7 Foolproof Strategies to Reduce Lost Revenue in Your HIM Department
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Each year, healthcare organizations lose about $315 billion throughout the revenue cycle management process due to errors, delays, and inefficiencies. That is about 15 cents for every dollar - gone.

As a HIM Director, you are at the very center of the revenue cycle. When your department is productive, accurate, and innovative, your organization thrives. When your department is error-prone, slow, and relies on the standard, your organization leaves a lot of money on the table.

Here are seven foolproof strategies to reduce lost revenue in your HIM department.
You know that a drop in medical coders' productivity rates impacts organizational revenue. When your team isn't at their most productive, your organization pays the price:

- Slowed revenue cycle
- Increased staffing problems
- Poor functioning, organization-wide

Here's how to improve your coders' productivity rates to keep funds flowing into your organization.

**Institute clear, balanced productivity goals**

Setting reasonable productivity standards can be tricky. Your expectations depend on the needs of your organization -- productivity can vary widely from hospital to hospital and from coder to coder.

There are many factors to take into account when establishing your productivity expectations:

- Record type
  - Outpatient
  - Inpatient
  - Ambulatory surgery
  - Clinic visit
  - Observation
  - Emergency Department
  - Ancillary Testing
- Number of beds in your organization
- Skill and experience level of individual coders
  - How fluent your coders are in ICD-10
  - How long they’ve been with your organization
  - How familiar they are with certain record types
- Level of non-coding duties assigned to coders
- Level of cooperation between coding and clinical staff
- Impact of organizational and staff transitions

To complicate things further, with the implementation of ICD-10, your productivity benchmarks are no longer useful. It’s crucial to redefine what productivity looks like.

**Mine your own data**

Before setting standards, collect detailed information on how your best coders are producing:

- Track the number of records processed by:
  - Hour
  - Day
  - Month
  - Quarter
  - Year

- Track the records processed by:
  - Speciality
  - Type
  - Physician
  - Individual coder

**Encourage open communication with your coders**

You need to be able to trust your coders to come to you with any issues. This will help prevent unwelcome surprises down the line. The best way to establish this trust? Transparency.
Invite coders to share anything that slowed them down when coding a file.

- Which procedures always trip up the coding process?
- Which diagnoses eat up most of your coders' time?
- Which clinicians' records require the most clarification?
- Which physicians copy and paste previous clinicians' notes without attribution?

By exploring these specifics with your coders, you can devise appropriate solutions.

- Create “cheat sheets” for complex diagnoses.
- Provide flow charts for the procedures that are the most cumbersome to code.
- Address chronic errors and other time sucks with clinicians.
- Encourage physicians to include attributions with any copied notes.

Outsource your medical coding

During tough transitions and staffing crunches, administrators often rely on the expertise of outsourced workers. They're confident contingent staff can save them time and money. In fact, in a survey of over 210 hospitals, 43% reported that remote medical coders had higher productivity rates than in-house coders.

Address non-coding drains on medical coding productivity

Non-coding work can detract from medical coders’ productivity levels. Not all non-coding tasks can be taken off coders' plates. But there are tasks you can streamline, reassign, and eliminate to improve productivity.

- **Problem:** Querying physicians to clarify information for more specific coding impacts coder productivity rates, according to 78% of hospitals.
- **Solution:** Raise awareness of this procedural bottleneck and brainstorm solutions with physicians.

- **Problem:** Coders spend too much time answering calls and questions from the business office and patient financial services, according to 68% of hospitals.
- **Solution:** Examine if, for your organization, these questions might be better directed elsewhere.
• **Problem:** Answering coding questions from utilization review or case management impedes productivity, according to 58% of hospitals.
• **Solution:** Strategically schedule reviews and other systemic oversight so they don’t impact coder productivity. Increase staffing during review periods.

If you’re concerned about individual coders or workplace distractions, you can install a time tracking application, such as [RescueTime](https://rescuetime.com) or [Chrometa](https://www.chrometa.com). This will help you see exactly how your coders are spending their time, whether they are remote or in-house. With this data, you can triage problems, adjust productivity standards, and customize training initiatives to address the specific productivity issues that your coders face.

**Incentivize productivity**

Reward individuals who exhibit high levels of productivity and proficiency. Consider a Coder of the Month initiative or goodies for coders who exhibit high productivity and accuracy levels. Encourage these exemplary coders to share their productivity tips with others.
Now that you've looked at general productivity solutions, it's time to focus more specifically on speeding up your coding cycle. This involves solutions to increase both coder-level and institutional efficiency.

Slow revenue retrieval and DNFB (discharged not final billed) rates have a strong impact on revenue. According to *Crain’s Chicago Business*, **coder error and delays contributed significantly to a $186 million operating loss for Presence Health in 2015**.

And, on the flip side, reducing DNFB can save your organization millions. For example, Naples Community Healthcare **saved $14 million by reducing DNFB by 87%** in a matter of months.

Here's how to take a page from their book.

**Get records to your department faster**

EHRS have reduced delays in information delivery. Still, they are far from eliminated. These holdups are a big stumbling block to speeding your billing cycle.

In an electronic environment, data delivery should be as close to instantaneous as possible. Keep an eye on how long it takes for patient records to reach your department. Keep data on the length of and reason for delays to help your organization fix problems.

- Set clear post-discharge turnaround goals.
- Follow up when those goals are unmet.
- Monitor DNFB daily so you can move quickly to remedy backlogs.
- Impose stricter definitions of record delinquency.
- Identify breakdowns in communication.
- Discuss common bottlenecks.
• Emphasize interdepartmental cooperation.
• Focus on problem-solving rather than finger-pointing.
• Spearhead education initiatives to increase organization-wide understanding of the financial importance of swift data delivery.
• Collaborate with patient financial services on reasonable timeline expectations.

Pay close attention to the highest-revenue departments

Though all records require keen attention, you want to devote extra time to the departments that generate the most funds for your organization. DNFB from these departments are more likely to have significant revenue impact.

Analyze staffing and skills gaps that may cause increased DNFB

If your current staff has high DNFB rates, you may need to invest in additional training or adjust staffing levels.

• How have staffing shortages affected your department’s speed?
• Do staffing levels respond to trends in patient volume?
• Do your uncoded files pile up on the weekends, vacations, or holidays?
• Do you need contract coders to fill in for staffing gaps?
• Do your coders have the tools to respond to workload fluctuations?

Identify missing information before the process coding begins

One key way to speed the coding cycle is to establish a system of pre-coding checks. By identifying missing information early on in a record’s lifecycle you can prevent problems down the line.

• Reduce the likelihood that information will be missing permanently.
• Reduce coding downtime waiting for clinical gaps to be filled.
• Increase coder productivity and overall system efficiency.

Keep track of data that is missing in these pre-coding checks. Use this information to define record-completion standards. Communicating these standards to both clinicians and coders will improve the speed of processing throughout the system.
Adapting to ICD-10 continues to impact revenue in two main ways.

- It has both temporary and permanent hits on efficiency.
- The increased specificity of ICD-10 improves your department’s ability to generate revenue from claims.

Here’s how to minimize the negative effects of ICD-10 while reaping its benefits.

**Keep strong data**

While initial ICD-10-related loss in productivity is estimated to be 50%-70%, the specific loss depends on the type of record being processed.

For example, a pilot study found that productivity rates plummeted by 65% when staff coded inpatient claims. For ambulatory claims, though, productivity only dipped a modest 6.7%.

Keep granular data on your coders during this transition. Examine not just your overall dip in productivity as your department comes back up to speed but how this varies based on record type and coder.

**Emphasize continued education**

The organizations that fare best in this transition focus on education. Move beyond webinars and seminars to expand your idea of what coder education looks like.

- Use real-life examples in your coder trainings.
- Craft lessons and tools around specific challenges your staff is facing.
- Expand education initiatives to clinical staff. Incomplete records are a major cause of slow down. ICD-10 requires physicians to change the way they work, too.
Encourage coder collaboration

According to Shelley Weems, RHIA, investigator on a medical coding productivity pilot study, “The benefit of facilitating group discussions among coders cannot be overstated.” Collaboration builds community, helps coders explain the reason for their choices, and facilitates group learning.

Adjust to a new normal

While some efficiency loss will be temporary, some may be intrinsic to using ICD-10. With its increased specificity and complexity, ICD-10 may mean a slower coding process for some record types is the new normal. Adjust your expectations and staffing levels to meet this new reality.

Embrace the power of ICD-10’s specificity

The good news is, the specificity of ICD-10 should bring in greater revenue. In fact, 41% of organizations indicate that ICD-10 will improve the specificity of claims, and 61% say that this increased specificity will improve claims processing and billing.
Productivity and speed expectations must be balanced with accuracy goals. When coders are too focused on meeting productivity goals, accuracy can suffer. Coders should not work so quickly that they make careless errors.

According to Susie James, the President of the Alabama Association of Health Information Management, an incorrectly coded procedure on a single file can have a reimbursement differentiation of more than $15,000.

Each inaccuracy, from under- and overcoding to mistakenly transposed modifiers, can impact your organization’s bottom line. When these errors go unnoticed and become chronic, the financial impact can be staggering.

Here’s how to combat costly coder inaccuracies.

**Monitor error reports and claim denials**

Better-performing medical practices report a claims denial rate of less than 5%. If your organization has a higher denial rate, dig in and determine why:

- Incomplete or irregular patient information
  - Missing, incomplete, or inconsistent social security number or date of birth
  - Misspelled or omitted first or last name
  - Omitted or incorrect insurance information
  - Duplicated patient information

- Coding to the incorrect level (see below)

- Invalid codes
  - Truncated codes
  - Out-of-date codes, carried over from previous years
  - Codes incorrectly entered into your database

**Establish stringent accuracy standards**
• Missing codes
• Missing documentation
• Failure to prove medical necessity
• Services outside of medical coverage
• Claim filed late

Engage coding and clinical staff in denials prevention

Identify the most common reasons your organization’s claims are denied, and work with clinicians and coders to prevent them.

• Educate clinical and coding staff about recurring errors.
• Remind coders, clinicians, and administrative staff to double-check their work. Reviewing a file for errors can save significant time and money in the long run.
• Share detailed data on registration-level errors with clinicians so they can improve intake accuracy.
• Review every code in an invalid code denial claim to locate the culprit.
• Keep track of invalid code denials and share them with your coding staff.
• Audit the codes in the drop-down menus of your database to ensure that they are complete, accurate, and up-to-date.
• Discourage over-reliance on memory. Your department can produce recurring errors -- and lose a lot of revenue -- if coders get too comfortable with a routine. Encourage coders to audit themselves, periodically rechecking codes they believe they have down.
• Engage coders in the audit process. Ask them to investigate the trickier denials, those that are hard to immediately understand or remedy. This will be a valuable education for them and help prevent similar denials in the future.

Emphasize collaboration

Your medical coders are not the only ones responsible for inaccuracies. Your strategy to move towards data precision and coding perfection needs to include standards for physicians, too. Researchers improved coding accuracy from 69% to 95% in a single cycle through improved coordination, communication, and consistency between clinicians and coders.
Promote collaboration between clinicians and coders.

- Encourage coders to contact clinicians for clarification when in doubt.
- Schedule physician-coder meetings, where physicians and coders:
  - Code a file together
  - Discuss common issues
  - Ask pressing questions

- Institute a coder shadow program, in which coders periodically sit in on patient visits. Have coders "live code" the visits and the physicians and coders compare notes.
- Educate physicians on common omissions, inconsistencies, and imprecisions.
- Tap clinical advisors to guide your coding staff on the intricacies of more complex procedures and diagnoses.

**Maintain pre-ICD-10's accuracy levels**

According to a new survey from AHIMA, ICD-10 implementation had virtually no effect on coding accuracy (0.65%). Embrace the power of ICD-10 when forecasting your accuracy expectations. Communicate to your coders that they should maintain pre-ICD-10 accuracy standards. Further, since they are benefiting from a more specific coding language, they should become increasingly adept at maximizing revenue.
Perhaps the most important aspect of accuracy when it comes to financial impact is coding at the appropriate level. A government audit found that 42% of evaluation and management claims are incorrect due to overcoding and undercoding, resulting in a loss of $6.7 billion.

Some over- and undercoding is an intentional attempt to gain more revenue or speed claims approval. Some results from carelessness or misinformation. All claims should be coded to optimize billing while remaining compliant and adhering to legal guidelines.

Here's how to address overcoding and undercoding.

**Educate your coders on the scope of the problem**

Overcoding is part of a larger trend of increasingly hefty medical claims. A recent study by the National Bureau of Economic Research found that overcoding generates billions of dollars in excess public spending annually and significant consumer choice distortions. For example, private Medicare plans generate 6% to 16% higher diagnosis-based risk scores than they would generate under fee-for-service Medicare, where diagnoses do not affect payments.

Undercoding often occurs when providers and HIM staff want to avoid the perception of overcoding. According to a study into undercoding rates, approximately one-third of medical visits are undercoded based on the given written documentation.
Strictly monitor and audit coders to prevent revenue loss

Keep an eye on all files and include overcoding and undercoding checks in your audits. Once you identify staff who are coding at the wrong level, sit down and talked to them. There are many reasons coders may code inappropriately:

- Lack of education
- Misunderstanding of what procedures can be unbundled
- Fear of audit
- Undercoding to guard against the perception of overcoding
- Attempt to earn more revenue for their organization

Once you determine why a coder has been miscoding, you can identify whether they need disciplinary action or simply more training.

Educate coders well and often about the ramifications of over- and undercoding

Coding at an inappropriate level is fraud. The costs of committing fraud far outweigh any perceived benefits of under- and overcoding.

- The penalty for violating the False Claims Act (FCA) can include fines of $5,500–$11,000 per false claim.
- Under the FCA, organizations and employees can also face criminal charges and hefty fines. For example, an anesthesiologist and his billing secretary paid $1.3 million dollars for submitting inflated bills to Medicare.
- Individual coders can also be fined and fired by their employers for over- or undercoding or other fraudulent activities.

It’s not just intentional fraud that can get coders in hot water. Warn your coders that they can be held responsible for costly errors, too. Though mere mistakes are not as dangerous as intentional misinformation, bending the rules or making habitual errors may be seen as abuse. And abuse can result in fines and firings, too.
You know that a honed, efficient, meaningful audit process does more than boost your bottom line. It helps your organization to thrive, improves coder proficiency, and increases patient satisfaction.

**Connect your audit process with your overall systemic goals**

Strong auditing goes beyond simply looking for errors. It's a chance to take a deep look at the functioning of your entire department and judge what's working and what needs improvement. To do this well, your audit process should be linked to your greater goals.

- For example, if your department is committed to improving coder education, an audit can help you tailor your education initiatives specifically to the areas where your coders need improvement.
- Or, if your department recognizes the need for staffing changes, an audit can give you granular information about what staff is essential, what reorganization is necessary, and where you might best place contingent staff.

Use your internal and external audits as an opportunity to face challenges head on and create data-backed solutions.
## Hone your audits process to improve revenue retention

| Perform quality checks at every level | Scanning and indexing  
|                                     | Staffing levels  
|                                     | Coder training  
|                                     | Workflow interruptions  

| Determine the source of revenue leakage due to errors | Coding delays and DNFB  
|                                                      | Undercoding and overcoding  
|                                                      | Lack of clarity from clinicians  
|                                                      | Repeated errors by the same coders  
|                                                      | Department-wide misinformation  

| Dig into data to seek out hidden patterns of revenue loss | Is under- or overcoding more common in a certain record type?  
|                                                         | Does your department have longer coding delays for certain specialties?  
|                                                         | Are your coders cherry picking some files while harder or less desirable work is languishing?  

Finally, perhaps the most important thing you can do to prevent revenue loss is to educate your entire organization. Clue them in on the sometimes surprising ways improperly handling medical information can impact financial health.

**Meet with clinical staff often**

In order for your coders to do their jobs well, clinicians and clinical staff must provide them with the most up-to-date information. To encourage best practices, be sure to engage your clinical staff on the data hygiene issues that come up most often in your department:

- Common inaccuracies in medical records
- Regularly omitted information
- Other clinical habits that can hinder coding efficiency and accuracy
- Sectors where both clinical and HIM teams can strive for improvement
- Interdepartmental delays or bottlenecks in information delivery

**Establish role-based education programs at every level of your organization**

You don’t need to take all of these responsibilities on. Your entire organization can fold education about good data practices into onboarding and training.

- Draw in physician advocates to educate other clinicians on the financial importance of clear and accurate charting.
• Encourage those who train intake specialists to give real-world examples of the dangers of missing initial patient information. They should stress how important attention to detail is, from the very first moment of contact with a new patient.
• Collaborate with the patient billing department to investigate what areas of instruction are necessary in this final revenue stage.

**Highlight areas of revenue loss or leakage**

Throughout all education, stress existing patterns of loss and how they impact the entire organization. During trainings, inspire creative thinking about how to anticipate and prevent future loss.
So there you have it -- seven surefire strategies to halt revenue loss in its tracks. Interested in bringing in some well-trained, proficient medical coders into your organization to combat revenue loss? Contact TotalMed today.