HAYES Maker of **MDaudit**

Healthcare Auditing and Revenue Integrity: 2021 Benchmarking and Trends Report

MDaudit® A Hayes Technology

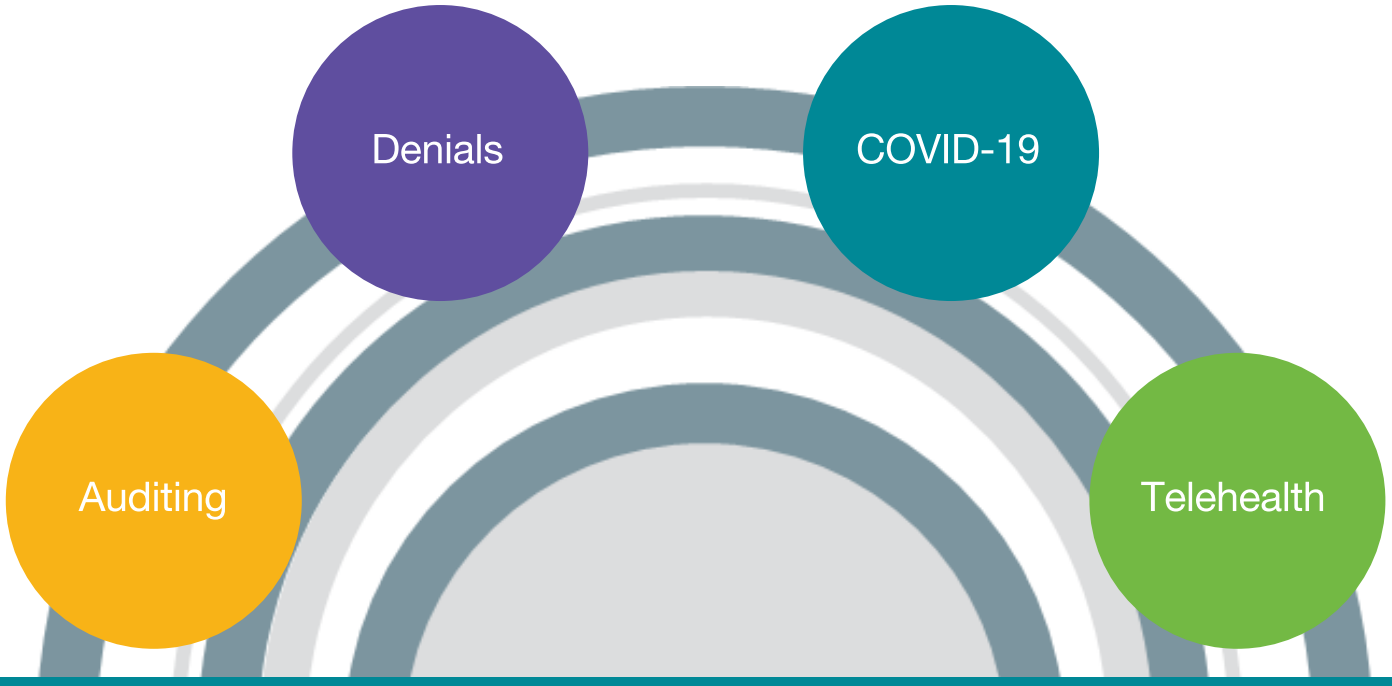
About This Report

The importance of having a shared goal for revenue integrity is more critical than ever and understanding how to measure an organization's progress towards that goal is challenging.

As a leading provider of enterprise healthcare auditing, compliance and revenue integrity software, Hayes is able to identify benchmarks and insights derived from the more than 50,000+ providers and 900+ facilities providing data to MDaudit to be used for auditing, charge and denial analysis.

By looking at the efforts of auditing, billing compliance and revenue cycle teams collectively, organizations can begin to understand the challenges, and opportunities, that impact their organization. Through this unified view of revenue integrity, organizations can optimize their efforts to mitigate compliance risk, reduce revenue leakage and find opportunities to improve revenue flow.

This report is intended to dive into the combined results of the teams contributing to revenue integrity and provide you with the insight needed to evaluate the effectiveness of your organization.



Executive Summary

Healthcare provider organizations have been stretched very thin when allocating clinical, operational and financial resources to deftly tackle the pandemic. A recent report from American Hospital Association (AHA) found “Under an optimistic scenario, hospitals would lose $53 billion in revenue this year. Under a more pessimistic scenario, hospitals would lose $122 billion thanks to a $64 billion decline in outpatient revenue”*. All these factors have accelerated the pressure on these organizations to optimize their billing compliance, revenue cycle and revenue integrity capabilities to reduce compliance risk while optimizing revenue flow.

In the first 10 months of 2021, almost $2.5B worth of professional and hospital charges were audited and $100B+ worth of denials were analyzed for trends and action using MDaudit Enterprise.

Key Insights include:

- 40% of COVID-19 related charges were denied and we also found 40% of professional outpatient audits for COVID-19 and 20% of hospital inpatient audits failed. A cohesive approach to establish a corrective action program will make a very significant impact for organizations.

- It is critical to address undercoding because the revenue risk is real and significant. Audits with findings that indicate an underpayment average $64 for a professional claim and $3,200 for a hospital claim.

- Overcoding is a pervasive issue this year. Medicare Advantage plans and payors continue to be scrutinized by the federal government for expensive inpatient claims for medical necessity, drug charges and clinical documentation to justify the final reimbursement. Companies should pay close attention to mitigate against this payment risk and claw back exposure.

- The most prevalent category for denials in a hospital setting is bundling errors with the top reason being the benefit is included in other service that has already been adjudicated. Organizations should focus on training and auditing their coders to help improve documentation and reduce denials.

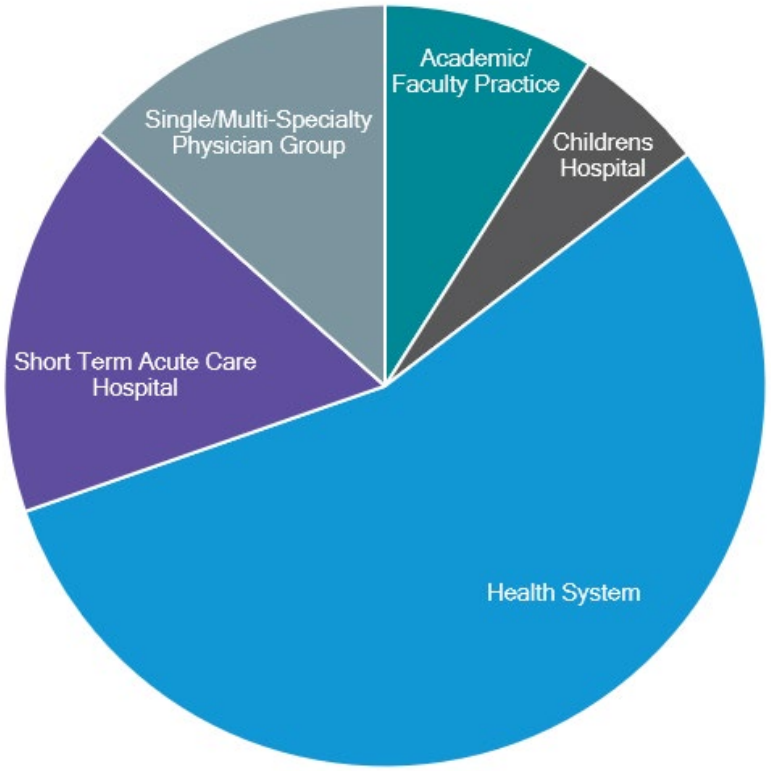
* https://www.fiercehealthcare.com/hospitals/kaufman-hall-hospitals-close-between-53-and-122b-year-due-to-pandemic

Demographic Overview

The analysis found in this report is based on current charge and remit data from MDaudit Enterprise customers.

The data used covers:

- 900+ facilities
- 50,000+ providers
- 1,500+ coders
- 700+ auditors

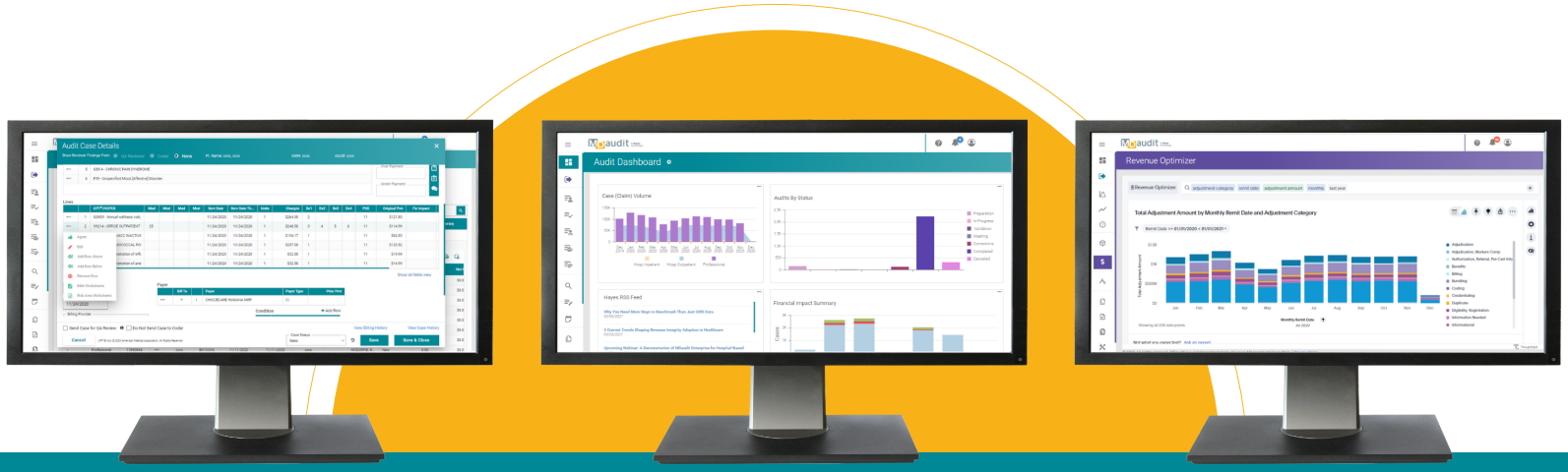


The customers include:

- Academic medical centers
- Hospitals
- Multi-location healthcare systems
- And more

All customers are based in the US and span coast to coast.

It is worth noting that the data includes charges and denials sent to all payers. Many publicly available analyses only includes CMS Medicare information.

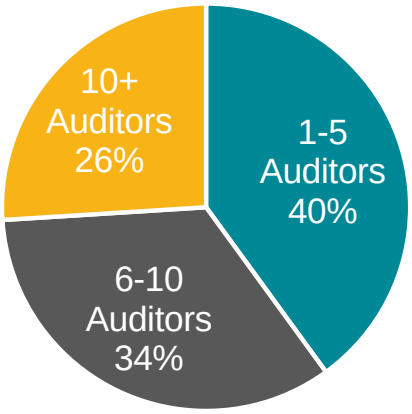


Audit Team Benchmarks

Auditing teams are busier than ever trying to keep up with the challenges 2021 has brought with the new E&M updates in addition to the COVID-19 and telehealth challenges that began in 2020.

Here are some details about the audit teams using MDaudit for internal auditing.

Team Size



Top Fields Being Audited

Hospital audits

1. Diagnoses
2. Present on Admission (POA) Indicator
3. Dx position
4. CPT/HCPCS
5. Units
6. Date of service

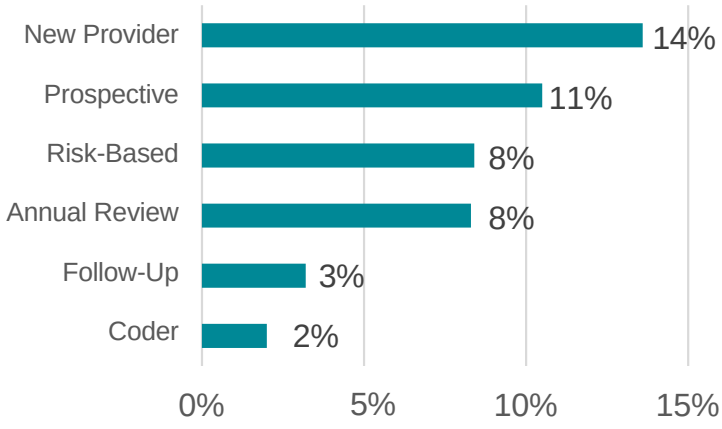
Professional audits

1. Diagnosis
2. Dx position
3. CPT/HCPCS
4. Date of service
5. ICD dx
6. Place of service
7. Units
8. Modifier

Types of Audits

Auditors are performing a variety of audits including retrospective and prospective to mitigate compliance and revenue risks. Of the many types of audits performed in MDaudit, we are seeing an increase in prospective audits since 2020 which allow organizations to identify errors prior to claim submission to reduce denials.

Top Audit Types Performed with MDaudit



Audit Performance

Whether doing planned annual audits or risk-based audits, on average, our auditors have "disagree" findings about 33% of the time for their internal audits. This represents a huge compliance and revenue risk for organizations

Hospital Billing

Average outcome from audits:
- 70.5% Satisfactory
- 29.5% Unsatisfactory

Average underpayment for a claim with findings: $3,200
Average E&M accuracy: 81%
% of coders who failed audits: 27%
% of attending providers who failed audits: 17%

Top Reasons for Hospital Disagree Findings

1. CPT/HCPCS code
2. Diagnosis
3. Dx Position
4. Modifiers
5. Dx Mapping to CPT/HCPCS

Professional Billing

Average outcome from audits:
- 64% Satisfactory
- 36% Unsatisfactory

Average underpayment for a claim with findings: $64
Average E&M accuracy: 75.3%
% of rendering providers who failed audits: 43%

Top Reasons for Professional Disagree Findings

1. Diagnosis
2. CPT/HCPCS code
3. Case Level
4. ICD Dx
5. Modifiers

Denial Performance-Hospital

One of the big highlights of 2021 is that bundling continues to be the number one reason hospital charges are denied. With 34% of inpatient charges initially being denied at an average value of $5300 each, there is a lot of money at risk.

Hospital Billing

Average charges initial denied: 34%
Average initial denial amount:
Inpatient: $5300
Outpatient: $585
Average lag days to resubmit initial claim:
Inpatient: 10 days
Outpatient 11 days

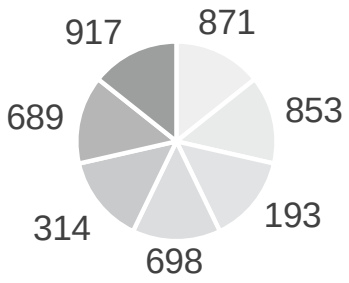
Top Denial Categories

Inpatient	Outpatient
1. Bundling	1. Bundling
2. Eligibility/ registration	2. Information needed
3. Information needed	3. Authorization, referral, pre-certification
4. Duplicate	4. Duplicate
5. Authorization, referral and pre-authorization	5. Non-covered

Top Denial Reasons for Hospital Inpatient

1. Benefit is included in other service/procedure that has been already adjudicated
2. Charges are covered under a capitation agreement
3. Missing documentation
4. Claim submission/billing error
5. Duplicate claims
6. Benefit maximum overreached

7 Most Reviewed MCCs by Denied Amount



Interesting to Note:

33% of charges with HCC codes submitted to payers were denied

HCC code “2: Septicemia, Sepsis, SIRS/Shock” is the top HCC related denial and contributed to 16% of the total denied charges.

Denial Performance-Professional

Denial trends related to professional billing are in a much better place than hospital denial trends with only 15% of charges being denied the first time. While this may seem to be an indication that professional coding is generally better than hospital coding, we know that internal auditors are disagreeing with the claims coding at a similar rate which indicates there are probably just as many problems but the payers are focusing on the higher value hospital claims when sending denials.

Professional Billing

Average charges initial denied: 15%
Average initial denial amount: $283
Average lag days to resubmit initial claim: 10 days

Top Denial Reasons for Professional Charges

1. Claim submission/billing errors
2. Lack of documentation
3. Duplicate claims
4. Bundling
5. Non-covered charges
6. Precertification/authorization

Top 10 Professional Codes Denied by Amount

99214
99213
99204
99215
99203
99205
99212
99202
99211
99201

Coding

Whether doing planned annual audits or risk-based audits on coders, on average, our auditors have "disagree" findings about 29% of the time for their internal audits. This represents a huge compliance and revenue risk for organizations.

Average Denied Amount per Claim due to Missing Modifiers

Hospital inpatient claim $690
Hospital outpatient claim $900
Professional claim $170

Top Modifier Related Denials

Professional: 26, RT, 25, LT, 59
Hospital outpatient: 25, RT, LT, TC, 59

The COVID-19 IMPACT

10% of coding related denials overall were associated with COVID-19 U07.1 diagnosis code.

Top 3 Denial Reasons Given:

- Invalid date of service
- Payer deems the information submitted does not support this level of service
- The date of death precedes the date of service

Top Denial Reasons Related to Coding Issues

Payer deems the information submitted does not support this level of service (25%)

The procedure code is inconsistent with the modifier used or a required modifier is missing (16%)

Diagnosis was invalid for the date(s) of service reported (14%)

The diagnosis is inconsistent with the procedure(8%)

This (these) diagnosis(es) is (are) not covered(7%)

Hot Topics in 2021: COVID-19

COVID-19 continues to be a driver in 2021 for all the health systems in creating clinical, operational and financial pressures. The need for an integrated revenue integrity program is most apparent when you look at COVID-19 related charges.

40% of COVID-19 related charges were denied

Plus…

40% of professional outpatient audits for COVID-19 and 20% of hospital inpatient audits failed

This is the time for billing compliance, coding and revenue cycle teams to work together to develop a corrective action plan that will address the COVID-19 challenges in a cohesive way.

Top Audit Failure Reasons

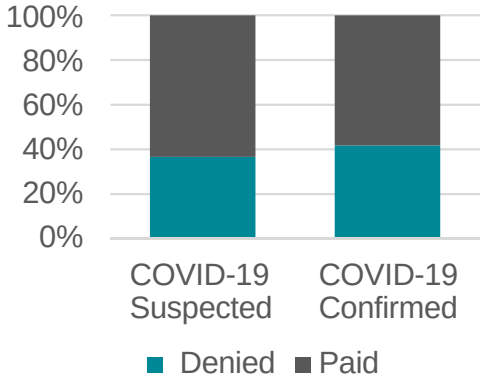
Hospital audits

1. Secondary diagnosis documented but not billed
2. No documentation
3. ICD procedure documented but not billed
4. Additional information
5. Condition code documented but not billed

Professional audits

1. Diagnosis documented but not billed
2. E&M service overcoded 1 level
3. E&M service undercoded 1 level
4. Diagnosis billed not documented
5. Incorrect E&M category

Approximately 40% of COVID-19 related claims were initially denied



Top Denial Categories

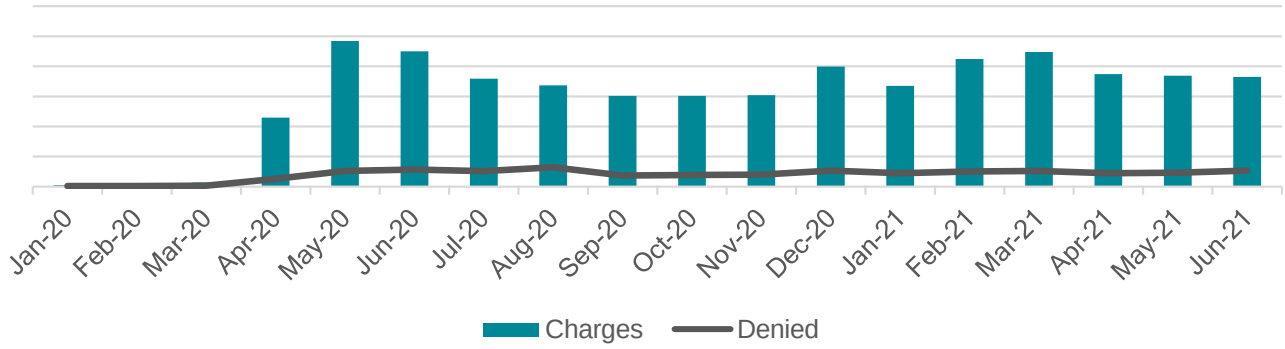
1. Bundling
2. Eligibility / registration
3. Duplicate claims

Hot Topics in 2021: Telehealth

Billing for telehealth is another area that proves the need for a cohesive revenue integrity program that looks at where denials are coming from and combines those insights with failing audit results.

13% Of Telehealth Charges Submitted Were Denied
17% Of Telehealth Claims Provider Audits Failed

A close look at the volume of charges and denials reveals that while telehealth volume has been decreasing slightly in 2021, it is still being used in a significant way.



Top Telehealth Denial Reasons

1. Claim lacks information / submission & billing errors (14%)
2. Non-covered charges (10%)
3. Duplicate claims (7%)
4. Incorrect modifier/required modifier missing (5%)
5. Procedure code/bill type/place of service code missing (2%)
6. Missing documentation (4%)
7. Pre-certification / authorization(4%)

Key Takeaways

Healthcare organizations should look to address both revenue risk and compliance risk through a unified revenue integrity-based approach. Our research has shown that both areas experience similar challenges and an integrated strategy offers an opportunity to use denial insights to help focus auditing efforts while also incorporating prospective audits to reduce denials. Together auditing, coding and denial management teams should use their collective insights to build a cohesive corrective action plan rather than having each team duplicating efforts by separately educating and training providers and coders.

As 2021 comes to a close, the areas that should be a focus include:

- COVID-19 related claims and denials, which continue to be high and a source of compliance and revenue risk.
- Coding and documentation audits on telehealth claims focused on modifiers, POS and procedure codes and fully vetting the clinical documentation submitted to the payers.
- Increasing the scope of audits to incorporate a risk-based approach and prospective audits which allow organizations to increase the impact of the compliance program by identifying and addressing risk faster to improve revenue flow and reduce the risk of takebacks.

For more information about this report or to learn more about how Hayes and MDaudit can help your organization, please call 617-559-0404 or email info@hayesmanagement.com.

About Hayes and MDaudit

Hayes is a leading healthcare technology provider that partners with the nation's premier healthcare organizations to improve revenue, mitigate risk and streamline operations to succeed in an evolving healthcare landscape. By combining our industry-leading auditing and revenue integrity software, MDaudit Enterprise, with unparalleled compliance and revenue cycle expertise, we help organizations collect, find, recover and retain more revenue dollars throughout the entire revenue stream.