The HIM department's role in the revenue cycle

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The HIM department is responsible for ensuring medical record documentation is completed for every patient encounter (e.g., admission, emergency department, or clinic visit). Today, many of the controls that are in place to ensure an encounter is completely documented are automated or rely on technology. For example, an open encounter report is used in a clinic environment to identify those visits that do not have a clinic visit note.

Many organizations have been able to transition the analysis function from an employee manually reviewing the record for documentation deficiencies to rule-based deficiency identification and other rules-based workflows. For example, a rule is created to identify which records should have an operative report. If the operative report is missing, a deficiency is automatically assigned to a provider. Often, an account identified as having a deficiency is not routed to the coder until the report is completed, thus saving the coder from reviewing the record only to find a critical report is missing.

HIM's use of such technology can improve timely and complete documentation, therefore decreasing costs overall.

Coding

Medical record documentation is reviewed for each patient encounter to identify appropriate diagnosis and procedure codes. The ICD-10-CM/PCS classification system and Current Procedural Terminology (CPT®) code set are the two tools used to translate diagnostic and procedural information in the record into codified clinical data. This codified data is transferred to the patient's claim. It can also be transferred or stored in various data repositories. Coded data is used for:

- Justifying medical necessity and evaluating healthcare practices and trends
- Public health reporting
- Quality measurement conducted by external organizations
- Reimbursement (submitting a claim for billing and receiving payment)
- Research, accreditation, and credentialing

Physician query process

When reviewing a record, a coder may need to ask a question of a physician to determine the most appropriate code. A query process allows physicians to add or clarify documentation when the clinical information in the patient record is unclear or incomplete. Because unclear or incomplete documentation may directly affect coding quality, diagnosis-related group assignment, or the patient's bill, the type and frequency of queries can be analyzed to target problematic conditions that require attention.

Coding accuracy audits

Coding accuracy is crucial to reimbursement, and coding guidelines are published by various official sources, including Medicare (program memorandums and local medical review policies), fiscal intermediaries, insurance carriers, and the American Hospital Association (in its *Coding Clinic*).

Adherence to ever-changing standards can be difficult to achieve without periodic review from both internal experts and external third parties. Depending on the encounter volume at a given facility and the results of prior audits, an organization may coordinate monthly, quarterly, or annual audits.

Requests for records/documentation (release of information)

The HIM department must ensure that requests from insurance carriers/payers for additional information to support claims payment are processed in a timely manner. Medicare has specific guidelines for the time frame in which additional development requests (ADR) are satisfied. During an ADR, a Medicare Administrative Contractor gathers information from a provider while the claim is still active. Regardless of who the payer is, delays in providing requested information can unnecessarily prolong the time before a facility receives payment for services rendered. Facilities also can identify proactively those payers or diagnosis/procedure groups that will require additional clinical information, such as an operative report, and send this information with the original claim to expedite payment.

Editor's note: *This article is an excerpt from "The Contemporary Guide to Health Information Management" by Chris Simons, MS, RHIA, Rose T. Dunn, MBA, RHIA, CPA, CHPS, FACHE, Lynette Kramer, MA, RHIA, and Laura Jacquin, RN, MBA.*

Related Topics:
Coding, Documentation improvement, HIM/HIPAA

AHA report highlights hospitals' biggest financial pressures

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Persistent cost growth, inadequate reimbursement, and shifting care patterns are creating a perfect storm of financial pressures for U.S. hospitals and health systems, according to a recent American Hospital Association (AHA) report.

The AHA highlighted how hospital expenses have surged and remained elevated in recent years, noting that labor continues to be the single largest category of hospital spending. However, Medicare reimbursement rates are not keeping pace with these rising expenses. Between 2022 and 2024, general inflation grew by 14.1% in the U.S., while net Medicare inpatient payment rates only increased by 5.1%, according to the report. The AHA estimated that this discrepancy resulted in $8.4 billion in lost hospital revenue during that time period.

The report also examined the growing financial impact of certain Medicare Advantage (MA) plans' practices. For example, MA plans are increasingly favoring extended observation stays over inpatient admissions. While observation stays for MA patients were 28.6% longer than those of traditional Medicare beneficiaries in 2019, but 36.9% longer in 2024, according to the AHA.

"Compared to inpatient admissions, observation stays are reimbursed at lower rates—or in some cases, not at all—leaving hospitals to absorb much of the cost," states the report. "In 2024, MA plans reimbursed just 49% of the actual cost for patients held in observation status."

A similar pattern has emerged in inpatient stays. The average length of stay for MA patients grew significantly compared to traditional Medicare between 2019 and 2024, yet hospital reimbursement from MA plans fell by 8.8%, according to the AHA.

The report also dissected the impact of tariffs on hospital costs and supplies, as a large portion of essential medical goods are internationally sourced. The AHA highlighted that almost 70% of U.S.-marketed medical devices are exclusively manufactured overseas, with over $75 billion in medical devices and supplies being imported in 2024 alone.

"Tariffs on these critical goods could exacerbate shortages, disrupt patient care, and raise costs for hospitals," states the report.

Looking ahead, the AHA called on policymakers to acknowledge that Medicare and MA payment policies must be updated to reflect the actual cost of care, as well as recognize that rising hospital expenses reflect real pressures, not inefficiencies. In addition, the association urged them to address structural drivers of cost, such as care delays and excessive administrative burdens, instead of simply cutting payments.

Editor's note: This article originally appeared in Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Auditing and monitoring, Medicare news

CMS issues draft guidance on Medicare Drug Price Negotiation Program

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CMS recently published draft guidance on policies for the third cycle of negotiations and first cycle of renegotiations for the Medicare Drug Price Negotiation Program, which will occur during 2026 and may result in negotiated maximum fair prices (MFP) that would become effective in 2028.

Established through the 2022 Inflation Reduction Act, the program allows CMS to negotiate the prices of eligible drugs with pharmaceutical manufacturers. Eligible drugs are those that account for the most Medicare spending and have no generic/biosimilar competition.

Previous program guidance has outlined what information should be used in negotiations, relevant timelines, and the number of drugs selected per cycle. The negotiated prices for the 10 Part D drugs selected in the first cycle are scheduled to take effect in 2026, and the prices for the 15 Part D drugs from the second cycle will take effect in 2027.

Building on policies established during the first two cycles of negotiations, the draft guidance includes new policies to incorporate Part B drugs into the program for the first time. CMS is soliciting comments on how to facilitate access to any negotiated MFPs for Part B drugs. The draft guidance also includes new policies to renegotiate prices for certain drugs from the first two rounds.

CMS has until February 1, 2026, to publish the list of 15 drugs selected for negotiation for initial price applicability year 2028, as well as any drugs selected for renegotiation, if applicable.

CMS also provided refinements and clarifications to MFP effectuation policies for 2026 and 2027, including adjustments to Medicare Transaction Facilitator operations, and the extension of such policies to 2028.

After publishing the draft guidance, CMS initiated a 45-day public comment period that will close on June 26. CMS is seeking comments on increasing transparency in the negotiation process, asking for feedback on data sources, calculation methods, clinical evidentiary factors, and more. The agency is also soliciting feedback on reducing burden, future modifications to MFP effectuation, and manufacturer oversight and compliance. Comments received by June 26 will be considered for final guidance on these policies, which CMS plans to publish later this year.

Revenue cycle professionals can read CMS' press release and fact sheet on the draft guidance for more information.

Related Topics:
Billing and reimbursement, Medicare news

CMS sets sights on enhancing MA auditing efforts

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CMS recently announced plans to enhance its risk adjustment data validation (RADV) auditing efforts for Medicare Advantage (MA) plans. The agency will begin auditing all eligible MA contracts for each payment year (PY) effective immediately, and it will devote resources to expedite the completion of audits for PYs 2018–2024.

MA plans receive risk-adjusted payments based on the selected diagnoses, and CMS conducts RADV audits to confirm that the diagnoses are supported in the documentation. Federal agencies estimate that MA plans may overbill by up to $43 billion per year, according to CMS. The agency stated that it is several years behind in these audit processes, noting that the last significant recovery efforts for MA overpayments occurred following the audit of PY 2007.

CMS plans to address the backlog and complete all remaining RADV audits for PYs 2018–2024 by early 2026. The agency will enhance its systems to more efficiently review medical records and identify unsupported diagnoses. In addition, it will increase its team of medical coders who manually verify flagged diagnoses from 40 to 2,000 by September 1.

These improvements will allow CMS to increase its previous audit volume of roughly 60 MA plans per year to all eligible MA plans (approximately 550 plans) in newly initiated audits, according to the press release. The agency also expects to be able to audit up to 200 records per health plan per year, as opposed to its previous volume of 35 records, for newly initiated audits.

CMS plans to work with the Office of Inspector General to recover uncollected overpayments identified in previous audits.

Related Topics:
Auditing and monitoring, Billing and reimbursement, Coding, Medicare news, Recovery auditors

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