Breaking Down the Walls:
Three Proven Ways to Decrease Compliance Risk in the Revenue Cycle

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Objectives

- **Identify the top 3 compliance risks within the revenue cycle:**
  - How to manage disclosure of PHI within revenue cycle departments
  - How to evaluate levels of direct payer access to EHR systems
  - How to effectively unite revenue cycle departments
- **Assess new ways for compliance officers to work collaboratively with revenue cycle leaders to:**
  - Reduce risk
  - Bridge communication gaps
  - Promote teamwork, while also supporting billing integrity and revenue recovery for the organization
- **Offer real-world guidance to improve compliance in centralized revenue cycle environment with focus on shoring up specific business office processes that may lead to inadvertent PHI disclosures during payer conversations, audits and disputes.**

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Healthcare Providers are at Risk

- **43 healthcare providers under CIA's in 2018**
- **450 hospitals at risk of potential closure according to Morgan Stanley analysis**
- **Health systems are cutting jobs**
- **Reimbursement is decreasing**

https://www.businessinsider.com/almost-20-of-hospitals-in-the-us-are-in-bad-shape-according-to-morgan-stanley-2018-8

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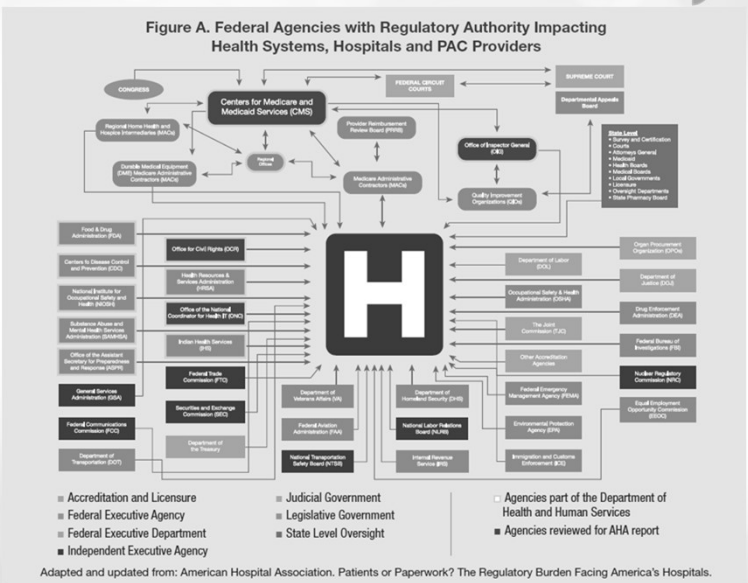
Figure A. Federal Agencies with Regulatory Authority Impacting Health Systems, Hospitals and PAC Providers



Adapted and updated from: American Hospital Association. Patients or Paperwork? The Regulatory Burden Facing America's Hospitals.

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Healthcare providers must find a way to work together to create efficiencies, promote compliance and retain revenue.

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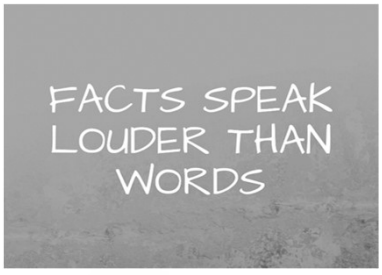
Team Engagement

- **Ensure your compliance team has stakeholders from each key area of the revenue cycle**
- **Executive Champion**
- **Service line Champion**
- **Trending Reports**



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Team Approach

3 reasons why compliance and revenue cycle teams should be allies:

1. Monitoring, Auditing and Corrective Action
2. False Claims Act
3. Disclosure Management

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Different Ways Providers Could Violate False Claims Act

1. Knowingly inflating costs included in the cost reports
2. Claiming certain items as reimbursable costs when those items were not reimbursable
3. Knowingly manipulating patient admissions, treatments or conditions to inflate the costs that will be reimbursed for the patients' stay
4. Kickbacks to physicians or other healthcare providers to influence those providers to refer patients to the hospital

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"Knowingly"

- **Definitions (1) the terms "knowing" and "knowingly"**
- **(A) mean that a person, with respect to information**
  - (i) has actual knowledge of the information;
  - (ii) acts in deliberate ignorance of the truth or falsity of the information; or
  - (iii) acts in reckless disregard of the truth or falsity of the information; and
- **(B) require no proof of specific intent to defraud**

https://www.law.cornell.edu/uscode/text/31/3729

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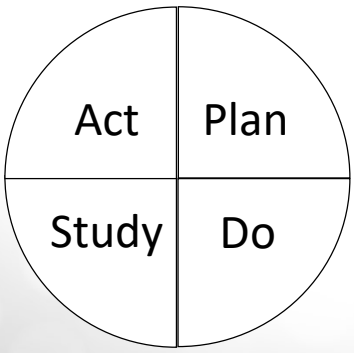
Getting Started – Make a plan



- **Step 1: Plan**
  - Plan the test, including a plan for collecting data
- **Step 2: Do**
  - Try out the test on a small scale
- **Step 3: Study**
  - Set aside time to analyze the data and study the results
- **Step 4: Act**
  - Refine the change, based on what was learned from the test

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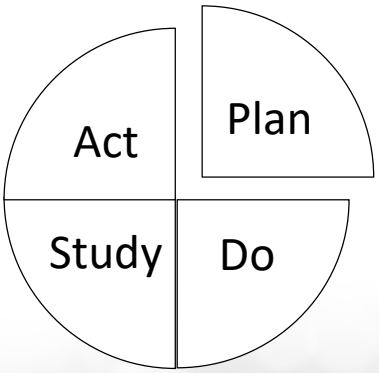
Plan

- **Identify your Risk**
  - Utilize your own internal data
  - Compare with external data sources
  - Look for outliers
  - Dig deep
    - Ask 5 why's to get to the root cause of the issue
  - Select 1 group of denials to tackle first



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How to know what to review?

- **Create a checklist for high volume/high dollar services**
- **Know your auditors and what they are auditing**
- **Use the following to develop your criteria:**
  - Evidenced Based Guidelines
  - LCD/NCD Requirements
    - Know the LCD's (local coverage determination) and NCD's (national coverage determination)
    - Review annually for changes on high volume procedures
  - CERT tips guidelines
  - Medicare Billing updates and communications
  - Government contractor websites – MAC's, QIO's, RAC's

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Tools in your Toolbox

- **Pepper Reports**
- **OIG Reports**
- **TPE Findings**
- **Internal Audit/ Denial Risk assessments**
- **Financial/Billing information**
  - Claims and remits

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PEPPER Report

- **PEPPER summarizes a hospital's Medicare claims data for diagnosis-related groups (DRGs) and discharges that have been identified as at higher risk for improper payments**

SHORT-TERM ACUTE CARE HOSPITALS
- User's Guide (PDF, 25th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

CRITICAL ACCESS HOSPITALS
- User's Guide (PDF, 7th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

HOME HEALTH AGENCIES
- User's Guide (PDF, 3rd Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of HHA PEPPER Retrievals by State

HOSPICES
- User's Guide (PDF, 7th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of Hospice PEPPER Retrievals by State

INPATIENT PSYCHIATRIC FACILITIES
- User's Guide (PDF, 8th Edition)
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INPATIENT REHABILITATION FACILITIES
- User's Guide (PDF, 8th Edition)
- Training & Resources
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LONG-TERM ACUTE CARE HOSPITALS
- User's Guide (PDF, 12th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of LT PEPPER Retrievals by State

PARTIAL HOSPITALIZATION PROGRAMS
- User's Guide (PDF, 6th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER

SKILLED NURSING FACILITIES
- User's Guide (PDF, 6th Edition)
- Training & Resources
- PEPPER Distribution - Get Your PEPPER
- Map of SNF PEPPER Retrievals by State

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Sample PEPPER

Target	Description	Number of Target Dischs	Percent	Hospital National %ile	Hospital Jurisdict. %ile*	Hospital State %ile*	Sum of Payments
Septicemia	Proportion of discharges with DRG equal to 870 (septicemia or severe sepsis w/ mechanical ventilation >96 hours); 871 (septicemia or severe sepsis w/o mechanical ventilation >96 hours with MCC), 872 (septicemia or severe sepsis w/o mechanical ventilation >96 hours w/o MCC), to discharges with DRG equal to 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC), 207 (respiratory system diagnosis with ventilator support 96+ hours), 208 (respiratory system diagnosis with ventilator support < 96 hours), 689 (kidney & urinary tract infections w/ MCC), 690 (kidney & urinary tract infections w/o MCC), 870, 871, 872	603	59.9%	50.0	71.3	67.3	$6,713,104
Medical DRGs with CC or MCC	Proportion of discharges of Medical DRGs with complication or comorbidity (CC) or major CC (MCC), excl DRGs which may be assigned on the basis of medication administration, to discharges of Medical DRGs with or without CC or MCC	3,472	72.6%	55.1	72.0	73.2	$29,544,498
Surgical DRGs with CC or MCC	Proportion of discharges of Surgical DRGs with complication or comorbidity (CC) or major CC (MCC), excl DRGs which may be assigned on the basis of a px being performed, to discharges of Surgical DRGs with or without CC or MCC	1,516	65.5%	74.3	75.0	70.5	$36,512,488
Single CC or MCC	Proportion of discharges with one CC or MCC coded on the claim, to discharges with one or more CC or MCC coded on the claim	1,403	23.3%	42.2	20.5	28.0	$12,744,045
Excisional Debridement	Proportion of discharges for the DRGs affected by excisional debridement procedure code(s) that have an excisional debridement procedure code on the claim, to discharges of the DRGs affected by excisional debridement procedure code(s)	25	11.0%	1.3	6.7	6.7	$377,954
Chronic Obstructive Pulmonary Disease	Proportion of discharges with DRG equal to 190 (chronic obstructive pulmonary disease w/ MCC), 191 (chronic obstructive pulmonary disease w/ CC), 192 (chronic obstructive pulmonary disease w/o CC/MCC), to discharges for medical DRGs in MDC 04 (DRGs 175 through 208)	128	20.5%	33.7	29.6	29.8	$712,240
Spinal Fusion	Proportion of discharges that have spinal fusion procedure codes on the claim, to discharges that have any spinal procedure codes on the claim	141	59.2%	41.8	51.8	45.9	$3,895,024
Two-day Stays for Medical DRGs	Proportion of discharges for medical DRGs with length of stay equal to two days excluding patient discharge status code of 02 (transfer to another short-term general hospital), 82 (transfer to another short-term general hospital with a planned acute care hospital readmission), 07 (left against medical advice) or 20 (expired), excluding claims with occurrence-span code 72 with "through" date on or day prior to inpatient admission, to all discharges for medical MS-DRGs excluding claims with pt dic status code 02, 82, 07, 20, occurrence-span code 72 with "through" date on or day prior to inpatient admission	1,108	22.1%	63.9	67.8	73.1	$6,190,192
Two-day Stays for Surgical DRGs	Proportion of discharges for surgical DRGs with length of stay equal to two days excluding patient discharge status code of 02 (transfer to another short-term general hospital), 82 (transfer to another short-term general hospital with a planned acute care hospital readmission), 07 (left against medical advice) or 20 (expired), excluding claims with occurrence-span code 72 with "through" date on or day prior to inpatient admission, to all discharges for surgical MS-DRGs, excluding claims with pt dic status code 02, 82, 07, 20, occurrence-span code 72 with "through" date on or day prior to inpatient admission	399	16.5%	41.0	50.0	57.3	$5,496,385
One-day Stays for Medical DRGs	Proportion of discharges for medical DRGs with length of stay equal to one day excluding patient discharge status code of 02 (transfer to another short-term general hospital), 82 (transfer to another short-term general hospital with a planned acute care hospital readmission), 07 (left against medical advice) or 20 (expired), excluding claims with occurrence-span code 72 with "through" date on or day prior to inpatient admission, to all discharges for medical MS-DRGs excluding claims with pt dic status code 02, 82, 07, 20, occurrence-span code 72 with "through" date on or day prior to inpatient admission	133	2.7%	1.7	1.8	2.1	$775,747
One-day Stays for Surgical DRGs	Proportion of discharges for surgical DRGs with length of stay equal to one day excluding patient discharge status code of 02 (transfer to another short-term general hospital), 82 (transfer to another short-term general hospital with a planned acute care hospital readmission), 07 (left against medical advice) or 20 (expired), excluding claims with occurrence-span code 72 with "through" date on or day prior to inpatient admission, to all discharges for surgical MS-DRGs excluding claims with pt dic status code 02, 82, 07, 20, occurrence-span code 72 with "through" date on or day prior to inpatient admission	134	5.5%	1.5	3.8	2.9	$1,823,467

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OIG Work Plan

- **Review what is on the OIG work plan or what was on it and compare with your services.**
- **"The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud hot spots."**
- **During Fiscal Year (FY) 2017, the Federal Government won or negotiated over $2.4 billion in health care fraud judgments and settlements.**

Announced or Revised	Agency	Title	Component	Report Number (s)	Expected Issue Date (FY)
January 2019	Centers for Medicare & Medicaid Services	Medicare Outpatient Outlier Payments for Claims With Credits for Replaced Medical Devices	Office of Audit Services	W-00-19-35819	2019

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CERT Improper Payment Rate 2019

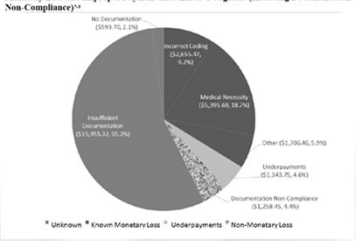
- **Medicare CERT evaluates a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.**

Claim Type	Improper Payment Rate	Improper Payment Amount (2)
Overall	**7.25%**	**$28.91 B**
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	8.07%	$13.34 B
Part B Providers	8.64%	$8.66 B
Hospital IPPS	3.57%	$4.47 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	30.70%	$2.44 B

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/

Monetary Loss Findings[6]

Figure 5: Improper Payments (in Millions) and Percentage of Improper Payments by Monetary Loss and Improper Payment Rate Error Categories (Including Documentation Non-Compliance)[3]



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CERT Report Example

Review and compare with internal risk analysis

Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS-DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$693,508,390	10.1%	7.9% - 12.2%	0.0%	35.3%	63.3%	1.3%	0.0%	2.3%
Psychoses (885)	$378,171,886	9.9%	3.0% - 16.7%	7.9%	80.1%	11.8%	0.1%	0.0%	1.3%
Septicemia Or Severe Sepsis WO MV >96 Hours (871, 872)	$275,840,496	3.1%	(1.9%) - 8.1%	0.0%	0.0%	0.0%	100.0%	0.0%	0.9%
Endovascular Cardiac Valve Replacement (266, 267)	$236,231,903	12.3%	6.4% - 18.1%	0.0%	83.7%	6.1%	0.8%	9.4%	0.8%
Spinal Fusion Except Cervical (459, 460)	$164,937,576	8.7%	1.3% - 16.2%	0.0%	31.9%	40.8%	27.3%	0.0%	0.6%
Heart Failure & Shock (291, 292, 293)	$125,598,571	2.6%	0.3% - 4.8%	0.0%	0.0%	51.1%	48.9%	0.0%	0.4%
Organic Disturbances & Intellectual Disability (884)	$109,540,492	21.1%	7.4% - 34.8%	0.0%	10.5%	85.3%	4.1%	0.0%	0.4%
Degenerative Nervous System Disorders (056, 057)	$103,318,415	13.7%	10.4% - 17.0%	0.0%	31.8%	64.5%	3.6%	0.0%	0.3%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$88,617,581	7.6%	3.5% - 11.8%	7.3%	0.0%	92.6%	0.1%	0.0%	0.3%
Cardiac Arrhythmia & Conduction Disorders (308, 309, 310)	$85,869,565	6.6%	3.1% - 10.1%	0.0%	0.0%	89.7%	10.3%	0.0%	0.3%
Other Musculoskelet Sys & Conn Tiss O.R. Proc (515, 516, 517)	$81,117,774	19.1%	7.7% - 30.5%	0.0%	0.0%	97.4%	2.6%	0.0%	0.3%
Chest Pain (313)	$73,056,701	26.9%	18.0% - 35.9%	0.0%	0.0%	100.0%	0.0%	0.0%	0.2%
Kidney & Urinary Tract Infections (689, 690)	$72,819,946	4.7%	0.5% - 8.9%	0.0%	0.0%	86.0%	14.0%	0.0%	0.2%
Cervical Spinal Fusion (471, 472, 473)	$70,841,951	12.2%	4.7% - 19.8%	0.0%	23.8%	66.8%	9.4%	0.0%	0.2%
Extensive O.R. Procedure Unrelated To Principal Diagnosis (981, 982, 983)	$67,881,752	5.1%	1.6% - 8.7%	0.0%	0.6%	79.4%	20.1%	0.0%	0.2%

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TPE – Targeted Probe and Educate

- **"Providers and suppliers who have high claim error rates or unusual billing practices, and items and services that have high national error rates and are a financial risk to Medicare."**
- **2 Common Claim Errors:**
  - Encounter notes did not support all elements of eligibility
  - Documentation does not meet medical necessity

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

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Review Claims Denied

- **A claim submitted to a payer may be denied:**
  - Entirely/Full – for all charges submitted
  - Partially – for a specific charge or line item
    - Look for short pays when a payer pays at a lower weighted DRG
- **Claim denials are communicated on the remittance advice (EOB) that is sent to the provider and/or via denial letter**
- **An explanation for the reason of the denial is through Reason or Remark codes**
  - Ex: adjustment code 55 = denied experimental/investigational

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Determine Denial Root Cause

- **Review information submitted against denial reason**
- **Claim/EOB information only tells part of the story**
  - Was documentation complete?
  - Has the information changed?
  - Ensure health information included support evidence (minimum LCD/NCD requirements)
    - Payer clinical policy bulletins
- **Documentation**
- **Coding**
- **Charging**
- **Billing**
- **Technical/ Administrative**

Look for trends

- **Codes**
- **Admit source**
- **Admit day**
- **Bed type**
- **Physician**
- **Discharge disposition**
- **Query present?**
- **What treatments were performed?**
- **Test ordered?**

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Understanding the Language of Audit and Denials

Medically Necessary	Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine – ex: Level of Care
Insufficient Documentation	Specific documentation or documents required to support services billed per LCD or health plan requirements
Incorrect Coding (aka DRG Validation)	Codes assigned per coding guidelines based on documentation provided in health information
Clinical Validation	An additional clinical review validation that determines whether the patient truly possessed the conditions documented in the medical record

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Documentation

- **A physician's documentation outlines the patient care and services required to treat the patient**
- **Other clinicians documentation will drive charges**
  - Physician orders in the patient's medical record
  - Order matches services billed
  - All documentation was submitted – Ancillary services? Outpatient care
- **As a general rule – if it is not documented, it wasn't done.**

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Payer Guidelines

- **Variations in payer guidelines contribute to the complexity of the billing and validation process**
- **Hospitals are required to comply with all provisions in their participating provider contracts**
- **Compliance with these guidelines is a condition for payment**
- **Monitor for changes!**
  - Ex: IP only list

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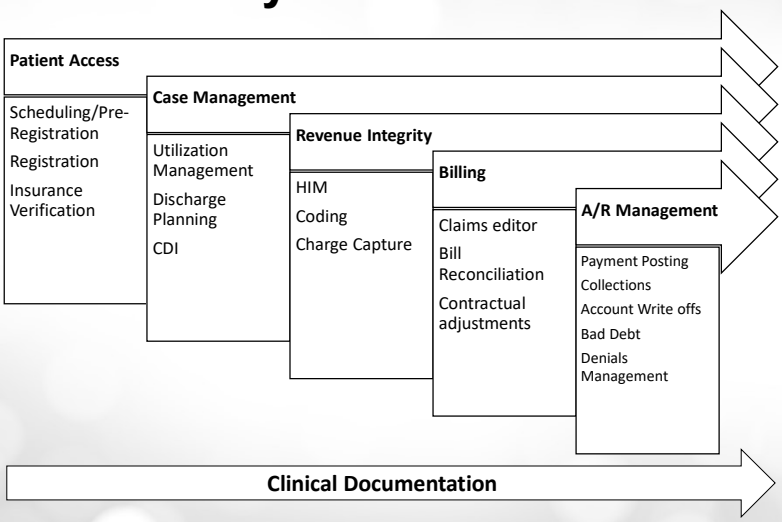
Revenue Cycle Teams



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Patient Access/Registration

- **A patient may come to the hospital provider in various ways:**
  - Through the Emergency Department
  - Directly from the patient's physician office
  - Prescheduled procedure or treatment

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Case Management/Utilization Management

- **Utilization Management**
  - Evaluates the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and level of care
  - Obtains authorizations from insurance companies for stay and procedures while patient is admitted
  - The purpose is to control costs, and ensure that quality care is provided to the patient
- **Discharge Planning**
  - Part of CM/UM team that assist with getting patient necessary post acute care set up
  - Ex. home health, rehab and long term care (LTC) services so that the patient can be discharged
- **Authorizations can be required on everything from an MRI to an extra day stay in the hospital… without the approval the claim or service can be denied.**

Case Management/Utilization Management

Common Denial Sources

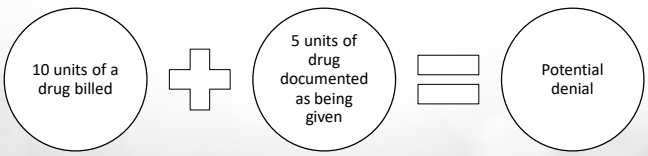
- **Delay in Discharge**
  - Unable to transfer home, LTC, rehab
- **IP Authorization Denial**
- **Procedure Authorizations**

Clinical Documentation Improvement

- **Clinical Documentation Improvement (CDI)**
  - Works with doctors to ensure the accurate representation of a patient's clinical status is captured in the medical record
  - What KPI's do CDI teams use to measure success?
    - If it is purely financial and not synced with denials you may have a compliance issue and revenue issue
  - Is there a query? Where was the response documented?
- **Ensure that CDI, Physician Advisors and Coding work collaboratively!**

Charge Capture

- **Charge capture is the process of doctors and staff documenting services and supplies**
  - How many IV bags were used?
  - How much of a drug was given?
- **These are then translated into codes for billing**
- **Hospitals often use a Chargemaster system to assist with capturing charges**



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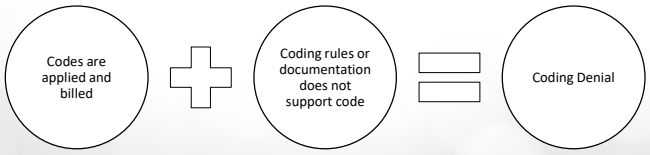
Coding

- **Reviews the Physician documentation and translates into codes**
- **Codes capture the diagnosis, procedure type and patient complications and comorbidities to be submitted on the claims**
- **Codes drive the billing and reimbursement but also tell us the story of the patient**
- **Example: Physician documents the signs and symptoms for pneumonia and states based on labs, that patient has pneumonia. The coder uses J18.9 = ICD-10 code for Pneumonia**



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Benefits of Preventing Denials

- **Financial savings**
  - Less aging of accounts receivables
  - Less rework
  - Staffing
- **Improved quality**
- **Reduce billing and compliance risk**
- **Responsive to trends and outliers**

More compliant organization!

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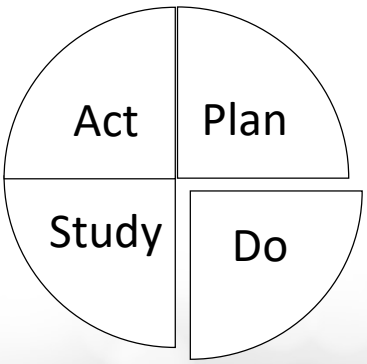
Do

- **Create a pilot project**
  - Determine small test project
    - Pick one type of risk
    - Define a time frame
  - Identify success factors
    - Fewer Denials?
    - Increased Revenue?
  - Monitor KPI's



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Steps to Take

- Identify team
- Identify needed enhancements
- Educate team
- Identify and track metrics
- Engage key stakeholders

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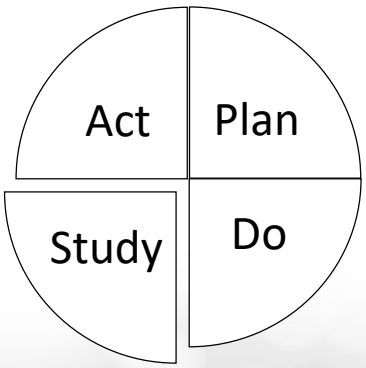
Study

- **Analyze the results**
- **Look for "easy wins"**
- **Engage team to submit additional observations**



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Experimental Procedure Denials

1. **Identify trend – denial code 55**
2. **Drill down into procedures and devices**
3. **Review with key stakeholders**
   - Surgeons, service line, supply chain, managed care
4. **Act on changes**

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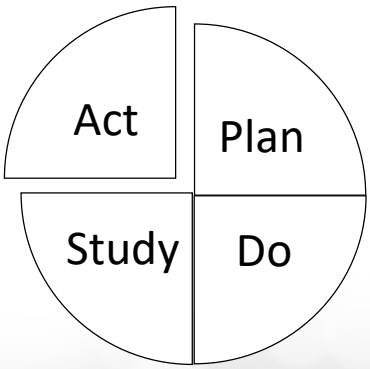
Act

- **Make necessary process updates**
- **Re-educate**
- **Institute long term monitoring practices**



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Tips to Stop Revenue Cycle Compliance Concerns

Identify your top concerns

Create checklists/templates to educate clinicians in understanding specific required documentation

Identify additional documentation needed for different service lines and specialties

Educate teams to answer the why's

Ensure clinicians understand the denial impact

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Trinity Health

Real World

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About Trinity Health

- **National Catholic Health System based in Livonia, Michigan**
- **Serves over 30 million patients in 22 states**
- **92 hospitals**
- **109 continuing care facilities, home care agencies and outpatient centers**
- **129,000 colleagues**

Trinity Health

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Health Information Management PHI Disclosure Management

- **Multiple points of disclosure within revenue cycle departments**
  - Electronic “file room”
- **Health Information Management (HIM/medical records) is the ultimate record custodian**
  - Resource limitations to manage all record releases
- **Accountability to provide complete, compliant medical records**
  - Missing record elements can have patient care, reimbursement and regulatory implications
  - Specific records needed depending on the request reason
  - Legal Health Record vs Designated Record Set
- **HIM wants to maintain monitoring and control of record releases**

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Components of Complete Medical Record – Where to look?

- **Multiple sources of information bolt on systems**
- **Pathology reports**
- **Radiology**
- **Operating rooms**
- **Rehab facilities or units**
- **Pharmacy**
- **ED and EMT notes**
- **Dietitians**
- **Clinic EMR’s**
- **Utilization management systems**
- **Other outpatient departments**

Payer EHR Access – Compliance Concerns

- **Monitor that access**
- **Assure access only to episode of care for which the carrier is currently paying**
- **In case of audits, assure that the carrier was the payer**
- **Assure data segmentation for protected information**
  - Perhaps patient paid cash for service during a stay
- **Remove access if the payer for the claim changes**
  - Often occurs with accident cases, etc.

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Common Revenue Cycle Releases

HIM – Routine ROI Medical records needed for patient care/continuation of care, patient use, third party requests such as attorney, disability claims and insurance
HIM – CDI Medical records are provided during the query follow-up process post-discharge
HIM – Coding Medical records are provided during order follow-up to clarify diagnoses
Utilization/Case Management Medical records are requested and provided to the insurance company for verification of coverage and to qualify the services to be provided
Discharge Planning Medical records are provided to the next level of care for patient acceptance and transfer

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Revenue Cycle Releases – Why?

Claim Attachment	Medical records needed for payment that are sent with the initial claim to the payer or immediately following claim submission (Expedite claims payment, Examples: VA records, high dollar claims to expedite payment, payer policy based on certain codes)
Pre-Payment	Medical records are requested by the payer after receipt of the initial claim for review of documentation (Pre-payment, pre-denial)
Post-Payment	Medical records are requested by a payer after a claim has been paid for a post payment audit or retrospective review (Post payment audit-key words audit, payment integrity review, may also have reasons of medical necessity, etc.)
Denial	Medical records are requested by the payer after billing but prior to payment (Payer has designated that the claim is denied due to missing information)
Appeal	Medical records are required to substantiate an appeal for determination of medical necessity or some other verification of service (Claim denied or short payed and medical record is being sent to with initial appeal or reconsideration)
Authorizations	Records or record components to obtain authorization for services

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Medical Record Access and Release

- **Maintain catalog or transaction of all record releases**
- **Submit records via monitored mediums**
  - Electronic portals
  - Carrier shipping with tracking and delivery receipt
  - Minimize risk of unauthorized disclosure or technical denial
- **Define request/release scenarios and assign department responsibility**
- **Conduct annual training on record components and elements to release**
  - Partner with HIM or Privacy Officer
- **Limit or prohibit direct payer access to your medical record system**

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Cost of Breach

- **Average cost of a data breach in 2020 estimated to exceed $150 million**
- **Reputational**
- **Financial**
- **Legal**
- **Operational**
- **Clinical**
- **OCR $2.17 Million HIPAA Breach Settlement**
  - Billing statements mailed to wrong patients
  - Failure to properly notify HHS

https://www.hhs.gov/about/news/2019/11/27/ocr-secures-2.175-million-dollars-hipaa-settlement-breach-notification-and-privacy-rules.html

https://www.ciab.com › resources › annual-global-data-breaches-could-cost-...

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Collaborative Revenue Cycle Processes

- **Map the life of a medical record and claim, including denial and appeal**
  - Identify opportunity for record disclosure during this lifecycle
  - Refer to best practices and training to avoid unauthorized disclosure
- **Utilize tracking software for any denial and appeal activity**
  - Allows transparency between departments
  - Monitor and trend volume
- **Regularly monitor activity processed in Revenue Cycle Departments**
  - Promotes team environment, assesses risk, and allows for communication to flow

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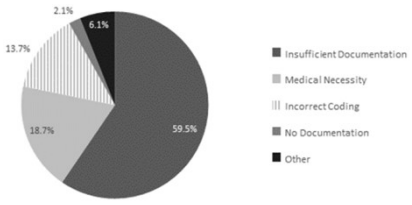
Audit ROI Activity and Best Practice

- **Audit ROI activity to ensure compliance**
  - Satisfy the request with complete record components
    - Requests are very specific
  - Review denial reasons compared with records provided
    - CERT denials include insufficient documentation
  - Continue the audit process cycle with your Revenue Cycle team
- **Modify record printing sequence**
  - Admission order first example

Common Causes of Improper Payments

Figure 2: Improper Payment Rate Error Categories by Percentage of 2019 National Improper Payments[4]



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Questions?

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Thank you!

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