Revenue Cycle Management

Dell Medical School

August 2020

The University of Texas at Austin
Office of Internal Audits
UTA 2.302
(512) 471-7117

OFFICE OF INTERNAL AUDITS
THE UNIVERSITY OF TEXAS AT AUSTIN

1616 Guadalupe St. Suite 2.302 · Austin, Texas 78701 · (512) 471-7117 · FAX (512) 471-8099
audit.utexas.edu • internal.audits@austin.utexas.edu

August 21, 2020

Interim President Jay C. Hartzell
The University of Texas at Austin
Office of the President
P.O. Box T
Austin, Texas 78713

Dear Interim President Hartzell,

We have completed our audit of Revenue Cycle Management at Dell Medical School as part of our Fiscal Year 2020 Audit Plan. The objectives of this audit were to review controls to prevent billing and coding errors for medical visits and to determine whether procedures for clinical billing operations are adequate for proper revenue cycle management and interfacing with electronic medical records systems. The review primarily focused on the design of revenue cycle processes within the areas of patient access, revenue integrity, and patient financial services.

Overall, UT Health Austin is managing certain revenue cycle billing and follow-up activities, such as the first-pass rejection rate, effectively; however, there are opportunities to enhance processes and controls necessary to scale operations for future growth.

Please let me know if you have questions or comments regarding this audit.

Sincerely,

Sandy Jansen, CIA, CCSA, CRMA
Chief Audit Executive

cc: Dr. C. Martin Harris, Associate VP of the Health Enterprise and Chief Business Officer
Dr. Daniel Jaffe, Interim Executive Vice President and Provost
Dr. S. Claiborne Johnston, Vice President for Medical Affairs and Dean
Ms. Rosemaria Martinelli, Chief of Staff, Office of the Executive Vice President and Provost
Mr. Carlos Martinez, Chief of Staff, Office of the President
Mr. Dwain Morris, Chief Administrative Officer, Dell Medical School

Contents

Executive Summary

Revenue Cycle Management

Dell Medical School
Project Number: 19.012

Audit Objective

The objectives of this audit were to:

- review controls to prevent billing and coding errors for medical visits; and
- determine whether procedures for clinical billing operations are adequate for proper revenue cycle management and interfacing with electronic medical records systems.

The engagement primarily focused on the design of revenue cycle processes within the areas of patient access, revenue integrity, and patient financial services.

Conclusion

UT Health Austin is managing certain revenue cycle billing and follow-up activities, such as the first-pass rejection rate, effectively; however, there are opportunities to enhance revenue cycle operations.

Audit Observations[1]

Recommendation	Risk Level	Estimated Implementation Date
Scheduling Resources	High	Implemented March 2020
Scheduling Holds	Low	February 2021 (Post COVID-19 public health emergency)
Accounts Receivable Roles and Responsibilities	Low	December 2020 (Pending COVID-19 public health emergency)

Engagement Team[2]

Patrick McKinney, CIA, Assistant Director
Michael L. Duke, Principal, Baker Tilly
Kimberly Ginn, CIA, Principal, Baker Tilly
Kyle McMahan, Manager, Baker Tilly

[1] Each observation has been ranked according to The University of Texas System Administration (UT System) Audit Risk Ranking guidelines. Please see the last page of the report for ranking definitions.
[2] This project was co-sourced with Baker Tilly Virchow Krause, LLP (Baker Tilly).

Audit Results

UT Health Austin (UTHA) is managing revenue cycle billing and follow-up activities to a level aligned with key performance indicators, such as the first-pass rejection rate. These successes are critical for billing compliance and for the submission of clean claims; however, there are opportunities to enhance processes and controls necessary to scale operations for future growth.

Certain processes and roles are not documented or clearly defined, and processes related to accounts receivable (A/R) payment and refund processing are not aligned with leading practices. Additionally, revenue metrics are directly tied to successfully scheduling and serving patients, thus current intake and scheduling issues may prevent UTHA from achieving its full revenue potential.

In addition to the opportunities above, the following strengths were identified:

- **First-pass rejection rate:** UTHA's first-pass rejection rate is in line with the industry benchmark (≤ 10 percent). The first-pass rejection rate for the period under review (February 2019 through January 2020) was approximately 10 percent (see **Appendix**).
- **Utilization of performance metrics:** UTHA runs various performance metrics and uses them effectively. Tableau dashboards are created both nightly and monthly, using information from Athena. The performance metrics include the percentage of card scans, co-pay collection rates, number of follow-up appointments, and call metrics. The clinical revenue cycle director has a monthly discussion with an Athena representative to review UTHA's key performance indicators (KPIs), such as charge lag, days in A/R and denial reasons.
- **Payer enrollment tracking:** UTHA does not have a backlog for payer enrollment. Personnel utilize a checklist to ensure all necessary steps and actions are completed when enrolling a payer. In addition, UTHA updates a shared spreadsheet of payers daily. Schedulers are able to refer to this spreadsheet when patients request an appointment. If providers are not credentialed with a patient's insurance, an appointment will not be scheduled.
- **Interface with electronic medical records system**: UTHA's clinical operations personnel provide the appropriate inputs to the system to ensure clean claims and other processing. There remains an opportunity to better document the processes and system interface points.

Observation #1 Scheduling Resources

Patient Access reports to Clinical Operations with a goal of enhancing the overall patient experience; however, certain processes that are the responsibility of the Patient Access team impact downstream processes and ultimately limit the potential for revenue. UTHA's Patient Access team is responsible for scheduling and registration, eligibility checks, authorizations, and point-of-service collections. In recent reports provided by UTHA, the inbound call abandonment rate is about 17 percent, and the average queue time for a patient waiting on the line is about 80 seconds. Both fall substantially below industry standards (i.e., 6 percent abandonment rate and 40 second average wait, respectively).

Patient Access is also responsible for referrals. Current staffing levels are not effectively managing referral volumes or meeting performance expectations. Under the current construct, UTHA is able to coordinate 40 phone calls per scheduler per day, which is significantly below the industry standard of 80 calls per scheduler per day.

These metrics suggest that existing resources should be able to take and schedule more calls with the automated call distribution (ACD) system in place. This gap in performance may be driven by the lack of direct connectivity with other functions within the revenue cycle to enable more effective scheduling. Leadership mentioned that other factors such as planned and unplanned leave have impacted productivity, as staffing levels are below what is needed to accomplish desired performance metrics at certain times.

The challenges related to receiving calls timely, scheduling appointments, and contacting referrals impacts the number of appointments scheduled and patients receiving services, thereby limiting the revenue received by UTHA.

Recommendation: UTHA should consider the following efforts to enhance Patient Access performance:

- Assess the need for a new position, or have a dedicated employee within Patient Access, responsible for the coordination of referrals. This dedicated role would allow the Patient Access group to focus on all inbound calls to better improve UTHA's abandonment rate and average queue time.
- Provide training on obtaining referrals so responsible personnel can capitalize on their efforts and create a positive impact in the referral stream.
- Formalize performance expectations for Patient Access staff to better align expectations with industry standards. Evaluate staffing levels after expectations are set.
- Consider aligning Patient Access resources under the overall revenue cycle leadership to better coordinate efforts across related function.

Management's Response: Prior to this audit, UTHA leadership identified that the access and outcomes center (AOC) leadership had been unable to meet performance goals consistent with national benchmarks and standards as outlined in the report. Thus, under pressure to develop an organizational plan and provide leadership to drive productivity consistent with standards, the director of the AOC resigned employment. UTHA then hired a call center leader with more than 20 years of call center experience in outpatient settings with the understanding that the leader would develop an organizational plan to reach national benchmarks and hold individual employees accountable to productivity metrics consistent with national standards. This position was hired along with two new call center associates. Additionally, some responsibilities were shifted to individual clinics for more efficient management of patients seeking to speak to a provider rather than scheduling an appointment.

Departmental goals and individual associate goals have been established with enhanced training for all employees. These expectations are managed with a call monitoring scorecard to measure

individual productivity. The changes described above have resulted in significant reductions of the average weekly incoming call abandonment rate; 23 percent to 1 percent. The average answer delay rate has similarly decreased; > 4 minutes to 21 seconds. Additional near-term plans include real-time displays of metrics to facilitate a nimble response to increased volumes, the addition of three additional staff to exclusively manage outbound calls, and a call tree to direct patients to the appropriate scheduling team.

Responsible Person: Patient Access Director and Executive Clinical Director

Planned Implementation Date: Implemented March 2020

Observation #2 Scheduling Holds

UTHA does not currently place holds on patient accounts to prohibit patients from scheduling appointments when they have outstanding balances. In Fall 2019, UTHA approved a policy regarding the termination of provider-patient relationships. As part of this policy, a patient relationship may be terminated if the patient has an outstanding balance greater than $1,000 and more than 120 days past due. Because of COVID-19 disruptions, enforcement of this policy is on hold. Industry best practice is to place scheduling holds if co-pays and smaller balances are past due; however, the mission of UTHA and the environment in which it operates may not be conducive to implementing this standard. As UTHA's operations and patient numbers grow, past-due balances will likely increase as well, and more stringent scheduling hold and collection policies, including up-front collections of deductibles and co-pays, may be necessary to limit financial risk.

Recommendation: UTHA should consider the following efforts to reduce the risk of financial loss related to accounts with bad debt:

- Communicate the patient termination policy and procedures to all employees and train revenue cycle staff on appropriate management of these cases.
- As UTHA's operations grow, consider whether more stringent scheduling hold and collection policies are necessary.

Management's Response: When the public emergency related to the COVID-19 pandemic has ended, management will begin to enforce the policy established in Fall 2019. Management will continue to monitor outstanding balances to determine if policy changes are necessary. In addition, management will review the need for enhanced upfront payment mechanisms in association with the start-up of the UTHA Ambulatory Surgery Center. As of June 2020, there are 22 patient accounts with balances greater than $1000 totaling $46,000. Most of these are for surgical procedures or obstetric deliveries in which the patients were not seen in a UTHA clinic prior to the provider performing the service in a hospital or surgery facility.

Responsible Person: Director of Revenue Cycle and Executive Clinical Director

Planned Implementation Date: February 2021 (Post COVID-19 public health emergency)

Observation #3 Accounts Receivable Roles and Responsibilities

UTHA distributes the A/R worklists among the billing specialists, A/R specialist, and the revenue cycle manager. Billing specialists focus on their area's A/R for 0-90 days. The A/R specialist works A/R aged 91-180 days for all areas, and the revenue cycle manager manages A/R exceeding 180 days.

A/R follow-up responsibilities do not appear to be well-documented in job descriptions and specifications, and there is limited guidance provided on how A/R should be worked by these professionals (e.g., working the highest dollar amount first). The A/R specialist currently "touches" approximately 75 accounts each week, whereas, industry standard is 55-65 accounts per day per specialist. While current A/R balances and metrics are in line with industry metrics, the current A/R process may not be scalable. As UTHA operations and A/R expand, the A/R specialist may need to handle more accounts to free up billing specialists to focus on other responsibilities.

Refer to the **Appendix** for the A/R analysis performed on the Aged Trial Balance (ATB).

Recommendation: UTHA should consider the following efforts to enhance A/R follow-up performance:

- Update applicable procedures to reflect how A/R should be worked and evaluated.
- Implement and monitor productivity standards. Enforce standards and include them in the annual review process.
- As UTHA operations and A/R expand, consider whether the A/R specialist should process a larger percentage accounts.

Management's Response: Athena works first-pass denials for the straight-forward and simple errors/corrections. The claims that are worked by the A/R Specialist are related to medical necessity denials, prior authorizations denials, tracking down of payments and/or requesting cancellation of lost checks, coding denials, and final appeals which are more time consuming to work. Resolution of the revenue receipt process mentioned subsequently in this document will reduce administrative burden with tracking down payments and requesting cancellation of checks.

A worklist management document has been created to properly reflect how A/R should be prioritized and worked. The worklist document has been shared with the outpatient billing team and the Ambulatory Surgery Center staff. Updates will be made regularly as the UTHA practice evolves to ensure proper A/R management. Productivity standards are being created for the billing specialist roles on the Revenue Cycle team. Those standards will be used during the annual review process.

Responsible Person: Director of Revenue Cycle

Planned Implementation Date: December 2020 (Pending COVID-19 public health emergency)

Additional Risk Observations

Refund Process
UTHA's Patient Financial Services team handles billing, account follow-up, and account resolution. Once refunds have been identified, a list is sent to the Finance Department to prepare the refund checks. Each check is manually typed and printed. The chief administrative officer and the director of finance, must sign each check by hand. Funding for refunds is provided through petty cash. The petty cash account is refilled by The University of Texas at Austin's (UT Austin) cash management area; however, it was noted during interviews that maintaining a sufficient petty cash balance is challenging, as it needs to be replenished and reconciled frequently. The petty cash account was established in order to create a solution that adhered to UT Austin's existing processes. However, this process is not scalable or sustainable as operations expand.

Opportunities: UTHA and UT Austin leadership (along with University Health Services, Moody College of Communication, and School of Nursing) should work together to implement an automated and scalable refund process.

Revenue Receipt Process
All UT Austin schools and departments, including UTHA, share a Taxpayer Identification Number (TIN) issued by the Internal Revenue Service (IRS). UTHA bills third-party payers (i.e., insurance agencies) for the services they provide to patients. The payers, with the exception of a few (e.g., Medicare and Medicaid), direct payments using the shared TIN. Because there are several schools and departments within UT Austin providing clinical services, payers must specify the payment recipient when directing payments to the TIN. Payments have been directed to the incorrect school and have caused an increase in administrative efforts to redirect payments to the correct recipient.

Although UTHA has established an administrative process to reconcile, redistribute, and post the misdirected payments, the process extends collection periods, increases the probability of errors, and creates other challenges, some of which can impact patients and reduce efficiency in managing the revenue cycle. Additionally, it is standard practice among industry peers to use separate TINs to segregate medical practice revenue from other sources.

Opportunities: UTHA and UT Austin leadership (along with University Health Services, Moody College of Communication, and School of Nursing) should establish a mutually-beneficial and more efficient process to receive patient revenues, such as establishing a separate banking TIN or an alternative accounting structure that segregates UTHA payments. Establishing a separate banking TIN will align UTHA with industry standards and streamline collection processes.

Ambulatory Surgery Center
UTHA is working to establish the first Ambulatory Surgery Center (ASC) by Fall 2020. However, clearly-defined and well-coordinated infrastructure plans are still evolving. UTHA has

recently begun to have conversations with the Athena representatives to integrate and set up ASC information.

Additionally, current staffing plans and employee roles and responsibilities do not account for the additional work that will come with opening the ASC. Revenue cycle leadership is in the process of determining how an ASC would impact resource needs. For instance, UTHA is planning to hire a separate scheduler who would be located at the ASC.

The lack of formalized, integrated plans (e.g., staffing and infrastructure plans) could create a delay in opening the ASC or a resource shortage. Resource strains can create potential gaps in key billing and collections processes.

Opportunities: UTHA should continue to formalize a plan for the ASC that considers existing resource needs and structure. If current staff will manage the ASC revenue cycle, UTHA should consider revising employee roles and responsibilities to ensure that they cover the needs of current clinics and the ASC. Training should be provided to employees on ASC-specific revenue cycle topics.

Management Update: Progress has been made on this effort, including hiring of ASC leadership and operations and revenue cycle staff. Overall, management of the ASC is the responsibility of the chief clinical officer and the executive clinical director, who also manage UTHA. Athena configuration is in progress with finalization pending completion of payer contracts. The Medicare enrollment application has been submitted and accreditation status is pending.

Expansion of Clinical Research

UTHA is working to expand clinical research activities; however, personnel noted UTHA does not have the infrastructure to support clinical trial billing and compliance. For instance, UTHA does not have a system to standardize billing. A process does exist to identify new research projects; however, the process for developing budgets is not streamlined. Clinical research coordinators are managed at the departmental level. Current processes are manual and do not allow for scalability (e.g., Athena cannot generate customizable invoices so the study number is added manually). Expansion of clinical research activities without the necessary infrastructure can increase the risk of non-compliance with applicable laws and regulations or result in False Claims Act violations for billing Medicare for services inconsistent with coverage analysis.

Opportunities: Because of the compliance risks surrounding clinical trials and research, and the lack of infrastructure to support such endeavors, UTHA should consider partnering with another healthcare entity that has clinical trial industry knowledge and billing infrastructure (e.g., MD Anderson, Ascension Seton). Such a partnership could reduce overall risk of non-compliance while also increasing the ability to expand operations.

Background

UT Austin's Office of Internal Audits (Internal Audits) partnered with Baker Tilly to conduct an audit of medical billing/revenue cycle management in the Dell Medical School. The new medical school was created in partnership with the surrounding community and built on the foundation of a top-tier research university. The revenue cycle management area of UTHA had not previously been audited. Since its inception, UTHA's net revenue reached six million, and averages $180 per visit (mostly clinical visits for specialty areas).

Scope, Objectives, and Methodology

The scope of this audit included revenue cycle operations and processes. The objectives of this audit were to review controls to prevent billing and coding errors for medical visits, and to determine whether procedures for clinical billing operations are adequate for proper revenue cycle management and interfacing with electronic medical records systems.

The review primarily focused on the design of revenue cycle processes within the areas of patient access, revenue integrity, and patient financial services.

To achieve the audit objectives, Internal Audits and Baker Tilly:

- Performed an initial risk assessment to identify high-risk areas
- Reviewed current, and applicable, UTHA documentation to understand:
    - Internal controls, policies, and procedures related to medical billing and the revenue cycle
    - Roles and responsibilities of staff members involved in the revenue cycle
- Interviewed management and select staff regarding current processes and controls
- Reviewed the current infrastructure of revenue cycle operations, including:
    - Organizational structure
    - Core technologies
    - Core revenue cycle activities and their comparison to industry-leading practices
- Assessed current controls related to the following revenue cycle functions and determined gaps related to industry-leading practices:
    - Coding errors
    - Billing errors
    - Billing submission
    - Account processing
    - Remittances
    - Collection processes
- Reviewed current management reporting capabilities and their practical use

Observation Risk Ranking

Audit observations are ranked according to the following definitions, consistent with UT System Audit Office guidance.

Risk Level	Definition
Priority	If not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of The University of Texas at Austin (UT Austin) or the UT System as a whole.
High	Considered to have a medium to high probability of adverse effects to UT Austin either as a whole or to a significant college/school/unit level.
Medium	Considered to have a low to medium probability of adverse effects to UT Austin either as a whole or to a college/school/unit level.
Low	Considered to have minimal probability of adverse effects to UT Austin either as a whole or to a college/school/unit level.

In accordance with directives from UT System Board of Regents, Internal Audits will perform follow-up procedures to confirm that audit recommendations have been implemented.

Report Distribution

The University of Texas at Austin Institutional Audit Committee
- Mr. Darrell Bazzell, Senior Vice President and Chief Financial Officer
- Mr. Cameron Beasley, Chief Information Security Officer
- Mr. James Davis, Vice President for Legal Affairs
- Mr. Jeffery Graves, Interim Chief Compliance Officer, University Compliance Services
- Dr. Jay C. Hartzell, Interim President
- Dr. Daniel Jaffe, Interim Executive Vice President and Provost
- Dr. John Medellin, External Member
- Mr. J. Michael Peppers, CAE, The University of Texas System Audit Office
- Dr. Alison Preston, Interim Vice President for Research
- Ms. Christine Plonsky, Chief of Staff/Executive Sr. Associate Athletics Director
- Dr. Soncia Reagins-Lilly, Vice President for Student Affairs and Dean of Students Ms. Susan Whittaker, External Member
- Ms. Elizabeth Yant, External Member, Chair

The University of Texas System Audit Office
Legislative Budget Board
Governor's Office
State Auditor's Office

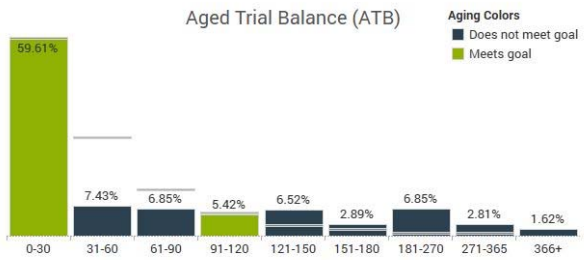
APPENDIX

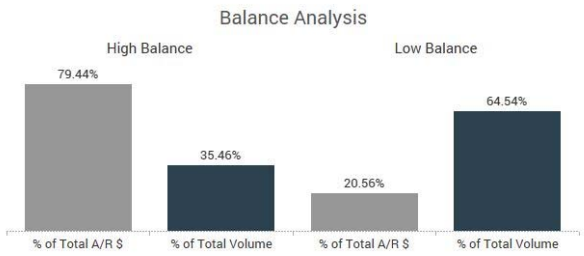
A/R Analysis: As of February 6th, 2020

HIGH-LEVEL INSIGHTS

Third Party A/R Analysis

$1.07M	3,985	26.09%	13%	$84.38K
3rd Party Balance	3rd Party Volume	3rd Party 91+ %	3rd Party 91+ Target	Total 3P Opportunity





A/R Analysis

- The financial class with the greatest A/R balance aged over 90 days is **Commercial** at **$99,184**. Within this financial class, the payer with the highest balance over 90 days is **BCBS-TX - UT SELECT (PPO) [466351]**.
- Medicare A/R over 90 days old currently equals **$106,617**.
- **HUMANA - CHOICE (MEDICARE REPLACEMENT PPO) [47006]** has the highest risk of write-offs due to its **$4,381** of A/R aged over 365 days.

Balance Analysis

- Balance ratios indicate that approximately **79%** of A/R constitute only **35%** of 3rd party accounts. In order to improve 3rd party A/R aging, work queues should be evaluated to ensure appropriate prioritization of accounts.
- The payer with the highest volume of low balance accounts is **BCBS-TX - UT SELECT (PPO) [466351]** with **401** accounts totaling **$34,941**.

Rejection Analysis: From February 2019 to January 2020

HIGH-LEVEL INSIGHTS

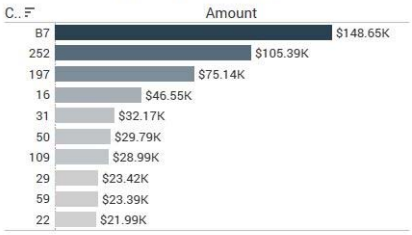
Overall First Pass Rejection Analysis

10.57%	$690.98K	$527	1,311
Rejection Rate	Amount	Avg $ per Rejection	Volume

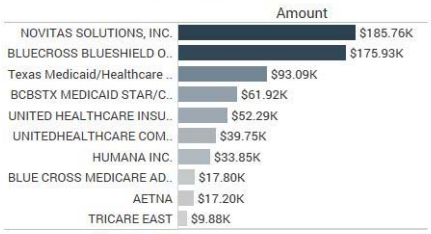
Rejections by Category

Remark Category	Amount	Volume
Billing	$233,846	466
Provider	$172,026	224
Authorization	$79,227	207
COB	$51,596	131
Medical necessity	$46,699	89
Eligibility	$44,295	82
Coding	$34,106	157
Untimely Filing	$29,182	62

Top 10 Rejections by CARC



Rejections by Payer



835 remittance review indicates first pass rejections for 12 months of data in the gross amount of **$2.8 million**. This first pass rejection rate typically requires significant business office rework to ensure the organization receives reimbursement.

Based on industry standards, we believe that 10% of all rejections result in denial adjustments which could result in **$170,796** in opportunity.

HIGH-LEVEL INSIGHTS

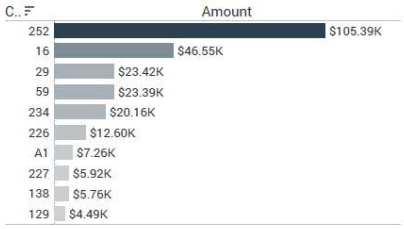
Patient Financial Services First Pass Rejection Analysis

4.02%	$263.03K	$509	517
Rejection Rate	Amount	Avg $ per Rejection	Volume

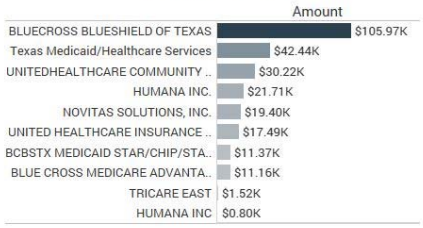
Rejections by Category

Remark Category	Amount	Volume
Billing	$233,846	466
Untimely Filing	$29,182	62

Top 10 Rejections by CARC



Rejections by Payer



The top Claim Adjustment Reason Codes (CARCs) among Untimely Filing, Billing, and Untimely filing rejections are **252** (An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).) and **16** (Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance).

The number one payer for patient financial services rejections is **Bluecross Blueshield Of Texas**, with **$105,972** in first pass rejections annually. The top Remittance Advice Reason Code (RARC) on Bluecross Blueshield Of Texas remittances is **M127** with **$59,644** in patient access rejections followed by **M80** with **$18,133** in rejections. The top procedure code rejected by Bluecross Blueshield Of Texas is **91035**.

HIGH-LEVEL INSIGHTS

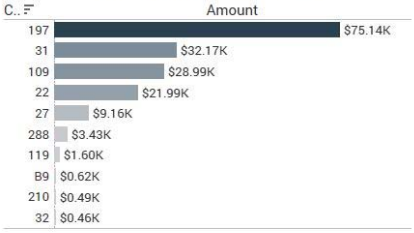
Patient Access Process Rejection Analysis

2.68%	$175.12K	$422	415
Rejection Rate	Amount	Avg $ per Rejection	Volume

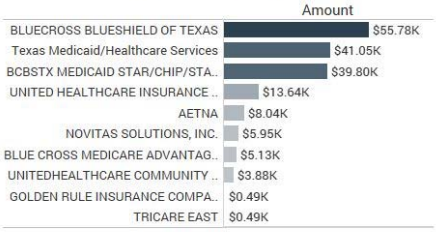
Rejections by Category

Remark Category	Amount	Volume
Authorization	$79,227	207
COB	$51,596	131
Eligibility	$44,295	82

Top 10 Rejections by CARC



Rejections by Payer



The top Claim Adjustment Reason Codes (CARCs) among Authorization, Eligibility, and COB rejections are **197** (Precertification/authorization/notification/pre-treatment absent.) and **31** (Patient cannot be identified as our insured.).

The number one payer for patient access rejections is **Bluecross Blueshield Of Texas**, with **$55,785** in first pass rejections annually. The top Remittance Advice Reason Code (RARC) on Bluecross Blueshield Of Texas remittances is **N598** with **$5,149** in Authorization, Eligibility, and COB rejections followed by **MA04** with **$2,156** in rejections.The top three procedure codes rejected by Bluecross Blueshield Of Texas are **27130, 99204, and 58953**.

HIGH-LEVEL INSIGHTS

Revenue Assurance Process Rejection Analysis

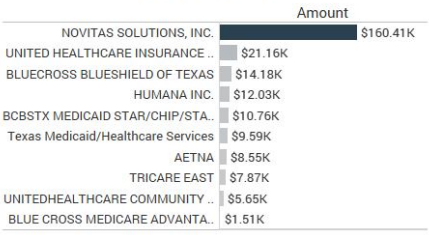
3.87%	$252.83K	$543	466
Rejection Rate	Amount	Avg $ per Rejection	Volume

Rejections by Category

Remark Category	Amount	Volume
Provider	$172,026	224
Medical necessity	$46,699	89
Coding	$34,106	157

Top 10 Rejections by CARC

Rejections by Payer



The number one payer for revenue assurance rejections is **Novitas Solutions, Inc.**, with **$160,414** in first pass rejections annually. The top Remittance Advice Reason Code (RARC) on Novitas Solutions, Inc. remittances is **M25** with **$10,110** in patient access rejections followed by **MA01** with **$4,517** in rejections.The top three procedure codes rejected by Novitas Solutions, Inc. are **43282, 43280, and 43213**.