.

A bigger challenge for her team is burnout due to the expansion of duties, she says.

"At UMMS, revenue integrity gets pulled in many directions, because if it's related to revenue I can›t just let it go," Henneman says. "This can stress the team out. For us [the solution is] one on one meetings with managers and renegotiating deadlines when possible.

Figure 22: **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
Relationship with clinical departments	89%	3%	6%	2%
Relationship with other middle revenue cycle departments	87%	4%	6%	3%
Relationship with IT/analytics	79%	4%	12%	4%
Use of automation (e.g., automation charges, edit management)	70%	6%	13%	10%
Resolving claim edits	67%	7%	19%	7%
Managing denials	61%	11%	20%	7%
Use of KPIs and/or benchmarks	56%	6%	25%	13%
Conducting internal audits	55%	3%	24%	18%
Use of productivity measures	41%	14%	27%	19%
Payer audits	33%	24%	27%	16%
Expansion of duties to functions unrelated to revenue integrity	32%	35%	19%	15%
Lack of qualified staff	7%	58%	20%	15%

Source: 2024 State of the Revenue Integrity Industry Survey

Having the open lines of communication has positively impacted the teams' ability to experience a good work-life balance."

See Figure 22 for more detailed information on positive and negative effects on revenue integrity.

To learn more about what else revenue integrity professionals are grappling with, NAHRI asked survey respondents to share their top current and upcoming challenges.

For many, keeping up with payer and regulatory changes and finding knowledgeable staff is proving difficult.

IT MIGHT BE HELPFUL IF WE WERE STAFFED TO MAKE THE CORRECTIONS THAT ARE IDENTIFIED. CURRENTLY, THOSE HAVE TO BE GIVEN BACK TO THE CODING TEAM TO REVIEW, AND THEN HANDED OFF TO A CHARGE CORRECTION TEAM TO MAKE THE CHANGES, WHICH SLOWS DOWN THE PROCESS
-ANONYMOUS SURVEY RESPONDENT

"[We have] new employees in revenue integrity roles with no real support system or outside support," one respondent said.

"I am finding our top challenge is the lack of knowledge, learning, and retention," another respondent said.

Other respondents pointed to issues with payers, such as increasing volumes of audits and denials.

"Payer charge audit denials, ever-changing payer guidelines, non-standardization of Medicare Advantage plans to Medicare's guidelines and medical necessity criteria, denial of a complete claim for one line item denial—just to name a few," a respondent said.

"Payers need to be held accountable to the hospitals and the beneficiaries for the denial rates," another respondent said.

Metrics, or rather the lack of good, meaningful metrics, was another commonly reported pain point.

"We are such a small organization where we wear many hats. So understanding the priority and obtaining metrics in an automated way [is needed] to make good decisions. Today getting metrics is incredibly manual and cumbersome," a respondent said.

"The staff has become frustrated by an automated productivity system that does not consider the human element in working accounts. We are held to strict productivity standards and are not given sufficient time on some accounts to do the required research," another respondent said.

Other respondents described communication breakdowns with other departments or even with executive leadership.

"Revenue cycle leadership hired from the outside are only interested in metrics, Epic trophies, and work queue clearance rather than actually collecting payment from health insurance payers. They would rather write off a denial to improve receivable days than contest the denials with the payers," one respondent said.

"The department previously known as revenue integrity has been split into separate departments with separate functions. Revenue integrity conducts charge reviews. Billing integrity resolves some of the bill edits and works with the facility chargemaster. Charge integrity helps to maintain the chargemaster. And there is a global partner offshore team that works most of the billing edits. It's become very difficult to figure out who does what, and not all of the new departments have people trained in review of some of the more complex services (e.g., radiation oncology)," another respondent said.

Despite these challenges, revenue integrity professionals are looking ahead to plan new projects and initiatives. To find out what goals revenue integrity professionals are working toward, NAHRI asked respondents about changes they're looking to implement in their programs.

Q&A: TRAINING AND SELECTING REVENUE INTEGRITY STAFF

Q: How do you train professionals hired into revenue integrity roles?

Kelly Bowley, RN, MBA, CRCE, senior director of healthcare business transformation, revenue cycle, at FTI Consulting in Washington, D.C.:

My first revenue integrity job managed teams across multiple facilities. At each facility we had a registered nurse with support staff, and having those [individuals who] were prior clinicians helps. There really is no program that teaches you how to function in a revenue integrity role because the roles, responsibilities, and tasks that are being assigned are constantly evolving. Edits, what you can and can't bill, and modifiers are always changing. Even if you had a manual, the maintenance of it and the constant upkeep would be a lot just because of the evolving regulations around that. If you have a mixture of skill sets on the team, that's what really makes it more robust and allows you to really be very effective in revenue monitoring.

Kelly Henneman, vice president of revenue integrity at University of Maryland Medical System in Baltimore, Maryland:

For us, it's on-the-job training. We do not have a manual. The technical aspects of the job can be challenging, and it's really taking the time to onboard and partner people up with others on the team that have experience. Unless it's management, or coders, we hire right out of school. We can train folks, and they can partner up with buddies and learn on the job.

"We are currently working on some new metrics. I think the department listens to our ideas and tries to implement as many as possible," one respondent said.

"I would like to establish a firm foundation for a revenue integrity department with specific goals and educational opportunities," another respondent said.

"It might be helpful if we were staffed to make the corrections that are identified. Currently, those have to be given back to the coding team to review, and then handed off to a charge correction team to make the changes, which slows down the process," a respondent said.

Several respondents mentioned projects and improvements related to mergers.

"We are working through a merger and bringing our organizations together. As we do this, we will need to develop a true revenue integrity department with a clear structure," one respondent said.

See the sidebar on p. 20 for more changes respondents would like to implement.

SETTING GOALS AND PLANNING IMPROVEMENTS

Revenue integrity doesn't stand still. To keep up with changes in the healthcare industry driven by factors ranging from advances in technology to shifting patient populations and payer activity, revenue integrity professionals are constantly on the lookout for better ways to do their work and prepare their department for the future. NAHRI asked respondents of the 2024 State of the Revenue Integrity Industry Survey to tell us what changes they'd like to implement in their programs. Here's some of what they shared:

- Revenue integrity work queues to identify common issues before they go to coding and billing.
- Additional focus on reporting and internal auditing for charge integrity, denial prevention, and reimbursement.
- Charge reconciliation, department reviews, internal chart audits.
- Expanding clinical audit function to identify opportunities for additional net revenue opportunities.
- Enhanced reporting and chargemaster management.
- The use of automation [and addressing] staffing shortages.
- Further integration of professional fee and hospital revenue integrity teams to optimize efficiencies and leverage internal talent and staff professional development.
- Increased auditing and staffing.
- Would like to consolidate all facility chargemaster data into one source.
- I need a report based on productivity. I am still on a manual tracking system and it is very time-consuming.
- I would like to see the revenue integrity department have more involvement in the prebill claim edits for resolution and prevention, as we do with the denials.
- Migration of all revenue integrity functionality under revenue integrity team.
- More staff to provide education and preventive measures vs. always being reactive.
- More automation, more staff, better structure of duties.
- Contract variance management and automating self-pay accounts.
- Upper management to hold revenue-generating departments accountable to posting charges timely.
- Better education for staff, structure, distinct job descriptions.
- We would like to expand our partnership with the chargemaster team, who currently resides under payer contracting. We also need to continue our charge methodology standardization work, as our healthcare system has grown significantly without expanding our support services.
- More regular and frequent departmental education and oversight of charge reconciliation.
- I would like to see more resources and subject matter experts available for complex charging areas.
- AI coding for services that would benefit to free up staff for other tasks. Improvements with recurring accounts and order issues.
- Revenue cycle analysis committee to evaluate all revenue cycle aspects of new services and procedures—send info back to clinical teams for use in workgroup meetings.
- Staff levels appropriate to scope.
- Increase automation of charge capture.
- More education for staff—especially newer members.
- Establish KPIs and a quality program to ensure the effectiveness of the department. Calculation of ROI of the revenue integrity department to the organization.
- Development of a team with solid KPIs and structure. Resources necessary to optimize the system. Highly skilled labor pool.
- More staff, more internal control checks, development of more robust KPIs/metrics.
- Bring in clinical documentation improvement into revenue integrity as well as utilization management.
- Would like to increase our involvement in denials management and hire more people.
- Personally I would like to implement more data-driven software into our revenue integrity suite.
- I would like revenue integrity to have a seat at the table in more meetings involving revenue.
- The different pieces of the organizational revenue integrity program are fragmented under several separate departments. Working to coordinate with these parties to improve controls across entity structure.
- Revenue cycle leadership that follows the organization mission statement and values. Revenue cycle leadership focused on supporting the practices rather than their own individual achievement goals.
- Add additional auditors to help clinical departments.