Q&A: Training HIM staff to better navigate audits

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News & Insights

Q: As payer analytics become more sophisticated, what specific skills or training should HIM professionals pursue to keep pace with evolving audit techniques?

Gina Stewart, MBA, BSN, RN, CCS, CCDS, vice president of coding quality and education at e4health: As payer analytics continue to advance, evolving audit techniques are becoming increasingly complex and difficult to understand. These methodologies can feel overwhelming, even for experienced professionals, and can easily create confusion if teams try to master every technical detail. The goal isn't for HIM professionals to become experts in payer algorithms. Rather, they should strive to remain aware of and informed about audit technique initiatives, trends, and shifts that may impact coding, documentation, or claim validation.

With that awareness in mind, HIM professionals should focus on expanding and growing their knowledge base in practical, targeted ways. Foundational training in data literacy, denial trending, and clinical reasoning helps staff interpret how payers might flag anomalies in claim data. Understanding basic data analysis concepts—such as identifying outliers, recognizing documentation risk signals, or interpreting pattern-based reviews—empowers teams to anticipate payer focus areas without needing deep technical expertise.

Cross-functional learning is also invaluable. As payer audits increasingly integrate medical necessity, quality measures, and utilization patterns, coders and CDI specialists benefit from developing broader insight into risk adjustment data validation methodologies, Office of Inspector General audit priorities, and clinical validation logic. By combining awareness of emerging audit tactics with practical analytical and clinical reasoning skills, HIM professionals strengthen their ability to adapt, communicate risk clearly, and help their organizations stay one step ahead of payer scrutiny.

Editor's note: *This Q&A was excerpted from our* HIM Briefings *newsletter.*

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Broad expansion proposed for sepsis ICD-10-CM coding

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News & Insights

At the public ICD-10 Coordination and Maintenance Committee Meeting held March 17–18, the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) discussed a draft proposal involving a broad expansion of sepsis diagnosis coding.

NCHS previously attempted to revise ICD-10-CM sepsis coding in September 2019, but the changes were never finalized due to negative public feedback. Now, the agency is exploring options to expand the code set to include impending sepsis. Additionally, it is proposing to create codes to identify the organ dysfunction present, as well as delete the severe sepsis code and terminology, based on Sepsis-3 definitional changes.

The draft proposal illustrates how these changes would impact code A41.9, which is currently used to report sepsis, unspecified organism. In this example, the code would be revised and split into A41.91 (sepsis, unspecified organism) and A41.92 (impending sepsis, unspecified organism) for further specificity. NCHS also detailed how the updates to code A41.9 would result in new, revised, and deleted codes under category R65 (symptoms and signs specifically associated with systemic inflammation). This example is only one of approximately 40 sepsis codes that the agency anticipates that the proposal would apply to.

The public has until May 15 to submit comments on diagnosis code updates being considered for implementation on April 1, 2027. NCHS noted that this sepsis proposal is meant to elicit public comments ahead of the September 2026 public meeting, during which a more formal presentation is expected. With this in mind, these changes are not likely to be finalized until at least 2027.

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

Related Topics:
Coding, Medicare news

Attend a focus group to receive a discount on an HCPro product

May 20, 2026
News & Insights

HCPro is looking to gain insights on healthcare organizations' current pain points and education needs. We want to speak directly with a few revenue cycle professionals to learn how we can improve our products, websites, news coverage, and more. Register for one of our upcoming focus groups to make your voice heard.

The first focus group, to be held on June 9, will focus on attendees' preferred methods and formats for Medicare education. Do you benefit more from on-demand, virtual, or in-person training? Do you prefer to stream webinars, attend boot camps, or subscribe to newsletters? What are your continuing education needs? Do you need more onboarding and training materials?

The second focus group, to be held on June 11, will give attendees an opportunity to share what Medicare topics they need education on. What CMS requirements do you struggle to comply with? What denial trends are you seeing? Do you have any current auditing struggles? What topics would you like to see covered on Revenue Cycle Advisor or other HCPro websites?

Current or previous use of HCPro products is not a prerequisite for registration. Those who register for and **attend** one of the focus groups will receive a $100 discount on an HCPro product. To ensure all attendees have an opportunity to share their opinion, we are limiting each focus group to five registrations. Sign up today to secure your spot.

Editor's note: *For questions regarding the upcoming focus groups or discount for attendees, contact our staff at revcycleadvisor@gmail.com.*

UnitedHealthcare to cut 30% of prior authorizations by end of 2026

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News & Insights

UnitedHealthcare recently announced its plans to cut prior authorization requirements for 30% of services that previously required insurer approval by the end of 2026.

These services include select outpatient surgeries, some diagnostic tests like echocardiograms, and certain outpatient therapies and chiropractic care. UnitedHealthcare plans to release a full list of services on its provider portal at a later date.

Prior authorization is currently required for 2% of UnitedHealthcare medical services, according to the press release. The payer stated that it approves 92% of submitted prior authorization requests, typically within 24 hours, and has fewer prior authorization requirements than all other insurers within Medicare Advantage.

UnitedHealthcare was one of the many commercial payers that pledged in 2025 to work with CMS to streamline and improve their prior authorization processes. Since then, leading health plans have eliminated 11% of prior authorizations across a range of medical services, according to AHIP. CMS has also taken steps to improve current processes, such as working with electronic health record vendors to improve interoperability and proposing to expand electronic prior authorization to drugs.

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

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