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# CHIAP® Body of Knowledge Roadmap

The CHIAP® Body of Knowledge (BOK) is a complete set of concepts, terms, and activities that make up the professional domain of a qualified health care internal auditor, as defined by the Association of Health Care Internal Auditors (AHIA). AHIA subject matter experts reviewed each domain, competency, and skill to ensure they were current with the healthcare internal audit industry standards. This thoughtful and critical review resulted in the development of the CHIAP BOK Roadmap. The Roadmap supplements the BOK and allows CHIAP candidates to identify practical ways to develop their skills, whether they are early in their career or more experienced. A self-reflective review of the Roadmap can help a candidate focus on areas where they may need to supplement their knowledge before sitting for the CHIAP program exam and design a plan to master the knowledge to be applied to be considered a Certified Healthcare Internal Audit Professional®.

Each of the four knowledge domains of the CHIAP BOK detail care settings, revenue cycle, provider reimbursement and regulatory concepts that healthcare internal audit professionals should be proficient in to enhance their skill sets, accelerate their careers, and in the end improve their department’s performance. The Roadmap will guide you through each domain of the BOK, providing a detailed description of the domain and the underlying concepts, terms, and activities, to assist you in self-assessing your level of knowledge. Suggested resources that can be used to increase or refresh your knowledge around specific concepts, terms, and activities are detailed within each domain.

The BOK Roadmap provides an overview of topics and identifies resources contained in the BOK Webinars (reference links included) and other resources that can be used to enhance knowledge around the topics. The user of this Roadmap may wish to consider the following:

- The Body of Knowledge Roadmap contains information that will assist the candidates with questions requiring recall. Questions requiring analysis and application will be based on that knowledge.
- In addition to the Industry knowledge specifications covered in this Roadmap, the CHIAP Candidate Handbook lists task specifications. The candidate may wish to review this list to help prepare for the exam.
- Webinars may contain state-specific information that will not be included in the exam questions.

The BOK Roadmap is organized below in the following 4 domains:

1. Business Aspects of Care Settings	2. Revenue Cycle	3. Regulatory Environment	4. Core Business Functions
A. Core Care Settings	A. Health Insurance Provider Revenue Cycle Elements	A. Regulatory Bodies	A. Operational/Financial
B. Other Care Settings	B. Healthcare Provider Reimbursement	B. Regulations	B. Information Technology
	C. Healthcare Provider Revenue Cycle Elements		C. Compliance
	D. Revenue Deductions		D. Administrative Functions

Knowledge Domain	Description Of Knowledge Domain And Underlying Concepts, Terms, And Activities, Including Resources Available To Increase Or Refresh Your Knowledge And Understanding
<b>1A. BUSINESS ASPECTS OF CARE SETTING</b>	
<b>Core Care Settings</b>	
<b>Summary Description</b>	<p>Identify processes and risks unique to core care settings, including Physician Practices, Acute Care Hospitals, and Post-acute Care.</p> <ul style="list-style-type: none"> <li>- <b>Acute Care Hospitals</b> - Acute care is where a patient receives active but short-term treatment as an inpatient for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. An acute setting is a medical facility in which patients remain under constant care, generally a hospital. Hospitals often include maternity services, intensive care, surgical departments, ancillary departments (Lab, radiology, and pharmacy) and other clinical care activities. Ancillary services are generally provided to help diagnose or treat medical conditions. However, hospitals may also include outpatient clinics which are clinically integrated into the hospital and provide outpatient services such as emergency or observation services, same day surgery, outpatient lab, and preventative and screening services.</li> <li>- <b>Post-Acute Care</b> - Post-acute care (PAC) includes rehabilitation or palliative services that patients receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home. PAC facilities include long-term care hospitals, inpatient rehab facilities, behavioral health, home care, skilled nursing facilities, assisted living, and hospice care. Patients who no longer need inpatient hospital care for an acute issue are often discharged to a post-acute care setting to ensure they receive appropriate transitional attention while they recover. Transitional care in these settings may include dressing changes, medication management, oxygen administration, physical therapy, restorative therapy, pain management, monitoring, and more. Similar to acute care with some additional areas of risk for specific PAC settings.</li> <li>- <b>Skilled Nursing</b> - A Skilled Nursing facility is an in-patient rehabilitation and medical treatment center staffed with trained medical professionals. They provide the medically-necessary services of licensed nurses, physical and occupational therapists, speech pathologists, and audiologists. These services can be very expensive, but most skilled nursing facilities are covered, at least in part, by private health insurance or else Medicare or Medicaid. Skilled nursing facilities give patients round-the-clock assistance with healthcare and activities of daily living (ADLs). There are numerous federal regulations regarding what skilled nursing facilities can and cannot do. Patients in a skilled nursing facility can be expected to remain there temporarily, in contrast to a more permanent nursing home setting.</li> <li>- <b>Home Health</b></li> </ul>

Home Health care is a wide range of health care services that can be given in a patient's home for an illness or injury. Home health care is usually less expensive, more convenient, and just as effective as care the patient get in a hospital or skilled nursing facility.

- **Hospice** - a facility, program, or lodging that provides palliative care and emotional support to the terminally ill, usually with an anticipated life expectancy of 6 months or less. Hospice also involves an interdisciplinary team of professionals that attends to the physical, psychosocial, and spiritual needs of the person and their family members or other caregivers
- **Behavioral Health** – Covers mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis and treatment of those conditions. Behavioral health looks at how behaviors impact someone's health — physical and mental.
- **Physician Practices** - a medical practice comprised of one or more physicians organized to provide patient care services, but which practice is not part of a Hospital; however, hospitals can acquire Physician Practices to be a part of their integrated health system

#### Select Risks in Other Care Settings

- **Urgent Care Centers**

Urgent care is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department (emergency room). Urgent care centers primarily treat injuries or illnesses requiring prompt attention, but not serious enough to require an emergency department visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site.

- **Freestanding Emergency Departments**

A freestanding emergency center is a health care facility that provides emergency care, but is completely separate from an acute-care hospital. Both freestanding emergency centers and hospital-based emergency rooms treat the same kinds of emergency conditions. Both are required to operate 24 hours a day, to always have licensed physicians on site, and to provide all patients with a medical screening regardless of their ability to pay i.e., are subject to EMTALA requirements.

- **Ambulatory Surgery Center (ASC)**

An ASC may also be referred to as an outpatient surgery center, same day surgery center, or SurgiCenter and is a health care facility where surgical procedures not requiring an overnight hospital stay are performed. The surgeries performed are commonly less complicated than that requiring hospitalization. An ASC often competes directly with a hospital outpatient surgery center and is

generally a lower cost alternative as they don't carry the overhead of a hospital outpatient surgery center. According to CMS an ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients who need no hospitalization and for whom the expected duration of services is less than 24 hours following admission.

- **Virtual Health Care/Telehealth**

Telehealth is the remote delivery of clinical health care, such as doctor visits or chronic condition management, through use of digital information and communication technologies. Virtual healthcare is a component of telehealth. Virtual healthcare refers to the "virtual visits" that take place between patients and clinicians via communications technology that allows "virtual" meetings to occur in real time, from virtually any location.

**A. Core Care Settings**

**1. Physician Practices (Professional Fee Services)**

Two basic models of Physician Practice; employed and independent aspects of Physician Practices:

- Employed:  
Hospitals may purchase and manage an existing physician practice or may directly hire physicians to start a new practice or work in an existing practice
  
- Independent:
  - Not employed by hospitals
  - Can be a solo practice or group practice
  - Group practices can be structured like small corporations with partner/owners and/or employed physicians
  - While not employed by hospitals they are likely privileged to perform services at one or more hospitals
  
- Miscellaneous Practice Models:
  - Independent contractors
  - Locum Tenens - temporary position filling in for physicians on leave

Potential Audit Topics include:

- Privacy/cyber security - Review for use of privacy filters, auto shutdown, locking before leaving processes. Co-worker access to medical records.
- Coding/Billing - Review for sufficient documentation and accurate E&M code assignment.
- Cash Controls - Review for proper security of cash, segregation of duties, reconciliations
- Drug diversion/controlled substances - Review for proper segregation of duties in ordering/stocking/reconciliations; proper storage/security/access, DEA reporting requirements, prescription pad storage/security/access, reconciliation, wasting and disposal of expired drugs.

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting>

<https://www.youtube.com/watch?v=93IHXI0Kdg> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<https://ahia.org/assets/Uploads/pdfUpload/WhitePapers/ControlledSubstances>

**2. Acute Care Hospitals (including emergency department, ancillary departments, and other clinical care activities)**

Acute care is where a patient receives active, but treatment as an inpatient for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. An acute setting is a medical facility in which patients remain under constant care, generally a hospital. Hospitals often include maternity services, intensive care, surgical departments, ancillary departments (Lab, radiology, and pharmacy) and other clinical care activities. Ancillary services are generally provided to help diagnose or treat medical conditions. However, hospitals may also include outpatient clinics which are clinically integrated into the hospital and provide outpatient services, such as emergency or observation services, same day surgery, outpatient lab, and preventative and screening services.

Acute Care Hospitals Select Risk Areas:

- HIPAA Privacy
- IT - network, devices
- Accreditation / Conditions of Participation
- Patient safety / Infections
- Regulatory - Stark, EMTALA

• **HIPAA Privacy**

The US Department of Health and Human Services states "The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patient's rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections."

- Office of Civil Rights (OCR) is the entity responsible for enforcement and oversight
- The rule sets the standards for what is allowable uses and disclosures of PHI
- PHI is broadly any part of a medical record or payment information in ANY form and includes 18 personal identifiers such as telephone, email, license plate that when linked to health info become PHI
- Allowable uses of PHI includes treatment, payment and operations (TPO)
- Allowable uses of PHI with prior patient authorization includes marketing, fundraising and research
- In all cases we must use/disclose only the minimum necessary to achieve required purpose

- Privacy Rule also covers patients' access to their medical information in that we must provide it within 30 days of receiving a request

#### Potential Audit Topics

- System User Access Reviews
- Privacy Program Effectiveness
- Monitoring processes
- Policy existence, sufficiency, training
- Business Associate Agreement (BAA) process – maintenance, existence, compliance
- IT - network, devices, NIST or COBIT frameworks
- Determine if your IT department ascribes to a framework such as NIST or COBIT as all of these frameworks can be the basis for your reviews
- Inquire about external reviews – obtain and review those results, inquire about corrective action

#### Potential Audit Topics

- Bring Your Own Device Policy – is the policy clear, how is the access of these devices monitored, how is the policy enforced
- Device Management – Inventory and maintenance processes
- Patching – review the process for identifying, acquiring, assessing and implementing patches – key to consider is the inventory process i.e. do we know the location/existence of devices with software that may require patches
- Security – security program effectiveness, how are risks determined, how are vulnerabilities addressed
- Disaster Recovery – determine the existence and effectiveness of the current IT disaster recovery plan and evaluate IT function's preparedness in the event of disruption

- **Accreditation/Conditions of Participation**

Accreditation is a self and external assessment process to assess performance against established standards and to engage in improvement activities. The most common one in the US is The Joint Commission. According to the Joint Commission website they accredit over 4,000 hospitals and 81% of US hospitals are accredited by them. The Joint Commission accreditation process is made up of announced and unannounced surveys with most surveys being unannounced or with short notice.

#### Potential Audit Topics

- Preparedness/maintenance – is accountability clear, what processes are in place for correcting and sustaining corrections, what monitoring is place, perform portions of the survey tool, review prior survey results, check for corrective action and whether it has been sustained
- Conditions of Participation – review for compliance with select portions

- **Patient Safety/Infections**

#### Potential Audit Topics

- Patient safety events
  - Review the adequacy of the policy and process for notifying leadership, investigation (often called root cause analysis) and corrective action for sentinel and adverse events
  - Review Corrective action plan elements including cause/contributory factors, responsibility for implementation, timelines, evaluation of effectiveness and approach to ensure sustainability
  - Are no-harm, close calls and hazardous conditions tracked and analyzed to determine action needed to prevent future harm
  - Is there a culture supporting reporting of safety events – consider a survey to address this
  - Infection Control – program adequacy including policies, procedures, training
  - Sterile Processing/Disinfection – adequate policies and procedures, use of protective gear, tracking, monitoring, storing, transporting, testing Use of restraints, disinfection in the OR

- **Regulations - Stark, EMTALA**

- Stark:

- Intended to prevent physicians' referral decisions from being clouded by financial motives.

- Basic Rule - If a physician (or immediate family member) has any financial relationship, direct or indirect, with an entity (e.g., a hospital) that furnishes designated health services (DHS) then the physician may not refer Medicare patients to that entity for those services (and the hospital is prohibited from billing Medicare for DHS provided to patients referred by that physician) unless a Stark exception applies.

- Exception - To make a monetary payment of any kind for physician services (e.g., medical director, contracted services), whether the payment is to the physician, physician's immediate family member, or a physician group you must meet all of the following requirements:

- Written agreement - signed by both/all parties, BEFORE any services are provided, specific services to be provided, duration of services (not less than a year) and specific, set-in-advance compensation to be paid for the services
        - Fair market value (FMV) - the compensation must be confirmed to be within FMV and must NOT take into consideration any potential volume or value of referrals.
        - Commercially reasonable - Services and compensation must be commercially reasonable, which means regardless of any potential referrals, the services are needed for a legitimate business purpose, and it makes business sense to pay for the services.
        - The same concepts apply to leases for space and equipment; a signed agreement, FMV and commercially reasonable.
        - Another exception within Stark is the giving of non-monetary items of value (swag, meals, entertainment, and CME credits) to physicians, immediate family members of physicians, or physician groups. Under Stark you may only do this if:
          - Physician did not ask for the item, Gifts are not based on referrals, and
          - Total annual value a hospital gives does not exceed the annual limit.

- Potential Audit Topics

- Lease Inventory – Identify all real estate / equipment leases and determine if these is a valid agreement in place i.e. signed, FMV, commercially reasonable
      - Service Contract Inventory – Identify all payments to physicians and determine if there is a valid agreement in place

- Contract compliance – Select a sample of leases/ contracts to determine if they are accurate and complied with. Is the space occupied reflective of the lease? Are the services provided in accordance with the contract and evidenced i.e., time and effort reporting.
- Non-monetary Compensation – Are the items provided being tracked by physician, by hospital? Are they in accordance with the annual limit?

**EMTALA:**

According to the American College of Emergency Physicians, “...imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.”

**Potential Audit Topics**

- Medical Screening – Review documentation showing provision of Medical Screening Exams to determine if an emergency medical condition exists; examination must be specifically determined to be a "qualified medical person" by the hospital bylaws (the hospital must make the designation in its bylaws or rules and regulations); if an emergency medical condition existed was stabilizing treatment provided
- Transfers - Patient treated and stabilized; is treatment needed at the receiving facility; medical risks are outweighed by the medical benefits of the transfer (these determinations must be certified in writing by a physician); receiving hospital contacted and agrees to accept the transfer; medical records accompany the patient; transfer is done by qualified personnel and transportation equipment (could include the use of necessary and medically appropriate life support measures during the transfer).
- Signage - Is there conspicuous signage which notifies patients and visitors of the right to be examined and to receive treatment and is it the required format.
- Payment

**Reference links from slides:**

[http://www.hipaaguide.net/hipaa-compliance-guide/#HIPAA\\_Security\\_Rule](http://www.hipaaguide.net/hipaa-compliance-guide/#HIPAA_Security_Rule)

<http://www.hhs.gov/hipaa/for-professionals/index.html>

<https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/survey-process-and-survey-activity-guide/2020-all-programs>

<http://www.acep.org/>

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Car-Setting>

<https://www.youtube.com/watch?v=93IHXI0KdgQ> (AHIA recording of presentation from BOK Webinar slides)

**3. Post-Acute Care (rehab, behavioral, skilled nursing facilities, home care, assisted living, durable medical equipment, hospice, retail pharmacy)**

Post-acute care (PAC) includes rehabilitation or palliative services that patients receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home. PAC facilities include long-term care hospitals, inpatient rehab facilities, behavioral health, home care, skilled nursing facilities, assisted living, and hospice care. Patients who no longer need inpatient hospital care for an acute issue are often discharged to a post-acute care setting to ensure they receive appropriate transitional attention while they recover. Transitional care in these settings may include dressing changes, medication management, oxygen administration, physical therapy, restorative therapy, pain management, monitoring, and more.

Select PAC Settings Overview:

- **Skilled Nursing** - Nursing home care often provides permanent custodial assistance, whereas skilled nursing is more often temporary, to solve a specific medical need or to allow recovery outside a hospital. Short stays (up to 100 days) in skilled nursing are generally covered for Medicare beneficiaries. Skilled nursing, nursing home, assisted living, hospice and other types of post-acute care can be provided in the same facility.
  - Patient Safety – Review of staff training, monitoring, tracking and corrective action processes
- Employee oversight/background checks – Review of processes to perform background checks and take appropriate action.
- Sanitation – Review for proper sanitation processes. Could include a physical observation, review of documentation showing completion of tasks.
  
- **Home Health** - Home health care provides clinical services, whereas home care provides non-clinical help with daily living. Home health care includes skilled nursing care, as well as other skilled care services, like physical and occupational therapy, speech/language therapy, and medical social services. These services are given by a variety of health care professionals at home and are generally covered by Medicare.

Services can cover:

- Doctor care - A doctor may visit a patient at home to diagnose and treat the illness(es) and also periodically review the home health care needs.
- Nursing care - The most common form of home health care is some type of nursing care depending on the person's needs. In consultation with the doctor, a registered nurse will set up a plan of care. Nursing care may include wound dressing, ostomy care, intravenous therapy, administering medication, monitoring the general health of the patient, pain control, and other health support, including activities of daily living.
- Physical, occupational, and/or speech therapy - Some patients may need help relearning how to perform daily duties or improve their speech after an illness or injury. A physical therapist can put together a plan of care to help a patient regain or strengthen use of muscles and joints. An occupational therapist can help a patient with physical, developmental, social, or emotional disabilities relearn how to perform such daily functions as eating, bathing, dressing, and more. A speech therapist can help a patient with impaired speech regain the ability to communicate clearly.
- Medical social services - Medical social workers provide various services to the patient, including counseling and locating

community resources to help the patient in his or her recovery. Some social workers are also the patient's case manager--if the patient's medical condition is very complex and requires coordination of many services.

#### Key Risk Areas

- Mileage/travel expense fraud – Review of the tracking, monitoring and accuracy of reimbursement for mileage and other allowable expenses
- Employee safety – Review of the process for assessing dangers present in a patient’s home and what steps are taken to protect employees and/or when events occur how reports are addressed.
- HIPAA Privacy and Security – Review of method for transfer of data/PHI if it occurs from a patient’s home or another unsecured network e.g., is it encrypted, does it auto time out, privacy screen. Do providers use their personal devices and if so are they properly protected. Are devices secured properly to prevent theft when unattended/after working hours? Does the training of home health providers address how to protect PHI from family/friends who are present in the home?
  
- **Hospice** - Care to support people in the final phase of a terminal illness (have less than 6 months life expectancy) and focuses on pain management and attending to their emotional and spiritual needs rather than a cure. The care is generally home based but can be provided in a facility such as a nursing home or hospital. This care is generally covered for Medicare beneficiaries.
- Certification - Medicare provides care for two 90-day periods in hospice, followed by an unlimited number of 60-day periods. At the start of each period of care, a doctor must re-certify that the patient has six months or less to live. They must explain their clinical findings and attest that their findings were based on their examination of the beneficiary or review of the medical records.
- Volunteers - Hospices that participate with Medicare are required to utilize volunteers alongside their paid clinical and administrative staff. Volunteers must provide day to day administrative and/or direct patient care services in an amount that, at a minimum, equals 5% of the total patient care hours of all paid hospice employees and contract staff. This use of volunteers also means there are other requirements such as training, background checks, and the use of volunteers must be included in the plan of care.
  - Key Risk Areas:
    - Meeting criteria
    - Physician Signature
    - Under Utilization of Services
    - Certification
    - Volunteers – Background screenings
    - Referral Services
  
- **Behavioral Health** - Behavioral health treatments are ways of helping people with mental illnesses or substance use disorders and can include counseling, specialized psychotherapies and medications that seek to change behaviors, thoughts, emotions, and how people see and understand situations. This type of care can be provided in many settings including outpatient, general hospital, or a specialty psychiatric hospital. This care is generally covered for Medicare beneficiaries.

- Key Risk Areas
- - Environment of Care
  - - Drug Diversion

- **Environment of Care**
- Review for the existence of policies/procedures and compliance
- Screening patients and visitors for hazardous items
  - Inspecting rooms
  - Use of restraints/seclusion
- Observe the physical environment for appropriateness e.g. unobstructed views, security equipment/surveillance, don't provide "hiding places"
- Drug Diversion - Controlled substances – review for inventory controls, wasting controls, access/storage

**Reference links from slides:**

- <http://www.medpro.com/>
- <http://www.iahss.org/>
- <http://www.osha.gov/>
- [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_m\\_hospice.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf)
- <http://www.nursinghomehelp.org/>

**AHIA links:**

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- <https://www.youtube.com/watch?v=93IHXIOKdgQ> (AHIA recording of presentation from BOK Webinar slides)

**1B. Other Care Settings**

**1. Urgent Care Centers**

Identify and Describe Urgent Care Center Risks:

- Urgent care is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department (emergency room). Urgent care centers primarily treat injuries or illnesses requiring prompt attention, but not serious enough to require an emergency department visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site.

The Urgent Care Association of America provides (but not limited to) the following criteria:

- Walk in services
- 7 days a week
- Licensed Physician on site
- Diagnostic equipment on site e.g., x-ray, phlebotomy

- Multiple exam rooms

Urgent Care Select Risks:  
 Similar to physician practice risks with some additional areas of risk  
 Patient Triage/Screening – should they be at ED vs Urgent – then appropriate transfer procedures  
 Competitive Environment

**Reference links from slides:**

<http://www.jucm.com/>

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting>

<https://www.youtube.com/watch?v=93IHXI0KdgQ> (AHIA recording of presentation from BOK Webinar slides)

**2. Ambulatory Surgery Centers**

Identify and Describe Ambulatory Surgery Center:

- Ambulatory surgery centers (ASC), also known as outpatient surgery centers, same day surgery centers, or SurgiCenters, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization. ASCs often compete directly with hospital outpatient surgery centers and are generally a lower cost alternative as they don't carry the overhead of a hospital outpatient department. According to CMS an ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients who need no hospitalization and for whom the expected duration of services is less than 24 hours following admission.

Ambulatory Surgery Center Risks:

- Patient Safety
- Clinical errors
- Sentinel events
- Transfer to Acute Care procedures

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting>

<https://www.youtube.com/watch?v=93IHXI0KdgQ> (AHIA recording of presentation from BOK Webinar slides)

**3. Freestanding Imaging Centers**

Identify and Describe Freestanding Imaging Center Risks:

- Freestanding Imaging Centers was not included in the handouts, but Freestanding Emergency Center was described as a health care facility that provides emergency care, but is completely separate from an acute-care hospital. Both freestanding emergency centers and hospital-

	<p>based emergency rooms treat the same kinds of emergency conditions. Both are required to operate 24 hours a day, to always have licensed physicians on site, and to provide all patients with a medical screening regardless of their ability to pay i.e., are subject to EMTALA requirements.</p> <p>Freestanding Emergency Center Risks include:</p> <ul style="list-style-type: none"> <li>- Physical Security</li> <li>- Proper notification to patients, i.e. patient is in an emergency room</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>4. Freestanding Emergency Departments</b></p>	
	<p>Identify and Describe Freestanding Emergency Center Risks:</p> <ul style="list-style-type: none"> <li>• A freestanding emergency center is a health care facility that provides emergency care, but is completely separate from an acute-care hospital. Both freestanding emergency centers and hospital-based emergency rooms treat the same kinds of emergency conditions. Both are required to operate 24 hours a day, to always have licensed physicians on site, and to provide all patients with a medical screening regardless of their ability to pay i.e., are subject to EMTALA requirements.</li> </ul> <p>Similar to physician practice and urgent care risks some additional areas of risk</p> <ul style="list-style-type: none"> <li>- Physical Security</li> <li>- Proper notification to patients, i.e., patient is in an emergency room</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>5. Specialty Hospitals</b></p>	
	<p>A hospital that provides a limited range of services (e.g., orthopedic surgery, ophthalmology, or obstetrics. Ancillary services are generally provided to help diagnose or treat medical conditions.</p> <p><b>AHIA Links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>6. Medical Office Buildings</b></p>	
	<p>Medical Office Buildings are office and clinic facilities, often located near hospitals or on hospital campuses, specifically constructed and designed for use by physicians and other health care personnel to provide services to their patients.</p>

	<p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p>
	<p><b>7. Virtual Medicine</b></p> <p>Virtual Medicine (i.e., Telehealth) is the remote delivery of clinical health care, such as doctor visits or chronic condition management, through use of digital information and communication technologies. Virtual healthcare is a component of telehealth. Virtual healthcare refers to the “virtual visits” that take place between patients and clinicians via communications technology that allows “virtual” meetings to occur in real time, from virtually any location.</p> <p>Virtual Healthcare Risks:</p> <ul style="list-style-type: none"> <li>- Equipment maintenance/malfunction</li> <li>- Licensure/Practicing across state lines</li> <li>- Non-coverage of services - billing and coding</li> <li>- Billing for correct Place of Service</li> </ul> <p><b>Reference links from slides:</b>  <a href="http://www.telehealthresourcecenter.org/">http://www.telehealthresourcecenter.org/</a>  <a href="https://healthsectorcouncil.org/wp-content/uploads/2018/08/AHIMA-Telemedicine-Toolkit.pdf">https://healthsectorcouncil.org/wp-content/uploads/2018/08/AHIMA-Telemedicine-Toolkit.pdf</a>  <a href="https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=35&amp;category=All&amp;topic=All">https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=35&amp;category=All&amp;topic=All</a></p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>2. Revenue Cycle</b></p>	
<p><b>A. Health Insurance Provider Revenue Cycle Elements</b></p>	<p><b>Summary</b></p>
<p><b>Summary</b></p>	<ul style="list-style-type: none"> <li>• Identify and Describe Risks to Revenue and Facility Regulations <ul style="list-style-type: none"> <li>- Financial Risks</li> <li>- Loss of Accreditation, Medicare/Medicaid</li> <li>- Civil and Criminal Lawsuits</li> <li>- Penalties and Fines</li> <li>- Loss of Out of Network Contracts</li> <li>- Medical Documentation, Patient Data</li> <li>- Financial - Collection of copays/deductibles</li> </ul> </li> </ul>

- Employees

Controls:

- Continuous Education/Certifications
- Auditing & Continuous monitoring
- Enterprise Risk Management
- Internal Control Effectiveness - Reconciliation

Insurance Enrollment & Eligibility

Cannot establish eligibility rules based on health status, medical condition, medical history, genetic make-up, disability or any other related factor deemed by the HHS Secretary.

- Claims Processing - Hospital  
Claims processed through clearing house
  - Hospital claims - Uniform Billing (UB) form – CMS 1450

Reimbursement

- IPPS – Inpatient Prospective Payment System
  - DRG (Diagnosis Related Group) (CMS MS-DRG) with Outliers when appropriate
- CMS Provider Manuals:
  - Benefit Policy Manual
  - Claims Processing Manual
  - Program Integrity Manual
  - Provider Reimbursement Manual
- Health Insurance Provider manual (if contracted)
- OPPOS – Outpatient Prospective Payment System
  - Ambulatory Payment Classification (APC)
  - CPT/HCPCS codes, revenue codes, modifiers, billable units
- Medicare Physician Fee Schedule (e.g., outpatient rehab therapy, mammography)
- Laboratory Clinical Laboratory Fee Schedule
  - Other Methodologies
    - Percent of Charges
    - Case Rates
    - Per Diem

- Claim Processing - Professional

Electronically processed through clearing house

- Professional claims submitted on HCFA (CMS) 1500
  - o Multiple Claims grouped by provider
- CPT/HCPCS codes, Place of Service (POS) Modifiers, Units of Service

Reimbursement

- CMS Provider Manuals
- Benefit Policy Manual
- Claims Processing Manual
- Program Integrity Manual
- Provider Reimbursement Manual
- Medicare Physician Fee Schedule
- Commercial Payors
  - Contracted rates based on CPT/HCPCS
  - Capitation

- Claim Appeals - Depends on the Payor

Involves multiple levels, e.g. Part A RACs - 5 levels

- Normally based on Milliman or InterQual criteria
  - o Medicare states payment not based on any software
- Depends on the insurance plan/program
  - o Non-covered service not medically necessary
  - o Claim not covered by payor, duplicate claim, timely
  - o Preapproval/preauthorization does not guarantee payment of service

Risk - Loss of revenue, balance billing patients inappropriately

- Pre and Post Payment Audits/Reviews

Medicare

- RAC – Recovery Audit Contractor
- OIG – Office of Inspector General
- MAC - Medicare Administrative Contractor
- TPE – Targeted Probe & Educate (TPE) Program audits
- ZPIC – Zone Program Integrity Contractors

Medicaid

- MIC – Medicaid Integrity Contractors

Commercial Payors

- 3rd Party Audit Firms

**A. Health Insurance Provider Revenue Cycle Elements**

**1. Enrollment and Eligibility**

- Insurance Enrollment & Eligibility  
 Changed with Affordable Care Act (ACA) - Cannot establish eligibility rules based on health status, medical condition, medical history, genetic make-up, disability or any other related factor deemed by the HHS Secretary.
  - No annual limits
  - Extended coverage for dependents
  - Can't discriminate based on salary
  - Improved access for Medicaid and CHIP programs

Risk – revenue loss, exclusion from the healthcare exchange, penalties.

Identify Risks in Insurance Enrollment and Eligibility:

- ACA Regulations
  - Revenue Loss
  - Exclusion from healthcare exchange
  - Penalties
  - Commercial Payors
- Medicare/Medicaid Enrollment & Eligibility Guidelines
    - Age 65 or older, young people with disabilities & End Stage Renal Disease (ESRD )
    - Medicare A – provided at no cost if eligible (paid taxes 10 years)
    - Medicare B – monthly premium deducted from Social Security, Railroad Retirement or CSR (cost sharing reductions check or billed quarterly)
    - Medicaid - Modified Adjusted Gross Income (MAGI) – FPL
    - Determines financial eligibility
      - One standard for multiple programs with Affordable Care Act (A A)
    - Dual Eligibility

Risk – Reimbursement and potential fraud

- Commercial Payors:  
 Eligibility and Enrollment based on the Plan & Location
  - Must follow ACA regulations
  - Purchased through exchanges, directly with payors or employer sponsored
  - Secondary insurance to cover copays & deductibles (Medigap)

- Dental and Vision
- Long Term Care

- Property Insurance & Auto Insurance Liability

**Reference links from slides:**

- <https://www.hhs.gov/sites/default/files/patient-protection.pdf>
- <https://www.hhs.gov/answers/medicare-and-medicaid/>
- <https://www.medicare.gov/medicaid/eligibility/index.html>
- <https://sfgmedicare.com/medicare-vs-medicaid-whats-the-difference/>

**AHIA links:**

- [https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar\\_Revenue-Cycle-Part-1-Handout\\_1-12-21.pdf](https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf)
- <https://www.youtube.com/watch?v=RqfFQqCcE4Q> (AHIA recording of presentation from BOK Webinar slides)

**2. Benefits administration**

- Electronic remit advice file – 835 HIPAA Compliant
  - o Standard format - payments, adjustments, based on each claim or service line
- Auto-post vs. manual posting
  - o Exceptions: Mis-posted payments and adjustments

**AHIA links:**

- <https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>
- <https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

**3. Reimbursement Fee Schedule**

Providers are often paid based off physician fee schedules. These fee schedules define how much a doctor will be paid for performing a service. In general, there are typically three levels of fee schedules: Medicare, Medicaid, and Commercial. The different levels of fee schedules offer varying levels of payment rates to the physician and are determined separately by the various involved parties.

- Claims Processing - Hospital
- Reimbursement
- DRG (CMS MS-DRG) with Outliers when appropriate
- CMS Provider Manual/Health Insurance Provider manual (if contracted)
- Percent of Charges

Claim Processing - Professional

- Reimbursement
  - CMS Provider Manual
    - OPPS – Outpatient Prospective Payment System
  - Commercial Payors
    - Contracted rates based on CPT/HCPCS

#### Payor Reimbursement Criteria

Reimbursement based on Medical Necessity – all payors

- Judged against current standards of care
- Necessary and appropriate for disease or injury
- Should include the following depending on service & site:
  - Physician evaluations & consults
  - Progress notes from Inpatient, Outpatient, SNF, IRF, Behavioral Health & Home Health
  - Hospital records including operative notes

CMS Program Integrity Manual 100-08, Chapter 3, Provider Manuals

#### Medicare Reimbursement

Title XVIII of the Social Security Act - enacted July 1965 providing health insurance to retirees – difficult for elderly to get private insurance.

- Medicare A covers inpatient care, SNF, Hospice and Home Health
  - Based on diagnosis, Treatment and other factors that include wage index and GME
- Medicare B covers outpatient services, ambulance, DME (durable medical equipment), Mental Health inpatient, outpatient and partial hospitalization

#### Reimbursements

- Inpatient MS-DRG (IPPS), Outpatient CPT/HCPCS (OPPS) & ASC schedules

#### Medicaid Reimbursement

Enacted in 1965 at the same time as Medicare (Medicaid.gov)

- Federal Medical Assistance Percentage (FMAP) – published annually
- Partially funded by states – withheld for Medicare/Medicaid overpayments
- Balance billing Medicaid patients – patient cannot be held financially liable for the difference between the gross charges and the allowed amount unless the states allow for cost sharing.
  - Outside of standard coverage
- Inpatient Paid by DRG – normally require prior authorization
- Enhanced Ambulatory Patient Groups (EAPG) for outpatient hospital claims - eliminates Fee for Service Schedules

Medicare Advantage - Coverage provided by private insurance (Medicare C)

- Reimbursement based on insurance plan & contract with providers

**Reference links from slides:**

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPS.html>

<https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures>

**AHIA links:**

[https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar\\_Revenue-Cycle-Part-1-Handout\\_1-12-21.pdf](https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf)

<https://www.youtube.com/watch?v=RqfFQqCcE4Q> (AHIA recording of presentation from BOK Webinar slides)

**4. Claims Processing**

Claims processing begins when a healthcare provider has submitted a claim request to the third-party payor (e.g., commercial insurance, Medicare, Medicaid). Sometimes, claim requests are directly submitted by medical billers in the healthcare facility and sometimes, it is done through a clearinghouse.

Hospital Claims Processing:

- Claims processed through clearing house based on National Electronic Insurance Clearinghouse (NEIC) codes
- Hospital claims Uniform Billing (UB) form - CMS 1450
- Type of Bill (TOB)

Reimbursement based on:

- DRG (CMS MS-DRG) with Outliers when appropriate. Outlier payment compensate hospitals based on a fixed amount per diagnosis related group (DRG) with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category.
- CMS Provider Manual/Health Insurance Provider Manual (if contracted)
- Percent of Charges

Claims Processing- Professional:

Electronically processed through clearing house

-Professional claims submitted on HCFA (CMS) 1500

-Multiple claims grouped by Provider

-Required Documentation:

-CPT/HCPCS codes, Place of Service (POS), Facility

Reimbursement based on:

-CMS Provider Manual

-OPPS - Outpatient Prospective Payment System

	<p>-Commercial Payors -Contracted rates based on CPT/HCPCS</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQgCcE4Q">https://www.youtube.com/watch?v=RqfFQgCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>5. Claim Appeals</b></p>	
	<p>When a provider wants to dispute a claim decision by a third-party payor (e.g., insurance company, Medicare, Medicaid) based on medical necessity or errors made on the part of the insurance company.</p> <p>Claim Appeals depend on the payor</p> <ul style="list-style-type: none"> <li>-Normally based on Milliman or InterQual criteria</li> <li>-Medicare states payment not based on any software</li> <li>-Depends on the Insurance Plan/Program</li> <li>-Non-covered service not medically necessary</li> <li>-Claim not covered by payor, duplicate claim, Timely submission</li> </ul> <p>Involves multiple levels</p> <p>Pre-approval does not guarantee payment of service</p> <p>Risk - Loss of revenue, balance billing patients inappropriately</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQgCcE4Q">https://www.youtube.com/watch?v=RqfFQgCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>2B. Health Care Provider Reimbursement</b></p>	<p><b>Reimbursement Criteria</b></p>
<p><b>Summary</b></p>	<p>Reimbursement is generally based on Medical Necessity for all payors</p> <ul style="list-style-type: none"> <li>- Judged against current standards of care</li> <li>- Necessary and Appropriate for disease or injury</li> </ul> <p>Should include following:</p> <ul style="list-style-type: none"> <li>- Physician evaluations &amp; consults</li> <li>- Progress notes</li> <li>- Hospital records</li> </ul>

- CMS Provider Manuals
- Benefit Policy Manual
- Claims Processing Manual
- Program Integrity Manual
- Provider Reimbursement Manual

Health Payors Reimbursement:

Payor Reimbursement Criteria

Reimbursement based on Medical Necessity – all payors

- Judged against current standards of care
- Necessary and appropriate for disease or injury
- -Should include the following depending on service & site:
- -Physician evaluations & consults
- -Progress notes from Inpatient, Outpatient, SNF, IRF, Behavioral Health & Home Health
- -Hospital records including operative notes

CMS Program Integrity Manual 100-08, Chapter 3, Provider Manuals

Medicare Reimbursement

- Title XVIII of the Social Security Act - enacted July 1965 providing health insurance to retirees – difficult for elderly to get private insurance
- Medicare A covers inpatient care, SNF, Hospice and Home Health
- Based on diagnosis, Treatment and others factors that include wage index and GME
- Medicare B covers outpatient services, ambulance, DME, Mental Health inpatient, outpatient and partial hospitalization
- Reimbursements
- Inpatient MS-DRG (IPPS), Outpatient CPT/HCPCS (OPPS) & ASC schedules
- -Quality Measures may reduce or increase reimbursement 2017

Medicaid Reimbursement

- Enacted in 1965 at the same time as Medicare (Medicaid.gov)
- Federal Medical Assistance Percentage (FMAP) – published annually
- Partially funded by states – withheld for Medicare/Medicaid overpayments
- Balance billing Medicaid patients
- Outside of standard coverage
- Inpatient Paid by DRG – normally require prior authorization

- Enhanced Ambulatory Patient Groups (EAPG) for outpatient hospital claims - eliminates Fee for Service Schedules

Advantage Programs

Medicare Advantage - Coverage provided by private insurance (Medicare C)

- Reimbursement based on insurance plan & contract with providers
- Cannot offer less coverage – More (Rx, dental, vision & wellness(Med A hospice)
- Varies by plan & location
- Many services require preapproval

Medicaid Advantage – Managed Care Organization

- Maximum Income to Qualify - 138% of the FPL, 200% for pregnant woman
- Insurance companies paid to manage care of beneficiaries

Commercial Payors & Self-pay

The power is in the contract!

- Understand contract language
  - Insurance provider manual
  - Inpatient/outpatient criteria
  - Normally require pre-approval for tests and admissions
- No contract - payors normally follow coding guidelines based on DRG, CPT, HCPCS & ICD Procedure Codes
- Self pay – patient/guarantor choose not to use health insurance
  - No monthly payment – patient can arrange an installment plan
  - Service on the payor non-covered list

Research Sponsors

Funding internal or external to the organization

- External funding is referred to as the Research Sponsor
  - Federal funding
  - Foundational funding
  - Industry funding - Pharma/Device
- Research Budget Includes:
  - Research staff salaries, services not considered standard of care
  - Some pass through costs for IRB (Institutional Review Board) & Pharmacy fees
  - Monies received offset expenses charge to the research activity
- Payors – no reimbursement for services under a research project

Title XVIII of Social Security Act - enacted July 1965 providing health insurance to retirees – difficult for elderly to get private insurance  
Medicare A covers inpatient care, Skilled Nursing Facility, Hospice, Home Health based on diagnosis, Treatment and other factors that include Wage Index, Graduate Medical Education  
Medicare B covers Outpatient services, ambulances, DME, Mental Health inpatient, outpatient and partial hospitalization

Reimbursements:  
-Inpatient MS-DRG (IPPS), Outpatient CPT/HCPCS (OPPS) & fee schedules, including physician and laboratory  
-Quality measures may reduce or increase reimbursement 2017

**Reference links from slide:**  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>  
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPS.html>

**AHIA links:**  
<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar Revenue-Cycle-Part-1-Handout 1-12-21.pdf>  
<https://www.youtube.com/watch?v=RqfFQqCcE4Q> (AHIA recording of presentation from BOK Webinar slides)

**2. Medicaid**

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Federal Medical Assistance Percentage (FMAP) - published annually  
-Partially funded by states - withheld for Medicare/Medicaid overpayments  
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-Enhanced Ambulatory Patient Groups (EAPG) for outpatient hospital claims - eliminates fee for service schedules

Reference links from slide:  
<https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance>

**AHIA links:**  
<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar Revenue-Cycle-Part-1-Handout 1-12-21.pdf>  
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**3. Advantage Programs**

Medicare Advantage - Coverage provided by private insurance (Medicare C)  
-Reimbursement based on insurance plan & contract with providers  
-Cannot offer less coverage – More (Rx, dental, vision & wellness(Med A hospice)  
-Varies by plan & location  
-Normally requires preapproval

	<p>Medicaid Advantage – Managed Care Organization</p> <ul style="list-style-type: none"> <li>-Maximum Income to Qualify – expressed as a percentage of the federal poverty level by individual state</li> <li>-Insurance companies paid to manage care of beneficiaries</li> </ul> <p>CMS Medicare Managed Care Manual 100-16/Medicaid manual under development</p> <p><a href="https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326">https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326</a></p> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQgCcE4Q">https://www.youtube.com/watch?v=RqfFQgCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>4. Commercial Payors</b>	
	<p>The power is in the contract!</p> <p>Understand contract language</p> <ul style="list-style-type: none"> <li>-Insurance provider manual</li> <li>-Inpatient/outpatient criteria</li> <li>-Normally require pre-approval for tests and admissions</li> </ul> <p>No contract - payors normally follow coding guidelines based on DRG, CPT, HCPCS &amp; ICD Procedure Codes</p> <p>AHIA links:  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQgCcE4Q">https://www.youtube.com/watch?v=RqfFQgCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>5. Self-Pay</b>	
	<p>Self-pay – patient/guarantor choose not to use health insurance</p> <ul style="list-style-type: none"> <li>-No monthly payment – may make installment plan arrangements</li> <li>-Service on the payor non-covered list</li> <li>-Financial counseling</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQgCcE4Q">https://www.youtube.com/watch?v=RqfFQgCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>6. Research Sponsors</b>	
	<p>Funding internal or external to the organization</p>

	<p>External funding is referred to as the Research Sponsor</p> <ul style="list-style-type: none"> <li>-Federal funding - NIH, DoD or AHRQ</li> <li>-Foundational funding - AHA</li> <li>-Industry funding - Pharma/Device</li> </ul> <p>Research Budget Includes:</p> <ul style="list-style-type: none"> <li>-Research staff salaries, services not considered standard of care</li> <li>-Some pass thru costs for IRB (Institutional Review Board) &amp; Pharmacy fees</li> <li>-Monies received offset expenses charge to the research activity</li> </ul> <p>Payors – no reimbursement for services under a research project</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar Revenue-Cycle-Part-1-Handout 1-12-21.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar Revenue-Cycle-Part-1-Handout 1-12-21.pdf</a>  <a href="https://www.youtube.com/watch?v=RqfFQqCcE4Q">https://www.youtube.com/watch?v=RqfFQqCcE4Q</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b><u>C. Health Care Provider Revenue Cycle Elements</u></b></p>	<p><b><u>Revenue Cycle Functions</u></b></p>
<p>Summary</p>	<p><u>Front End</u>          -Scheduling, Preregistration, Precertification, Insurance Verification &amp; Registration</p> <p><u>Middle</u>          -Patient Care, Provider/Nursing Documentation, Ancillary Services &amp; Discharge, Charge Capture, HIM Coding</p> <p><u>Back End</u>          - Claim and Billing Edits, Billing, Payment Posting, Denials Management</p> <p><u>Healthcare Revenue Cycle</u>          An interdependent process involving multiple departments and staff members, each of whom must complete key job functions in order to ensure the revenue cycle functions efficiently.</p> <p><u>Improve Risk Management - Accreditation</u>          Required to Receive Payment from Medicare/Medicaid Programs          Medicare Conditions of Participation (CoPs) - Must meet in order to begin and continue participating in the Medicare and Medicaid programs. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs.</p>

The Joint Commission – The Joint Commission standards focus on state-of-the-art performance improvement strategies that help health care organizations continuously improve the safety and quality of care.

Risk - Standard or Condition Level Deficiency

#### Healthcare Provider Revenue Cycle

Extremely Complex System - Multiple Players - Very Easy to Make Errors - Many Opportunities for Gaps

#### Audit Cycle Practices

##### Front End

-Scheduling, Preregistration, Precertification, Insurance Verification & Registration

##### Middle

-Patient Care, Provider/Nursing Documentation, Ancillary Services & Discharge

##### Back End

-Charge Capture, HIM Coding, Professional Coding, Billing & IT

#### Front End Practices

##### Registration

- Insurance information

- Verify coverage for inpatient admissions, ED visits & surgeries

- Potential for fraud – use of another’s insurance information

-Verification of Patient Information – combined responsibilities

- General consent – treatment, Informed consent for surgeries/procedures

- ABN (Advanced Beneficiary Notice) – tests/services may not be covered (CMS)

- IMM (Important Message from Medicare) – Inpatient (CMS)

- MOON (Medicare Outpatient Observation Notice) – Outpatient (CMS)

-Documentation

##### Middle

Patient Care - multiple individuals performing services under their Scope of Practice

- Physician responsible for Management of Care

- Documentation of services provided or requested

- Discharge Planning/Plan of Care

- Nurse, Specialists - Care at the direction of provider

- Wound therapy, Physical, Respiratory, Dietary

- All care documented in the medical record

- Charge Capture – people and software

- Health Information Management
- Professional Coding

#### Backend Practices

Departments considered the 'Backend' of the Revenue Cycle

- Billing
- IT & Customer Service
  - Reporting
  - Analysis

#### Charge Capture

Charge Capture – documentation converted to standard codes

- Charge Description Master – validated by CDM team
  - Pricing, Standard long & short descriptions for codes, hard and soft-coded items
    - Hard-coded – the line item charge in the CDM does not differ from the description or by patient, or clinical scenario (e.g., radiology exam)
    - Soft-coded – the line item charge in the CDM may differ based on the service provided, time and resources needed. HIM abstracts the code to align to the charge (e.g., surgical procedures)
- Routed through the system & reformatted
  - Charge Router, Charge Entry Preprocessor
- Transforms to an appropriate CPT/HCPCS Code on claims
- Submitted electronically 837i and/or 837p

CMS requires all charges at a facility be uniformly applied to all patients

#### Professional Coding

Certified by AAPC or AHIMA

- Classify Diseases, injuries based on standard guidelines
  - ICD-9/10-CM diagnostic codes
- Assign codes based on credentials & scope of practice
  - Other Providers
- Additional Responsibilities
  - Provider education
  - Auditing
  - Compliance

Risk – Under/Over Coding

*Health Information Management (HIM)*

	<p>Credentialed by AHIMA, AAPC - Hospital</p> <ul style="list-style-type: none"> <li>-Interpret &amp; convert medical documentation to diagnoses and procedures</li> <li>-DRGs - Software</li> <li>- Diagnosis, comorbidities &amp; procedures</li> <li>- Discharge status – Post Acute Care Transfers <ul style="list-style-type: none"> <li>- Provider/Care Management collaboration</li> </ul> </li> </ul> <p>CDI – Clinical Documentation Integrity</p> <ul style="list-style-type: none"> <li>- AHIMA and ACDIS – CDI guidelines <ul style="list-style-type: none"> <li>- Improve Clinical Documentation</li> </ul> </li> </ul> <p><b>Billing &amp; IT - Complete &amp; Accurate</b></p> <p>Billing Hospital &amp; Professional Services</p> <ul style="list-style-type: none"> <li>-Knowledge of billable/non-billable CPT/HCPCS</li> <li>-Medical Necessity <ul style="list-style-type: none"> <li>- NCD &amp; LCD – National/Local Coding Determinations</li> <li>- EMR Documentation</li> </ul> </li> </ul> <p>Information Technology</p> <ul style="list-style-type: none"> <li>-Electronic transmission of claim data</li> </ul>
<b>1. Scheduling</b>	
	<p>Discussed as part of the front end section of audit cycle practices.</p> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a></p> <p><a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>2. Preregistration</b>	
	<p>Patient pre-registration is the process of collecting relevant patient information before the day of the appointment. Similar to the patient intake process followed at the facility, key demographic, clinical data, insurance information, payments, and consents are obtained before the patient presents for their visit at the hospital or physician clinic.</p> <p>Discussed as part of the front end section of audit cycle practices.</p> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a></p> <p><a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>3. Registration / Patient Access</b>	

	<p><u>Registration</u></p> <ul style="list-style-type: none"> <li>-Insurance information – Birthday Rule</li> <li>-Verify coverage for inpatient admissions, ED visits &amp; surgeries</li> <li>-Potential for fraud – use of another’s insurance information</li> </ul> <p><u>Verification of Patient Information – combined responsibilities</u></p> <ul style="list-style-type: none"> <li>-General consent – treatment, Informed consent for surgeries/procedures</li> <li>-ABN (Advanced Beneficiary Notice) – tests/services may not be covered (CMS)</li> <li>-IMM (Important Message from Medicare) – Inpatient (CMS)</li> <li>-MOON (Medicare Outpatient Observation Notice) – Outpatient (CMS)</li> </ul> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>4. Provision of Services and Documentation</b></p>	
	<p>Provision of services covers the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. The clinician reflects the results of services in medical record documentation</p> <p>Discussed as part of patient care - multiple individuals performing services under their Scope of Practice  Physician responsible for Management of Care</p> <ul style="list-style-type: none"> <li>-Documentation of services provided or requested</li> <li>-Discharge Planning/Plan of Care</li> </ul> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>5. Charge Capture</b></p>	
	<p>Charge Capture is the process used by doctors and other health care providers to get paid for their services. In its simplest form, it is the process whereby the department or provider record information on services, which is then sent out to different payers and insurance companies for reimbursement.</p> <p>Charge capture is critical for the success of every healthcare organization that seeks reimbursement for their services, whether from third-party payors on the patient themselves. If the services aren’t captured, then the clinician or facility simply won’t get paid for those services, which results in lost revenue. If the services are captured in a way that doesn’t fully codify the variety or complexity then the reimbursement may result in an</p>

underpayment for services delivered. Finally, if the medical coder overstates the types of services delivered, the organization could be at a risk for overpayment which can cause significant issues downstream if and when the insurance company requests an audit.

Charge Capture – documentation converted to standard codes

- Charge Description Master – validated by CDM team
  - Pricing, Standard long & short descriptions for codes
- Routed through the system & reformatted
  - Charge Router, Charge Entry Preprocessor
- Transforms to an appropriate CPT/HCPCS Code on claims
- Submitted electronically 837i and/or 837p

CMS requires all charges at a facility be uniformly applied to all patients

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<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

**6. Discharge**

Patients preparing to leave a hospital after treatment go through a process called hospital discharge. A hospital will discharge patients when they no longer need to receive inpatient care and will either send the patient home or to another type of facility, so that the patient’s medical condition can still be attended to and cared for until recovered.

Many hospitals have a discharge planner. This person helps coordinate the information and care needed after the patient leaves. It is important to convey the injury or illness and next steps to be taken. This may include taking medicine and caring for a bandage, as well as who to contact if the patient has a question or a problem.

Discussed as part of the clinical audit cycle practices.

Physician responsible for Management of Care

- Discharge Planning/Plan of Care

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<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

**7. Coding Guidelines for Clinics**

Coding is the transformation of healthcare diagnosis, procedures, medical services and equipment into universal medical alphanumeric codes. Put simply, this refers to the process of translating important medical information into simple codes for the purpose of documenting medical records and informing accurate medical billing.

Certified by AAPC or AHIMA

- Classify Diseases, injuries based on standard guidelines
  - ICD-10-CM diagnostic codes
- Assign codes based on credentials & scope of practice
  - Other Providers
- Additional Responsibilities
  - Provider education
  - Auditing
  - Compliance

\*Risk – Under/Over Coding

**AHIA links:**

<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

**8. Billing**

In healthcare, billing is a payment practice. It's a process in which a healthcare provider generates and submits a medical claim to the payer (patient directly or third-party payor) to receive payment for services offered. It involves several steps; patient registration and collecting personal and insurance information, generating a bill after coding the diagnosis and procedures, generating and submitting a claim, and collecting payments. Most third-party payors use a similar process, whether they are private companies or government sponsored programs. Medical coding reports what the diagnosis and treatment were, and prices are applied accordingly.

Billing Hospital & Professional Services

- Knowledge of billable/non-billable CPT/HCPCS
  - CCI Edits – buffering of what can be billed together
  - MUE Edits – verify appropriate quantities billed
- Medical Necessity
  - NCD & LCD – National/Local Coding Determinations
  - EMR Documentation

Information Technology  
-Electronic transmission of claim data

**AHIA links:**

<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

## **2D. Revenue Deductions**

Summary	<p>Revenue deductions represent the difference between full established charges and amounts received or to be received from patients or payors (e.g., commercial insurance, Medicare, Medicaid) on behalf of patients</p> <p>Payer Discounts</p> <ul style="list-style-type: none"><li>- Difference between what is charged and what the payer allows</li><li>- Payer Discount = Total Charges - Payer Allowed Amount</li></ul> <p>Uncompensated Care</p> <ul style="list-style-type: none"><li>- Uninsured discount</li><li>- Charity care</li><li>- Bad Debt</li></ul> <p>Additional Considerations</p> <ul style="list-style-type: none"><li>- Denials</li><li>- Other write-offs (e.g., Administrative Adjustments)</li></ul> <p><u>Contractual and Administrative Adj</u></p> <p>A contractual adjustment refers to the amount that a healthcare provider agrees to write off as a result of a contractual agreement with an insurance company or a government program.</p> <p>Administrative adjustments are non-contractual adjustments or write-offs of charges taken in accordance with eligible participant policies.</p> <p>Agreements – 3rd party payors, service line coverage</p> <ul style="list-style-type: none"><li>-Frames, defines &amp; governs the relationship</li><li>- Medicare/Medicaid –</li><li>- Commercial -</li></ul> <p>-Negotiate &amp; enforcement of contract</p> <ul style="list-style-type: none"><li>- Law Department Review</li></ul> <p>Administrative Adjustments</p> <ul style="list-style-type: none"><li>-Exceptions</li></ul>
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- Prompt pay

#### Charity Care & Bad Debt Write-Offs

Uncompensated Care provided by a hospital – no payment received from patient or insurance (CC+BD)

- Charity Care (also referred to as Financial Assistance) – Care for which hospitals do not expect to be reimbursed (reduction in revenue)
- Bad Debt Write-Offs – Expected reimbursement not received -currently reimbursed by Medicare at 65%
- Recorded as Bad Debt on Medicare Cost Report

#### Payment Posting & Collections

Insurance Payments & Explanation of Benefits

- Electronic remit advice file – 835 HIPAA Compliant
  - Standard format - payments, adjustments, based on each claim or service line
- Auto-post vs. manual posting
  - Exceptions: Mis-posted payments and adjustments

Collections – applied same as non-Medicare patients

- Uncollectible after 120 days – reasonable effort
- Copays & deductibles – Medicare will reimburse 65% of allowable Medicare bad debt that remains unpaid

#### Key Performance Indicators (KPI)

Monitor & Analyze relevant processes to improve satisfaction, performance & revenue

- Average Hospital Stay – LOS (Length of Stay)
- ED Waiting Time and Clinical Throughput
- Denials (inpatient and outpatient)
- Days Receivable Outstanding
- Average Daily Revenue
- AR > 90 Days

#### Revenue Cycle Management

Software/processes to track patients from registration thru payments to prevent operating losses resulting from error, fraud or technological breakdowns

Information to Know:

Billing - Relevant Facts

- A service may be covered and you can bill – may not be paid
- What is paid today may not be paid tomorrow

	<ul style="list-style-type: none"> <li>- Services covered in one state may not be covered in others</li> <li>- Many rules – impossible to know all of them</li> <li>- Not knowing all the rules can get you in trouble</li> <li>- Ignoring the rules is not an option</li> </ul>
<p><b>1. Contractual adjustments</b></p>	
	<p>Third-party insurers and government programs have contracts that state what each party will pay for different medical services. Usually, the reimbursement amount is lower than the total billed amount to patients. A contractual adjustment, or contractual allowance, is the portion of a patient’s bill that a doctor or hospital must adjust off (not charge for) because of billing agreements with the third-party payors It is the most common type of adjustment made by medical providers.</p> <p>Agreements – 3rd party payors, service line coverage</p> <ul style="list-style-type: none"> <li>-Frames, defines &amp; governs the relationship <ul style="list-style-type: none"> <li>-Medicare/Medicaid</li> <li>-Commercial -</li> </ul> </li> <li>-Negotiate &amp; enforcement of contract <ul style="list-style-type: none"> <li>-Law Department Review</li> </ul> </li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>2. Administrative adjustments</b></p>	
	<p>An Administrative adjustment represents the amount the institution is unable to collect due to billing policy or institutional error.</p> <p>Administrative Adjustments</p> <ul style="list-style-type: none"> <li>-Exceptions</li> <li>-Prompt pay</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf">https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=GgDGLoP1cbA">https://www.youtube.com/watch?v=GgDGLoP1cbA</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<p><b>3. Charity care</b></p>	
	<p>Uncompensated care is health care or services that hospitals or health care providers do not get reimbursed for It is the sum of a hospitals' financial assistance and bad debts. Financial assistance is provided for care that hospitals never expected to be paid for or provided at a reduced cost for those in need. Uncompensated care often arises when people do not have insurance and cannot afford to pay the cost of care.</p>

Uncompensated Care provided by a hospital – no payment received from patient or insurance (CC+BD)

Charity Care – Care for which hospitals do not expect to be reimbursed (reduction in revenue)

Reference links from slides:

<https://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/pp-board-statement>

AHIA links:

<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

#### **4. Bad debt write-offs**

Bad debt is the cost of a treatment that a patient cannot pay. Providers consider this money unrecoverable and label it as bad debt. Often, bad debt only accumulates from patients that can't afford to pay, rather than patients who refuse to pay—most frequently, uninsured patients. It is a form of uncompensated Care provided by a hospital – no payment received from patient or insurance (CC+BD)

Bad Debt Write-Offs – Expected reimbursement not received - currently reimbursed by Medicare at 65%

-Recorded as Bad Debt on Medicare Cost Report

Reference links from slides:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

AHIA links:

<https://ahia.org/wp-content/uploads/2022/12/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

#### **5. Payment Posting**

Payment posting is a critical step of the revenue cycle management of any physician practice or healthcare organization. It involves posting and deposit functions and reconciling posting activities with deposits. The payment posting process affects many other functions of the billing process and can have a major impact on patient satisfaction, efficiency, and overall financial performance.

Timely and accurate reflection of Patient and Insurance payments & Explanation of Benefits is critical to the payment posting process.

-Electronic remit advice file – 835 HIPAA Compliant

-Standard format - payments, adjustments, based on each claim or service line

-Auto-post vs. manual posting

-Exceptions: Mis-posted payments and adjustments

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**6. Collections**

Overall, the traditional billing workflow is an inadequate strategy for collecting payments from patients. That is why such a high percentage of patient bills end up being forwarded to a collections agency. The collection process is referred to as a clear financial policy and effective communication with patients. Additionally, a medical billing specialist collects all necessary information, including patient demographics, clinical services provided, and insurance details; prepares and submits medical bills to payers for reimbursement. To begin the billing process, most healthcare organizations will send three physical paper statements to a patient at home. Then, they may make two phone calls attempting to collect the payment before the bill is transitioned to collections.

- Collections – applied same as non-Medicare patients
- Uncollectible after 120 days – reasonable effort
- Copays & deductibles – 65%

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<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

**7. Management Monitoring / Key Performance Indicators**

Best practice is to ensure periodic management monitoring of the results of key business processes is performed to ensure staff are performing their duties and activities are accurately recorded; additionally key performance indicators are trended to identify whether results differ significantly from expected performance

- Monitor & Analyze relevant processes to improve satisfaction, performance & revenue
- Average Hospital Stay – LOS (Length of Stay)
- ED Waiting Time
- Inpatient Denials – Preauthorization
- Days Receivable Outstanding
- Average Daily Revenue
- AR > 90 Days
- Service Line

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### **3. REGULATORY ENVIRONMENT**

#### **Summary Description**

##### U. S. Department of Health and Human Services (HHS)

A government department that provides health and human services and promotes research in social services, medicine, and public health through 11 agencies that manage more than 100 programs, including Medicare & Medicaid

##### Centers for Medicare & Medicaid Services (CMS)

CMS is part of the HHS. CMS oversees many federal healthcare programs, including those that involve health information technology, such as the meaningful use incentive program for electronic health records (EHR).

##### Office of Civil Rights (OCR)

OCR is the enforcement agency for HHS. Through the federal civil rights law, OCR insures that people have equal access and opportunity to participate in certain healthcare and human services programs without unlawful discrimination. In addition, under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, OCR protects patients' health information privacy.

##### Individually Identifiable Health Information (IIHI), also referred to as Personally Identifiable Information (PII)

Under Federal HIPAA and State regulations all identifiers listed below are considered protected and if accessed, used and disclosed inappropriately could be considered a breach: Name, Date of Birth, Address, city, county, zip code, Medical Record #, SSN #, Account #, Name of relative or employer, Health Plan #, Telephone #, Device Identifiers and Serial #, Photographic images and other comparable images, Any other unique identifying #, code, or characteristic, Email address, Web URL.

##### Social Security

Sections of the Social Security Act piggyback on patient rights regulations by making it illegal for hospitals to pay physicians to limit services to Medicare or Medicaid patients. In contrast, organizations can be penalized for offering gifts to a patient to get their business.

##### Department of Justice (DOJ)

The Fraud Section's Health Care Fraud Unit focuses solely on prosecuting the nation's most complex health care fraud matters and the illegal prescription, distribution, and diversion of opioids.

##### Office of Inspector General (OIG)

Anti-Kickback Provisions (AKS), Physician Self-Referral ("Stark") Law, False Claims Act (FCA) & Whistleblower Provision, Exclusion Statute, Civil Monetary Penalties

##### Drug Enforcement Agency (DEA)

	<p>The mission of the Drug Enforcement Administration (DEA) is to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.</p> <p><u>Food and Drug Administration (FDA)</u> The Food and Drug Administration is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation.</p> <p><u>Federal Trade Commission (FTC)</u> The Red Flags Rule, a law the Federal Trade Commission (FTC) begin enforcement on August 1, 2009, requires certain businesses and organizations — including many doctors' offices, hospitals, and other health care providers —to develop a written program to spot the warning signs — or "red flags" — of identity theft.</p> <p><u>The Joint Commission</u> The mission of the Joint Commission on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.</p> <p><u>State Regulators</u> Each state has its own regulatory agencies.</p>
<b>3. REGULATORY ENVIRONMENT</b>	<b><u>A. Regulatory Bodies</u></b>
	<b><u>1. CMS</u></b>
	<p>The Centers for Medicare &amp; Medicaid Services (CMS) is part of the U.S. Department of Health and Human Services. CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).</p> <p>Encompasses the following regulatory bodies:  Affordable Care Act (ACA)  Physician Payment Sunshine Act  CMS Conditions of Participation  CMS Conditions of Payment  Emergency Medical Treatment and Labor Act (EMTALA)</p>

**AHIA links:**  
<https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf>  
<https://www.youtube.com/watch?v=iRx8PWFe5hM> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**  
<https://www.cms.gov/>  
<https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance>

**2. OIG**

The Office of Inspector General (OIG) is within the US Department of Health and Human Services and from their website has been at the forefront of the Nation's efforts to fight waste, fraud and abuse and to improving the efficiency of Medicare, Medicaid and more than 100 other Department of Health & Human Services (HHS) programs. Some of these efforts include the below:

**Reference links from slides:**  
 Anti-Kickback Provisions (AKS) - <https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf>  
 Physician Self-Referral (“Stark”) Law - <https://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm>  
 False Claims Act (FCA) & Whistleblower Provision - <https://oig.hhs.gov/faqs/whistleblower-protection-coordinator-faq/>  
 Exclusion Statute <https://oig.hhs.gov/exclusions/background.asp>  
 Civil Monetary Penalties - <https://oig.hhs.gov/fraud/enforcement/about/>

**AHIA links:**  
<https://www.youtube.com/watch?v=iRx8PWFe5hM> AHIA recording of presentation from BOK Webinar slides

**3. OCR**

The Office for Civil Rights (OCR) is the enforcement agency for Health and Human Services (HHS). Through the federal civil rights law, OCR insures that people have equal access and opportunity to participate in certain healthcare and human services programs without unlawful discrimination. In addition, under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, OCR protects patients’ health information privacy.

Encompasses the following regulatory bodies:  
 Health Insurance Portability & Accountability Act (HIPAA)  
 Individually Identifiable Health Information (IIHI)

**AHIA links:**  
<https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf>  
<https://www.youtube.com/watch?v=iRx8PWFe5hM> AHIA recording of presentation from BOK Webinar slides

	<p><b>Reference links from slides:</b>  <a href="https://www.hhs.gov/ocr/index.html">https://www.hhs.gov/ocr/index.html</a>  <a href="https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html">https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html</a></p>
	<p><b>4. DEA</b></p>
	<p>The mission of the Drug Enforcement Administration (DEA) is to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.</p> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> AHIA recording of presentation from BOK Webinar slides</p> <p><b>Reference links from slides:</b>  <a href="https://www.fda.gov/home">https://www.fda.gov/home</a></p>
	<p><b>5. FDA</b></p>
	<p>The Food and Drug Administration is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation.</p> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)  <a href="https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf">https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=jiSK1UYTXrg">https://www.youtube.com/watch?v=jiSK1UYTXrg</a> (AHIA recording of presentation from BOK Webinar slides).</p> <p><b>Reference links from slides:</b>  <a href="https://www.fda.gov/home">https://www.fda.gov/home</a>  <a href="https://www.fda.gov/drugs/guidance-compliance-regulatory-information">https://www.fda.gov/drugs/guidance-compliance-regulatory-information</a></p>
	<p><b>6. The Joint Commission (TJC)</b></p>

	<p>The mission of the Joint Commission (TJC) on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. Accreditation means that staff has made an extra effort to review and improve the key areas that can affect the quality and safety of patient care. Accreditation by The Joint Commission is considered the gold standard in health care.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> <b>(AHIA recording of presentation from BOK Webinar slides)</b></p> <p><b>Reference links from slides:</b>  <a href="https://www.jointcommission.org/">https://www.jointcommission.org/</a></p>
	<p><b>7. State Regulators</b></p>
	<p>It is noted that each state may have different regulations that health care organizations must abide by when providing care within that jurisdiction.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> <b>(AHIA recording of presentation from BOK Webinar slides)</b></p> <p><b>Reference links from slides:</b>  <a href="https://www.classlawgroup.com/employment/faq-differences-california-federal-labor-laws/">https://www.classlawgroup.com/employment/faq-differences-california-federal-labor-laws/</a>  <a href="https://www.classlawgroup.com/employment/wage-and-hour/">https://www.classlawgroup.com/employment/wage-and-hour/</a>  <a href="https://edd.ca.gov/">https://edd.ca.gov/</a>  <a href="https://www.dfeh.ca.gov/">https://www.dfeh.ca.gov/</a>  <a href="https://www.eeoc.gov/">https://www.eeoc.gov/</a>  <a href="https://www.labor.ca.gov/">https://www.labor.ca.gov/</a>  <a href="https://www.dir.ca.gov/dlse/">https://www.dir.ca.gov/dlse/</a>  <a href="https://www.cdph.ca.gov/">https://www.cdph.ca.gov/</a></p>
<p><b>3. Regulatory Environment</b></p>	<p><b>Regulations</b></p>
<p><b>Summary Description</b></p>	<p>Department of Health and Human Services (HHS) -</p> <p><u>Affordable Care Act (ACA)</u>  The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”).</p> <p><u>Physician Payment Sunshine Act</u>  The Physician Payments Sunshine Act (PPSA)--also known as section 6002 of the Affordable Care Act (ACA) of 2010--requires medical product manufacturers to disclose to the Centers for Medicare and Medicaid Services (CMS) any payments or other transfers of value made to physicians or teaching hospitals.</p>

#### CMS Conditions of Participation

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.

#### CMS Conditions of Payment

Conditions of Payment. As the name suggests, a condition of payment is a rule, regulation, or requirement that must be met in order for a healthcare provider to lawfully request and receive reimbursement from a federal healthcare coverage provider (e.g., Medicare, Medicaid, or TRICARE). The government imposes conditions of payment to ensure providers are offering patients quality service congruent with set standards within the medical community.

#### Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated by a qualified medical professional, regardless of their insurance status or ability to pay, but since its enactment in 1986 has remained an unfunded mandate.

#### Health Insurance Portability & Accountability Act (HIPAA)

Protects the patient's right to privacy of health information.

#### Department of Justice (DOJ):

##### False Claims Act

Prohibits submission of a fraudulent bill to a government agency.

##### Federal Anti-Kickback Statute and the Stark Law

##### Internal Revenue Service (IRS)

##### Anti-Kickback Statute

Prohibits giving or receiving any remuneration (something of value) in exchange for referring a patient or purchasing an item or service that will be paid for by a government program (Medicare).

##### Stark Law

	Prohibits physicians from referring patients to facilities or providers if physician or immediate family has a financial relationship with the facility or provider.
	<b>1. HIPAA</b>
	<p>Health Insurance Portability and Accountability Act (HIPAA) - Protects the patient's right to privacy of health information. What is Protected Health Information (PHI)?</p> <p>PHI is patient's information that must be protected from unauthorized access, use and disclosure</p> <p>PHI is patient information created, as well as, information received from other healthcare providers</p> <p>State and Federal Laws mandate the protection of patient health information</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=jiSK1UYTXrg">https://www.youtube.com/watch?v=jiSK1UYTXrg</a> (AHIA recording of presentation from BOK Webinar slides)  <a href="https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf">https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.techtarget.com/searchhealthit/definition/HIPAA">https://www.techtarget.com/searchhealthit/definition/HIPAA</a>  <a href="https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html">https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html</a></p>
	<b>2. Stark and Anti-Kickback</b>
	<p>Anti-Kickback Statute – Prohibits giving or receiving any remuneration (something of value) in exchange for referring a patient or purchasing an item or service that will be paid for by a government program (Medicare).</p> <p>Stark Law - Prohibits physicians from referring patients to facilities or providers if physician or immediate family has a financial relationship with the facility or provider.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf">https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf</a>  <a href="https://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm">https://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm</a></p>
	<b>3. False Claims Act</b>
	False Claims Act - Prohibits submission of a fraudulent bill to a government agency. This includes claims submitted to Medicare or Medicaid. Violating the False Claims Act is a very serious matter. Organizations can be required to pay up to three times the amount of damages sustained

by the United States government, and they may also be excluded from participation in Medicare and Medicaid in the future. Medicare-participating providers are in violation of the False Claims Act if they submit Medicare bills, and are paid, for care that is deemed any of the following:

- Inappropriate
- Unnecessary
- Misrepresented (e.g., through upcoding or false documentation)
- Not provided

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf>  
<https://www.youtube.com/watch?v=iRx8PWFe5hM> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<https://www.gibsondunn.com/2019-mid-year-false-claims-act-update/>  
<https://oig.hhs.gov/faqs/whistleblower-faq.asp>

**4. CMS Conditions of Participation**

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.

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<https://www.youtube.com/watch?v=iRx8PWFe5hM>

**Reference links from slides:**

<https://www.cms.gov/regulations-and-guidance/legislation>

	<p><b>5. CMS Conditions of Payment</b></p> <p>Conditions of payment is a rule, regulation, or requirement that must be met in order for a healthcare provider to lawfully request and receive reimbursement from a federal healthcare coverage provider (e.g., Medicare, Medicaid, or TRICARE). The government imposes conditions of payment to ensure providers are offering patients quality service congruent with set standards within the medical community.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.cms.gov/regulations-and-guidance/regulations-and-policies/medicare-fee-for-service-payment-regulations">https://www.cms.gov/regulations-and-guidance/regulations-and-policies/medicare-fee-for-service-payment-regulations</a>  <a href="https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol3/xml/CFR-2017-title42-vol3-part424.xml">https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol3/xml/CFR-2017-title42-vol3-part424.xml</a></p>
	<p><b>6. Affordable Care Act</b></p> <p>The comprehensive health care reform law was enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”). The law has 3 primary goals:</p> <ul style="list-style-type: none"> <li>-Make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.</li> <li>-Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)-Support innovative medical care delivery methods designed to lower the costs of health care generally.</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.healthcare.gov/glossary/affordable-care-act/">https://www.healthcare.gov/glossary/affordable-care-act/</a></p>
	<p><b>7. Physician Payment Sunshine Act</b></p>
	<p>The Physician Payments Sunshine Act (PPSA)--also known as section 6002 of the Affordable Care Act (ACA) of 2010--requires medical product manufacturers to disclose to the Centers for Medicare and Medicaid Services (CMS) any payments or other transfers of value made to physicians or teaching hospitals.</p>

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<https://www.youtube.com/watch?v=iRx8PWFe5hM> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<https://www.cms.gov/OpenPayments>

<https://www.healthaffairs.org/doi/10.1377/hpb20141002.272302/full/>

**8. EMTALA**

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated by a qualified medical professional, regardless of their insurance status or ability to pay, but since its enactment in 1986 has remained an unfunded mandate. The purpose of EMTALA is to prevent "patient dumping," the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions [are] stabilized. "

**AHIA links:**

<https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf>

<https://www.youtube.com/watch?v=iRx8PWFe5hM> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index>

<https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/>

**9. IRS Regulation 501(r)**

501(r): IRS Regulations and the Hospital Revenue Cycle. First enacted as part of the Affordable Care Act in 2010, 501(r) imposes four requirements on nonprofit hospitals and health systems in order to maintain their tax-exempt, nonprofit status. Three of these requirements relate directly to a hospital's revenue cycle operations. Failure to comply could result in substantial penalties or the loss of nonprofit status, so it's important to understand what's required under this law.

IRS Finalizes Regulations Under Section 501 (r) These requirements include the obligation to perform a community health needs assessment every three years, the obligation to establish written policies on financial assistance and emergency care, and the imposition of certain limitations on billing and collection actions.

**AHIA links:**

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<https://www.youtube.com/watch?v=iRx8PWFe5hM> (AHIA recording of presentation from BOK Webinar slides)

	<p><b>Reference links from slides:</b>  <a href="https://www.irs.gov/charities-non-profits/section-501r-reporting">https://www.irs.gov/charities-non-profits/section-501r-reporting</a></p>
<p><b>4A. Core Business Functions</b></p>	<p><b>Operational / Financial</b></p>
<p><b>Summary Description</b></p>	<p><u>Human Resources (HR)</u>  Hospitals are 24 HR, 365 DAY Operations. Unique employee types: Physicians, Physician Assistants, Nurse Practitioners, Nurses (professionals often in labor unions), Various technical employees: coders, lab, etc. (some unionized), and Volunteers. Impact on system access: proper identification, timely termination notification, etc. Human Resources Risks: Difficulty recruiting qualified employees, Employees versus Independent Contractors, Pay equity challenges, Various labor compliance matters, Credentialing &amp; Medicare/Medicaid Exclusion, and Productivity. Human Resources Controls: Compensation structure, Position management, Current Policies, Procedures and Guidance, Duty Segregation, Compliance accountability / monitoring, IT Access controls, and Performance management structure.</p> <p><u>Payroll</u>  The Healthcare Industry Offers Most Payroll Challenges: 24 Hour Operation, Executive Payroll and Benefits, Nurses, Physician / Faculty Compensation, Exempt versus Non-Exempt, Manual Time Tracking and Automated Time, Manual Paychecks and Direct Deposit, Payroll Deductions, Health Benefits, Leave Benefits, Investment Benefits, Taxes, Workers Compensation Insurance Contributions, and Union Impact. As such, payroll risks abound: Contractual limitations, Wage theft / time falsification / processing errors, Lack of structured approval processes, Leave Abuse (hourly employees vs salaried employees), Ghost Employees, Compliance Lapses / Systemic Errors, and Unauthorized System Access / Data Compromise. Some Key Payroll Controls: Duty Segregation: HR vs Payroll Functions, Formal approvals, HR and Payroll System edits, Contractual review and approval, Account verification, and Positive Pay.</p> <p><u>Procurement</u>  Focuses on purchase of needed goods &amp; services. Procurement Risks: Purchase authorization, Purchase Order (PO) accuracy and completeness, Bid rigging, Kickbacks, Insufficient medical supplies, Quantity / Pricing Errors, and Payment for goods / services not received. Procurement Controls: Budget controls, Proper Authorizations, Strategic business alliances with suppliers, Proper receipting / three-way match, Purchase Orders and Contracts, Vendor management / Authorized vendor inventory, and Materials Management Interface.</p> <p><u>Materials Management</u>  Focus on maintaining &amp; distributing goods/materials both where and when needed. Materials Management Risks: Theft, Insufficient Supply, Proper quantity identification, Proper pricing, and Quality control / inspection. Materials Management Controls: Policy, procedure and house-wide process focus, Inventory management, Supplier agreements / back-up suppliers, and Strategic cost management.</p> <p><u>Contract / Vendor Management</u>  A lot of contracts in healthcare. Key Risks: Contracted services are typically not well-monitored, Bid issues / Kickbacks, and Owner / Vendor non-compliance. Key Controls: Contract review, Bid controls, and Accountability for contract monitoring.</p>

### Joint Ventures

Probably not many health systems without some type of joint venture. Key Risks: Contract language: ability to manage / monitor and Compliance Considerations. Key Controls: Contract review and Due diligence.

### Finance / Accounting

Accounting maintains the financial history / reports on financial position of the entity. Finance focuses on financial analysis and the future financial success of the entity. Finance / Accounting Key Risks: Data integrity: errors and omissions, High days in A/R, Credit risk: with suppliers, Credit risk: accounts receivable (AR), Management Override / Fraud / Misappropriation, Market Risks / Competition / Ineffective Business Model, Poor budget management, Third party data protection. Finance / Accounting Key Controls: Data validation, Accounts receivable management, and Bond rating management.

### Cash Management

Hospitals are employee intensive organizations = huge payrolls. Decentralized and accountability as cash is often collected in many places under the authority of many: central, clinics, etc. Cash Management Risks: Misappropriation / theft, Insufficient cash to cover current expenses, Cardholder data protection, and Poor controls over cash in clinic settings. Cash Management Controls: Duty Segregation, Effective central and decentralized cash oversight, Policies and Procedures, and monitoring for compliance, Timely deposit, Reconciliation, and Physical security.

### Business Continuity

Emergency Management vs Business Continuity / Resiliency. Community Impact: Hospitals are more than just a business. Emergency management includes planning and infrastructure design to address community medical emergencies (9/11/01). Business continuity / resiliency deals with how well the organization can recover from a disaster (Joplin tornado). Key Risks: Leadership buy-in and resources and Once designed / planned: maintaining focus and keeping it current – especially, as time passes without disaster. Key Controls: Business Impact Analysis & Continuity Plan, Business Continuity Champion / Accountability, and Periodic plan testing, reassessment and update.

### Research

Consists of Human Subjects and Institutional Review Boards, Animals an Institutional Animal Care & Use Committees, Academic Freedom, Organization funded / subsidized research, Federal, State and local government awards / grants and related regulations, Commercially sponsored research, Publication, and Intellectual Property & Patents. Key Research Risks: Complex regulations: If you have research, you likely have compliance gaps, Theft of intellectual property, Scientific integrity, Academic freedom, Underfunded research / entity subsidies, Patent protection / lost royalties, Human subjects harm / lack of patient/subject consent, and Reputation. Key Research Controls: Focused research compliance function, Grant support & grant accounting, Research oversight, review and approval, Institutional Review Board, Institutional Animal Care & Use Committees, Safe research space, Intellectual property & patent oversight / management, and Royalty management.

### Foundations

Fundraising has been and is key to healthcare missions. The healthcare community relationship is key to successful fundraising. Foundation Risks: HIPAA Privacy – patient privacy and donor identification, Poor management / Misappropriation / Theft, Reputation, and Donor recognition & Tax

	<p>letters. Foundation Controls: Policies and Procedures, Conflict of interest management, Duty Segregation, Cash Management, and Reputational awareness</p>
	<p><b>1. Payroll</b></p>
	<p>The Healthcare Industry Offers Most Payroll Challenges, such as: 24 Hour Operation: Differential, Shift, Overtime, Alternate Work Schedules, Holiday Pay, On Call, Remote, Executive Payroll and Benefits, Nurses: Professionals Paid Hourly, Physician / Faculty Compensation, Exempt versus Non-Exempt, Manual Time Tracking and Automated Time, Manual Paychecks and Direct Deposit, Payroll Deductions: Benefits, Investment Contributions, Payroll Taxes, Workers Compensation, Garnishments, Health Benefits: Medical, Dental, Vision, etc., Leave Benefits: PTO, Sick Time, etc., Leave Accruals, Investment Benefits: Pension, 403B Match, Taxes: Fed, Medicare, FICA, State, Local, Unemployment, Workers Compensation Insurance Contributions, and Union Impact: Nurses, Technicians, Housekeeping, etc.</p> <p>Risks:</p> <ul style="list-style-type: none"> <li>-Contractual limitations</li> <li>-Wage theft / time falsification / processing errors</li> <li>-Lack of structured approval processes: Off-cycle payroll runs, Time worked / Unearned overtime, Compensation changes, and Benefit changes</li> <li>-Leave Abuse (hourly employees vs salaried employees)</li> <li>-Ghost Employees</li> <li>-Compliance Lapses / Systemic Errors</li> <li>-Unauthorized System Access / Data Compromise</li> </ul> <p>Controls:</p> <ul style="list-style-type: none"> <li>-Duty Segregation: HR vs Payroll Functions - HR: Employee verification and set-up, comp updates, terms. Payroll: Process pay relative to HR and department time records. System Access should match employee roles.</li> <li>-Formal approvals</li> <li>-HR and Payroll System edits</li> <li>-Contractual review and approval</li> <li>-Account verification</li> <li>-Positive Pay</li> </ul> <p><b>AHIA links:</b></p> <p><a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf</a>  <a href="https://www.youtube.com/watch?v= bm-lCwjEos">https://www.youtube.com/watch?v= bm-lCwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p>
	<p><b>2. Procurement</b></p>
	<p>Focus on purchase of needed goods &amp; services. Lots of unique purchasing activity such as: Consulting, Imaging: e.g., radioisotopes with shelf-life limitations, Medical devices / equipment, Medications / Pharmacy, and Medical Supplies. Bid management, RFP and contract execution. Centralized versus decentralized procurement such as: Imaging, IT, Pharmacy, and Research. Group Purchasing Organizations.</p>

- Risks:
- Purchase authorization
  - Purchase Order (PO) accuracy and completeness
  - Bid rigging
  - Kickbacks
  - Insufficient medical supplies
  - Quantity / Pricing Errors-Payment for goods / services not received

- Controls:
- Budget controls
  - Proper Authorizations
  - Strategic business alliances with suppliers
  - Proper receipting / three-way match
  - Purchase Orders and Contracts
  - Vendor management / Authorized vendor inventory
  - Materials Management Interface

**AHIA links:**

[https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational\\_Financial-Handout\\_12-15-20.pdf](https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf)

<https://www.youtube.com/watch?v= bm-lCwjEos> (AHIA recording of presentation from BOK Webinar slides)

**3. Materials Management**

Focus on maintaining & distributing goods/materials both where and when needed. The patient support supply chain is critical: can't heal / save people with insufficient or inappropriate materials. System-wide, on-site and just-in-time inventory considerations. Optimum Inventory Levels: Par Levels and "Carts." Waste management – Environmental Compliance.

- Risks:
- Theft
  - Insufficient supply: Mismanagement / untimely distribution processes, Errors in purchase / shipped / received, Critical supplier shortages (Rx, etc.), and Not managing drug / supply expirations.
  - Proper quantity identification
  - Proper pricing
  - Quality Control / Inspection

- Controls:
- Policy, procedure and house-wide process focus
  - Inventory management: Cycle counts, par levels, total cost focus

- Supplier agreements / back-up suppliers
- Strategic cost management: linking medical / clinical staff with materials management planning and process.

**AHIA links:**

[https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational\\_Financial-Handout\\_12-15-20.pdf](https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf)

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**4. Foundations**

Fundraising has been and is key to healthcare missions. The healthcare community relationship is key to successful fundraising.

Risks:

- HIPAA Privacy – patient privacy and donor identification
- Poor management / Misappropriation / Theft
- Reputation
- Donor recognition & Tax letters

Controls:

- Policies and Procedures
- Conflict of interest management
- Duty Segregation
- Cash Management
- Reputational awareness

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<https://www.youtube.com/watch?v= bm-lCwjEos> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<http://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html>

**5. Cash Management**

Hospitals are employee intensive organizations = huge payrolls. Decentralized and accountability as cash is often collected in many places under the authority of many: central, clinics, etc.

Risks:

- Misappropriation / theft
- Insufficient cash to cover current expenses
- Cardholder data protection

- Poor controls over cash in clinic settings
- Controls:
- Duty Segregation
  - Effective central and decentralized cash oversight
  - Policies and Procedures, and monitoring for compliance
  - Timely deposit, Reconciliation
  - Physical security

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[https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational\\_Financial-Handout\\_12-15-20.pdf](https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf)  
<https://www.youtube.com/watch?v= bm-lCwjEos> (AHIA recording of presentation from BOK Webinar slides)

**6. Human Resources**

Hospitals are 24HR, 365 DAY Operations with unique employee types such as: physicians, physician assistants, nurse practitioners, nurses, various technical employees, and volunteers. There is an impact on system access with proper identification, timely term notification, etc.

Risks:

- Difficulty recruiting qualified employees
- Employees versus Independent Contractors
- Pay equity challenges
- Various labor compliance matters such as: citizenship validation (I-9), discrimination (Civil Rights), employee protections (EEO, Civil Rights, etc.), Family Medical Leave Act (FMLA), and sexual assault (Civil Rights / Title IX), etc.
- Credentialing & Medicare/Medicaid Exclusion (not typically HR but critical physician hiring processes)
- Productivity

Controls:

- Compensation structure
- Position management
- Current Policies, Procedures and Guidance
- Duty Segregation
- Compliance accountability / monitoring
- IT Access controls
- Performance management structure

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	<p><a href="https://www.youtube.com/watch?v= bm-lCwjEos">https://www.youtube.com/watch?v= bm-lCwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="http://www.uscis.gov/i-9">http://www.uscis.gov/i-9</a>  <a href="https://www2.ed.gov/policy/landing.ihtml?src=pn">https://www2.ed.gov/policy/landing.ihtml?src=pn</a>  <a href="http://www.eeoc.gov/">http://www.eeoc.gov/</a>  <a href="https://www.dol.gov/general/topic/benefits-leave/fmla">https://www.dol.gov/general/topic/benefits-leave/fmla</a></p>
	<p><b>7. Joint Ventures</b></p> <p>Probably not many health systems without some type of joint venture.</p> <p>Key Risks:</p> <ul style="list-style-type: none"> <li>-Contract language: ability to manage / monitor</li> <li>-Compliance Considerations</li> </ul> <p>Key Controls:</p> <ul style="list-style-type: none"> <li>-Contract review</li> <li>-Due diligence</li> </ul> <p><b>AHIA links</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf</a>  <a href="https://www.youtube.com/watch?v= bm-lCwjEos">https://www.youtube.com/watch?v= bm-lCwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p>
	<p><b>8. Finance / Accounting</b></p> <p>Accounting maintains the financial history / reports on financial position of the entity. Finance focuses on financial analysis and the future financial success of the entity.</p> <p>Key Risks:</p> <ul style="list-style-type: none"> <li>-Data integrity: errors and omissions</li> <li>-High days in A/R</li> <li>-Credit risk: with suppliers</li> <li>-Credit risk: accounts receivable (AR)</li> <li>-Management Override / Fraud / Misappropriation</li> <li>-Market Risks / Competition / Ineffective Business Model</li> <li>-Poor budget management</li> <li>-Third party data protection (e.g., Blackbaud Data Compromise)</li> </ul> <p>Key Controls:</p> <ul style="list-style-type: none"> <li>-Segregation of Duties</li> <li>-Data validation:</li> </ul>

	<ul style="list-style-type: none"> <li>--Contract management (Medicare, Medicaid, Insurer)</li> <li>--Focused data integrity functions</li> <li>--Revenue management</li> <li>--System edit controls</li> <li>--Seasonal / trend management</li> <li>-Accounts receivable management</li> <li>-Bond rating management</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf</a>  <a href="https://www.youtube.com/watch?v= bm-ICwjEos">https://www.youtube.com/watch?v= bm-ICwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>9. Contract/Vendor Management</b>	
	<p>There are a large number of contracts with vendors in healthcare. In a number of instances, each and every business relationship with a vendor requires an executed written contract to be agreed upon by both parties. This presents a number of risks related to keeping these contracts and vendor relationships current and accessible.</p> <p>Key Risks:</p> <ul style="list-style-type: none"> <li>-Contracted services are typically not well-monitored</li> <li>-Bid issues / Kickbacks</li> <li>-Owner / Vendor non-compliance</li> </ul> <p>Key Controls:</p> <ul style="list-style-type: none"> <li>-Contract review</li> <li>-Bid controls</li> <li>-Accountability for contract monitoring</li> </ul> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf</a>  <a href="https://www.youtube.com/watch?v= bm-ICwjEos">https://www.youtube.com/watch?v= bm-ICwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p>
<b>10. Business Continuity</b>	
	<p>Emergency Management vs Business Continuity / Resiliency. Community Impact: Hospitals are more than just a business. Emergency management includes planning and infrastructure design to address community medical emergencies (9/11/01). Business continuity / resiliency deals with how well the organization can recover from a disaster (Joplin tornado).</p> <p>Key Risks:</p> <ul style="list-style-type: none"> <li>-Leadership buy-in and resources</li> </ul>

-Once designed / planned: maintaining focus and keeping it current, especially as time passes without disaster

**Key Controls:**

- Business Impact Analysis & Continuity Plan
- Business Continuity Champion / Accountability
- Periodic plan testing, reassessment and update

**AHIA links:**

[https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational\\_Financial-Handout\\_12-15-20.pdf](https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf)

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<https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf>

<https://www.youtube.com/watch?v=jiSK1UYTXrg> (AHIA recording of presentation from BOK Webinar slides)

**11. Research**

Research examples: Human Subjects and Institutional Review Boards, Animals and Institutional Animal Care & Use Committees, Academic Freedom, Organization funded / subsidized research, Federal, State and local government awards / grants and related regulations, Commercially sponsored research, Publication, Publication, Publication, and Intellectual Property & Patents.

**Risks:**

- Complex regulations: If you have research, you likely have compliance gaps. Such as proper grant charging – time and effort reporting, indirect costs, theft.
- Theft of intellectual property
- Scientific integrity such as: conflicts of interest, data falsification, and pressure to publish.
- Academic freedom
- Underfunded research / entity subsidies
- Patent protection / lost royalties
- Human subjects harm / lack of patient/subject consent
- Reputation: human / animal subject harm

**Controls:**

- Focused research compliance function
- Grant support & grant accounting
- Research oversight, review and approval
- Institutional Review Board
- Institutional Animal Care & Use Committees
- Safe research space
- Intellectual property & patent oversight / management

	<p>-Royalty management</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Operational_Financial-Handout_12-15-20.pdf</a>  <a href="https://www.youtube.com/watch?v= bm-lCwjEos">https://www.youtube.com/watch?v= bm-lCwjEos</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="http://www.insidehighered.com/views/2010/12/21/defining-academic-freedom">http://www.insidehighered.com/views/2010/12/21/defining-academic-freedom</a></p>
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**4B - INFORMATION TECHNOLOGY**

<p><b>Summary Description</b></p>	<p><b><u>Revenue Cycle Systems</u></b>  In the Revenue Cycle, clinical systems interact with medical billing IT systems. In turn, information is exchanged with multiple third party systems between clearinghouses, payers (commercial insurance payors, CMS, Medicaid, etc.), statement systems for patients and providers, as well as payment collection vendors. The Healthcare Financial Management Association (HFMA) defines Revenue Cycle as: “All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.” Revenue Cycle represents a patient account from creation until payment for a single encounter or a series of encounters.</p> <p><b><u>Electronic Medical Record and Clinical Systems</u></b>  An Electronic Medical Record (EMR or EHR) system is an electronic version of a patient’s medical history, that is maintained by the care provider over time, and includes key clinical data relevant to that persons care under particular provider(s) including demographics, medical history, progress notes, vital signs, problems, medications, laboratory data, immunizations and radiology reports.</p> <p><b><u>Information Governance</u></b>  Refers to the “leadership, organizational structures and processes to ensure that the organization's IT sustains and extends the organization's strategies and objectives.”</p> <p><b><u>Cybersecurity</u></b>  Information Security is comprised of the People, Processes, &amp; Technology to provide an appropriate level of safeguards (internal controls) to ensure the Confidentiality, Integrity, Availability (CIA) of data stored in databases and unstructured data, information, networks, servers, applications, and related dependent technology services relying on the IT infrastructure and interfaces.</p> <p><b><u>Biomedical Systems</u></b> Many biomedical devices are IT devices that collect patient monitoring data and send over the wireless network to nurses’ central stations and/or to Electronic Health Record.</p>
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**1. Electronic Medical Record Systems**

	<p>An Electronic Medical Record (EMR or EHR) system is an electronic version of a patient’s medical history, that is maintained by the care provider over time, and includes key clinical data relevant to that persons care under particular provider(s) including demographics,</p>
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medical history, progress notes, vital signs, problems, medications, laboratory data, immunizations and radiology reports.

Examples of EMR & EHR Risk Areas:

- Access control risks
- Privacy risks
- Patient safety risks
- IT Operational risks
- IT Business continuity risks

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**2. Revenue Cycle Systems**

In the Revenue Cycle, clinical systems interact with medical billing IT systems. In turn, information is exchanged with multiple third party systems between clearinghouses, payers (commercial insurance payors, CMS, Medicaid, etc.), statement systems for patients and providers, as well as payment collection vendors.

The Healthcare Financial Management Association (HFMA) defines Revenue Cycle as: “All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.” Revenue Cycle represents a patient account from creation until payment for a single encounter or a series of encounters.

- Revenue Cycle IT System Risk Areas:
- Pre- Encounter (Pre-registration, Registration & Intake)
  - Patient Encounter (Clinical/Patient Care)
  - Financial (Charge Capture, Claims & Billing, Payment Processing)

**AHIA links:**

[https://ahia.org/AHIA/media/Certification-Documents/BOK-Webinar\\_Revenue-Cycle-Part-1-Handout\\_1-12-21.pdf](https://ahia.org/AHIA/media/Certification-Documents/BOK-Webinar_Revenue-Cycle-Part-1-Handout_1-12-21.pdf)

<https://www.youtube.com/watch?v=RqfFQqCcE4Q> (AHIA recording of presentation from BOK Webinar slides)

<https://ahia.org/AHIA/media/Certification-Documents/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>

<https://www.youtube.com/watch?v=GgDGLoP1cbA> (AHIA recording of presentation from BOK Webinar slides)

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**3. Information Governance**

IT Governance refers to the “leadership, organizational structures and processes to ensure that the organization's IT sustains and extends the organization's strategies and objectives.”

IT Governance Examples in Healthcare

- Board of Trustees Cybersecurity Committee
- Executive IT Steering Committee
- IT Risk Committee
- Revenue Cycle Steering Committee
- Billing Compliance Oversight Committee
- Information Security Committee
- Privacy & Data Protection Committee
- IT Systems Implementation Project Steering Committees
- Biomedical Device & Bioengineering Oversight Committee
- Compliance Department Activities
- Internal Audit Department Activities

**AHIA links:**

<https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf>

<https://www.youtube.com/watch?v=jiSK1UYTXrg> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

<http://www.isaca.org>

<https://cobitonline.isaca.org/about>

**4. Cybersecurity**

The National Institute of Standards & Technology (NIST) Cybersecurity Framework: Identify, Protect, Detect, Respond, and Recover. Its mission is "to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life." As noted on their website, NIST measurements support the smallest of technologies to the largest and most complex of human-made creations — from nanoscale devices so tiny that tens of thousands can fit on the end of a single human hair up to earthquake-resistant skyscrapers and global communication networks.

**Reference links from slides:**

5 Leading Frameworks:

COBIT 5.0 Framework (ISACA) - <https://cobitonline.isaca.org/about>

Center for Internet Security (CIS) Critical Security Controls (SANS Top 20) - <https://www.cisecurity.org/controls/cis-controls-list/>

National Institute of Standards & Technology (NIST) Cybersecurity Framework - <https://www.nist.gov/cyberframework>

HITRUST - Health Information Trust Alliance - <https://hitrustalliance.net/hitrust-csf/>

ISO 27001 - <https://www.iso.org/isoiec-27001-information-security.html>

**AHIA links:**

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**5. Biomedical Devices**

The Center for Devices and Radiological Health of the U.S. Food and Drug Administration (FDA) defines a medical device as “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar article that is intended for use in the diagnosis of disease or other conditions." Many biomedical devices are IT devices that collect patient monitoring data and send over the wireless network to nurses’ central stations and/or to the Electronic Health Record.

Categorized by FDA into 3 classes:

- I. low to no risk level
- II. Potentially more risk
- III. Potential for adverse outcome

**Risks:**

1. Maintaining accurate biomedical device tracking inventory to prevent and detect theft
2. Accurate preventative maintenance records/scheduling
3. Recalibration of instruments
4. Software updates and patching
5. Wireless security and stability
6. Privacy risks when disposing of biomedical devices
7. Security of biomedical devices

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<https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf>

<https://www.youtube.com/watch?v=jiSK1UYTXrg> AHIA recording of presentation from BOK Webinar slides)

**6. Clinical Systems**

A clinical information system (CIS) is an information system designed specifically for use in the critical care environment, such as in an Intensive Care Unit (ICU). It can network with the many computer systems in a modern hospital, such as pathology and radiology. In the Revenue Cycle, clinical systems interact with medical billing IT systems.

**Consists of:**

Offices & Clinics

	<p>Labor &amp; Delivery  Cardiology  Critical Care  Radiology &amp; Imaging  Emergency Department  Pharmacy  Laboratory</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf">https://ahia.org/AHIA/media/Certificatin-Documents/AHIA-Nov-3-2020-BOK-Webinar-Information-Technology-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=jiSK1UYTXrg">https://www.youtube.com/watch?v=jiSK1UYTXrg</a> <b>(AHIA recording of presentation from BOK Webinar slides)</b></p>
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**4C – COMPLIANCE**

<p><b>Summary Description</b></p>	<p><b>Corporate Compliance / Legal</b>  Corporate compliance is the process of making sure your company, employees, and volunteers follow the laws, regulations, standards, and ethical practices that apply to your organization. Effective corporate compliance will cover both internal policies and rules and federal and state laws. Corporate compliance creates and executes the organization's corporate compliance program relative to its role. Management and all members of the organization are responsible for ensuring that compliance with laws, rules and regulations occurs. Legal Compliance can be narrowly defined to mean the process by which an organization ensures that it observes and complies with the external statutory laws and regulations.</p> <p>Internal Audit provides advice and consultation relative to the compliance program. Internal Audit is responsible for auditing compliance program implementation and evaluating program effectiveness.</p> <p><b>Privacy</b>  The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect your fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy. OCR protects your rights by: Teaching health and social service workers about civil rights laws, conscience and religious freedom laws, health information privacy, and patient safety confidentiality laws. Educating communities about civil rights, conscience and religious freedom rights, and health information privacy rights. Investigating civil rights, conscience and religious freedom, health information privacy, and patient safety confidentiality complaints to identify discrimination or violation of the law and taking action to correct problems.</p> <p><b>Credentialing and Privileging</b>  Hospitals often use the term credentialing to imply a process used to make decisions regarding membership and the granting of privileges. The two terms are, however, quite different. Technically the term credentialing represents the verification of a person's education, training and experience (as in "to verify a person's credentials"). Hospitals often extend the meaning to include evaluation of collected information and making</p>
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a decision to appoint a physician (as in "he has been credentialed as a member of the staff). Privileging is completely different. This term implies that a person has been given permission or "privileges" to engage in specified clinical activities, within well-defined limits, based on the Individual's professional license, competence, experience, ability and judgement, and on organization's ability to provide and support the service. It is important to recognize that the terms membership and privileges are different. Membership means that a person is a member of the medical staff and (within hospitals) can call himself a member, attend meetings, vote if in the active category, and receive all other benefits of such membership. There may also be requirements which go along with membership, such as paying dues, attending patients in the emergency department, etc. Privileges are needed in order to treat patients.

**Accreditation**

Joint Commission accreditation can be earned by many types of health care organizations, including hospitals, doctor's offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services.

**Conflict of Interest**

A conflict of interest occurs when an individual's personal interests – family, friendships, financial, or social factors – could compromise his or her judgment, decisions, or actions in the workplace. Government agencies take conflicts of interest so seriously that they are regulated.

**1. Corporate Compliance / Legal**

Effective corporate compliance will cover both internal policies and rules and federal and state laws. Corporate compliance is the process of making sure your company and employees follow the laws, regulations, standards, and ethical practices that apply to your organization. Effective corporate compliance will cover both internal policies and rules and federal and state laws. Corporate compliance creates and executes the organization's corporate compliance program relative to its role. Management and all members of the organization are responsible for ensuring that compliance with laws, rules and regulations occurs.

Legal Compliance can be narrowly defined to mean the process by which an organization ensures that it observes and complies with the external statutory laws and regulations.

**1st Line of Defense (Sr. Management)**

- Management Controls
- Internal Control Measures

**2nd Line of Defense (Sr. Management)**

- Financial Controls
- Security
- Risk Management
- Quality
- Inspection
- Legal

	<p>-Compliance</p> <p>3rd Line of Defense (Governing Body/Audit Committee)</p> <p>-Internal Audit</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf</a>  <a href="https://www.youtube.com/watch?v=KcK2g1uF0gQ">https://www.youtube.com/watch?v=KcK2g1uF0gQ</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://oig.hhs.gov/compliance/">https://oig.hhs.gov/compliance/</a></p>
	<p><b>2. Privacy</b></p>
	<p>The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect your fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy. OCR protects your rights by:</p> <ul style="list-style-type: none"> <li>-Teaching health and social service workers about civil rights laws, conscience and religious freedom laws, health information privacy, and patient safety confidentiality laws.</li> <li>-Educating communities about civil rights, conscience and religious freedom rights, and health information privacy rights.</li> <li>-Investigating civil rights, conscience and religious freedom, health information privacy, and patient safety confidentiality complaints to identify discrimination or violation of the law and taking action to correct problems.</li> </ul> <p>Privacy rule identifies what is to be protected and outlines the individual’s rights to control access to their Protected Health Information (PHI). Security rule requires Covered Entities (CE) to protect PHI in electronic form. The security rule only applies to PHI maintained or transmitted in electronic form, called ePHI. You can have security without privacy but you cannot have privacy without security.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf</a>  <a href="https://www.youtube.com/watch?v=KcK2g1uF0gQ">https://www.youtube.com/watch?v=KcK2g1uF0gQ</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.hhs.gov/hipaa/index.html">https://www.hhs.gov/hipaa/index.html</a></p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a></p>

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<https://www.youtube.com/watch?v=93lHXl0KdgQ&feature=youtu.be> (AHIA recording of presentation from BOK Webinar slides)  
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<https://www.youtube.com/watch?v=jiSK1UYTXrg> (AHIA recording of presentation from BOK Webinar slides)

**3. Credentialing and Privileging**

Hospitals often use the term credentialing to imply a process used to make decisions regarding membership and the granting of privileges. The two terms are, however, quite different.

Technically the term credentialing represents the verification of a person's education, training and experience (as in "to verify a person's credentials"). Hospitals often extend the meaning to include evaluation of collected information and making a decision to appoint a physician (as in "he has been credentialed as a member of the staff).

Privileging is completely different. This term implies that a person has been given permission or "privileges" to engage in specified clinical activities, within well-defined limits, based on the individual's professional license, competence, experience, ability and judgement, and on organization's ability to provide and support the service.

It is important to recognize that the terms membership and privileges are different. Membership means that a person is a member of the medical staff and (within hospitals) can call himself a member, attend meetings, vote if in the active category, and receive all other benefits of such membership. There may also be requirements which go along with membership, such as paying dues, attending patients in the emergency department, etc. Privileges are needed in order to treat patients.

**AHIA links:**  
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<https://www.youtube.com/watch?v=KcK2g1uF0gQ> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**  
<https://www.cms.gov/>

**4. Accreditation**

Joint Commission accreditation can be earned by many types of health care organizations, including hospitals, doctor's offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services.

**AHIA links:**  
<https://ahia.org/AHIA/media/Certification-Documents/BOK-Webinar-Revenue-Cycle-Part-2-Handout.pdf>  
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	<p><a href="https://www.youtube.com/watch?v=KcK2g1uF0gQ">https://www.youtube.com/watch?v=KcK2g1uF0gQ</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.jointcommission.org/accreditation">https://www.jointcommission.org/accreditation</a></p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf">https://ahia.org/AHIA/media/Certification-Documents/Updated-AHIA-Dec-2,-2020-BOK-Webinar-Regulatory-Environment-Handout.pdf</a>  <a href="https://www.youtube.com/watch?v=iRx8PWFe5hM">https://www.youtube.com/watch?v=iRx8PWFe5hM</a> (AHIA recording of presentation from BOK Webinar slides)  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting">https://ahia.org/AHIA/media/Certification-Documents/AHIA-Nov-10-2020-BOK-Webinar-Business-Aspects-of-Care-Setting</a>  <a href="https://www.youtube.com/watch?v=93IHXI0KdgQ">https://www.youtube.com/watch?v=93IHXI0KdgQ</a> (AHIA recording of presentation from BOK Webinar slides)</p> <p><b>Reference links from slides:</b>  <a href="https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/survey-process-and-survey-activity-guide/2020-allprograms-organization-sag.pdf">https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/survey-process-and-survey-activity-guide/2020-allprograms-organization-sag.pdf</a></p>
	<p><b>5. Conflict of Interest</b></p>
	<p>A conflict of interest occurs when an individual’s personal interests – family, friendships, financial, or social factors – could compromise his or her judgment, decisions, or actions in the workplace. Government agencies take conflicts of interest so seriously that they are regulated.</p> <p><b>AHIA links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-2020-BOK-Webinar-Compliance-Handout_12-9-20.pdf</a>  <a href="https://www.youtube.com/watch?v=KcK2g1uF0gQ">https://www.youtube.com/watch?v=KcK2g1uF0gQ</a></p> <p><b>Reference links from slides:</b>  <a href="https://oag.ca.gov/conflict-interest">https://oag.ca.gov/conflict-interest</a>  <a href="http://www.fppc.ca.gov/learn/conflicts-of-interest-rules.html">http://www.fppc.ca.gov/learn/conflicts-of-interest-rules.html</a>  <a href="https://ori.hhs.gov/education/products/ucla/chapter4/default.htm">https://ori.hhs.gov/education/products/ucla/chapter4/default.htm</a>  <a href="https://oig.hhs.gov/compliance/physician-education/04vendors.asp">https://oig.hhs.gov/compliance/physician-education/04vendors.asp</a></p>
<p><b>4D - ADMINISTRATIVE FUNCTIONS</b></p>	
<p><b>Summary Description</b></p>	<p>Organizational Governance Hospitals have several key governance structures: Traditional Business, Physician Leadership, Nursing Leadership, Academic Leadership if AMC (Academic Medical Center), Local / State Government if Public (City, County, Veterans), and Insurance Commissions for Payers.</p> <p>Key Risks:</p> <ul style="list-style-type: none"> <li>- Lack of formalized governance,</li> <li>- Lack of documented governance direction and policy,</li> <li>- Lack of Board / CEO engagement / oversight, Unaddressed / poor handling of significant adversities,</li> </ul>

- Conflicts of Interest (kickbacks, inappropriate romantic relationships, etc.),
- Executive / Physician Leadership disconnect,
- Uncontrolled rogue physicians, and
- Physician / Nursing Leadership disconnect.

Key Controls: Corporate Bylaws and Policy, Board Structure & Key Committees, Strategic Planning, Planned Meetings, Meeting Minutes, Executive Sessions, Morbidity and Mortality Conference, Conflict of Interest Policy & Implementation, Active Executive, and Physician and Nursing interaction / collaboration.

#### Strategic Planning

Strategic planning in healthcare should address not only competition related objectives but also objectives related to the key components of today's presentation: risk, patient safety and quality. Strategic planning is the responsibility of the CEO and executive leadership. However, every area of the organization can benefit from the process. The organizational units must align with and support organizational strategy. Each executive monitors achievement of strategic objectives related to both their units / areas of responsibility as well as the impact on overall strategy.

Key Risks: Lack of a robust, meaningful strategy development process, Lack of executive and management strategy ownership, Strategic direction leads to failure, all or in part (wrong strategy), Failure to recognize external factors like regulatory change, social change, market change, etc., Inability to build the infrastructure, processes, etc. to properly support strategy achievement (failure to properly execute), Failure to recognize / respond effectively to market / industry disruption and market / industry innovations, and Lack of a strategy.

Key Controls: Formal strategy adoption by the Board, CEO and executives, Defined strategy development and related updates, identification of meaningful strategic objectives, Monitoring of progress against strategic objectives, Monitoring of key factors identified as opportunities and threats.

#### Risk Management

Risk management typically refers to that function in a healthcare setting that addresses patient safety and worker protection risks, and insurable liabilities. The Risk Management function often reports up through the CFO. Risk Management Risks: Patient harm, Ineffective oversight / lack of oversight, Ineffective data collection / reporting across the organization, Staffing expertise, Lack of or ineffective incident reporting, Insufficient education and training, Poor clinical quality control systems, and Poor, insufficient or missing medical record documentation. Risk Management Controls: Centralized risk management, Patient safety, quality and risk management alignment, Applicable policies, procedures, protocols and guidelines, Strong medical record organization / documentation practices, Application of Root Cause Analysis to identified issues, and Insurance.

#### Enterprise Risk Management

ERM is "the culture, capabilities, and practices, integrated with strategy setting and performance, that organizations rely on to manage risk in creating, preserving, and realizing value." ERM Goal: Influence executive decision-making and ideally all key decision-making.

#### Patient Safety and Quality

Patient safety is an important element of an effective, efficient and quality-oriented health care system:

Safety has to do with lack of harm.  
Quality has to do with efficient, effective, purposeful care: right job at the right time.  
Safety focuses on avoiding bad events.  
Quality focuses on doing things well.  
Safety makes it less likely that mistakes happen.  
Quality raises the ceiling so the overall care experience is a better one

### **1. Risk Management**

Risk management typically refers to that function in a healthcare setting that addresses patient safety and worker protection risks, and insurable liabilities. The Risk Management function often reports up through the CFO. Per the American Society for Healthcare Risk Management, risk management focuses on “developing and implementing safe and effective patient care practices, the preservation of financial resources and the maintenance of safe working environments.”

#### Risks:

- Patient harm
- Ineffective oversight / lack of oversight
- Ineffective data collection / reporting across the organization
- Staffing expertise
- Lack of or ineffective incident reporting
- Insufficient education and training
- Poor clinical quality control systems
- Poor, insufficient or missing medical record documentation

#### Controls:

- Centralized risk management: data collection, reporting and education
- Patient safety, quality and risk management alignment
- Applicable policies, procedures, protocols and guidelines
- Strong medical record organization / documentation practices
- Application of Root Cause Analysis to identified issues
- Insurance

#### **AHIA links:**

[https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Administrative-Functions-Handout\\_1-5-21.pdf](https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Administrative-Functions-Handout_1-5-21.pdf)

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<https://www.youtube.com/watch?v=jiSK1UYTXrg> (AHIA recording of presentation from BOK Webinar slides)

	<p><b>SMRP Body of Knowledge PDF:</b> Detailed BOK PDF</p>
	<p><b>2. Enterprise Risk Management</b></p> <p>ERM differs from traditional Risk Management. ERM is “the culture, capabilities, and practices, integrated with strategy setting and performance, that organizations rely on to manage risk in creating, preserving, and realizing value.”</p> <p>Key Components of ERM:</p> <ul style="list-style-type: none"> <li>-Risk Assessment <ul style="list-style-type: none"> <li>--Probability or Likelihood</li> <li>--Severity or Impact</li> </ul> </li> <li>-Inherent versus Residual Risk</li> <li>-Risk Appetite &amp; Risk Tolerance</li> <li>-Risk Response / Risk Action Plan: <ul style="list-style-type: none"> <li>--Optimize Opportunities</li> <li>--Eliminate, Mitigate, Transfer, or Accept Challenges</li> </ul> </li> </ul> <p><b>AHIA Links:</b>  <a href="https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Administrative-Functions-Handout_1-5-21.pdf">https://ahia.org/AHIA/media/Certification-Documents/AHIA-BOK-Webinar-Administrative-Functions-Handout_1-5-21.pdf</a>  <a href="https://www.youtube.com/watch?v=ZRyWVXioFN4">https://www.youtube.com/watch?v=ZRyWVXioFN4</a> <b>(AHIA recording of presentation from BOK Webinar slides)</b></p>
	<p><b>3. Quality</b></p> <p>Per health.gov, “Keeping patients safe in health care settings is fundamental to achieving high-quality health care for all Americans.”</p> <p>Quality Risks - The overall quality risk is harm to patients, which can result from:</p> <ul style="list-style-type: none"> <li>-Patient Safety Risks as noted previously</li> <li>-No formal quality management / oversight</li> <li>-Bad morale</li> <li>-Failure to hold individuals accountable</li> <li>-Poor labeling of materials, meds and patients</li> <li>-Inter-discipline communication breakdown</li> <li>-Lack of or insufficient training and education</li> </ul> <p>Quality Controls:</p> <ul style="list-style-type: none"> <li>-Board Quality Committee</li> <li>-Utilization Review</li> <li>-Root-Cause Analysis Processes</li> </ul>

- Required Education & Training
- Checklists, forms, etc.
- Quality Indicators Tracking & Follow-up

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<https://www.youtube.com/watch?v=ZRyWVXioFN4> (AHIA recording of presentation from BOK Webinar slides)

**Reference links from slides:**

[https://www.hospitalsafetygrade.org/what-is-patient-safety\\_m](https://www.hospitalsafetygrade.org/what-is-patient-safety_m)  
<https://www.ahrq.gov/talkingquality/measures/six-domains.html>

**4. Patient Safety**

Patient safety is an important element of an effective, efficient and quality -oriented health care system. When we talk about patient safety, we're really talking about how hospitals and other health care organizations protect their patients from errors, injuries, accidents, and infections.

**Risks:**

- Clinician Egos
- Clinician Fatigue (overworked doctors, nurses, etc.)-Diagnostic Errors / Alarm Fatigue
- Discharge Errors, Lack of Follow-up, etc.
- Hospital Safety Issues / Acquired Conditions (e.g., Bed Sores, falls, etc.)
- Medication Errors, Lapses, Theft, etc.
- Medical Device / Reprocessing / Sterilization / Cybersecurity Issues
- Electronic Health Record Errors (systemic design errors, data entry errors, etc.)
- Unidentified / Undocumented / Ignored Allergy Alerts
- Super Bugs (COVID)
- Untrained or improperly trained clinician and staff

**Controls:**

- Policy, procedure, protocol & related accountability, measure and follow-up
- Root-cause analysis processes
- Required education & training
- Safety issue reporting processes
- Non-retaliation policy
- Patient Surveys & Hospital Safety Climate Surveys
- Patient Monitoring Processes / Adverse Event Measures

- Pharmacy Verification of Medication Orders
- Patient Discharge: medication reconciliation, patient-centered hospital discharge education, and post discharge continuity checks

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**Reference links from slides:**

[https://www.hospitalsafetygrade.org/what-is-patient-safety\\_m](https://www.hospitalsafetygrade.org/what-is-patient-safety_m)

<http://www.ecri.org/>

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**5. Organizational Governance**

Risks:

- Lack of formalized governance
- Lack of documented governance direction and policy
- Lack of Board / CEO engagement / oversight
- Uncontrolled rogue CEOs or other executives
- Unaddressed / poor handling of significant adversities
- Patient or human subject harm / deaths, IT breach, significant fraud, etc.
- Conflicts of Interest (kickbacks, inappropriate romantic relationships, etc.)
- Executive / Physician Leadership disconnect
- Uncontrolled rogue physicians
- Physician / Nursing Leadership disconnect

Controls:

- Corporate Bylaws and Policy
- Board Structure & Key Committees
- (E.g., Audit, Quality, etc.)
- Strategic Planning
- Planned Meetings
- Meeting Minutes
- Executive Sessions
- Morbidity and Mortality Conference

- Conflict of Interest Policy & Implementation
- Active Executive, Physician and Nursing interaction / collaboration
- Employee Surveys

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**6. Strategic Planning**

Strategic planning in healthcare should address not only competition related objectives but also objectives related to the key components of today's presentation: risk, patient safety and quality. Strategic planning is the responsibility of the CEO and executive leadership.

Risks:

- Lack of a robust, meaningful strategy development process
- Lack of executive and management strategy ownership
- Strategic direction leads to failure, all or in part (wrong strategy)
- Failure to recognize external factors like regulatory change, social change, market change, etc. -Inability to build the infrastructure, processes, etc. to properly support strategy achievement (failure to properly execute)
- Failure to recognize / respond effectively to market / industry disruption and market / industry innovations (e.g. COVID impact)
- Lack of a strategy

Controls:

- Formal strategy adoption by the Board, CEO and executives
- Defined strategy development and related updates
- Identification of meaningful strategic objectives (e.g., application of SMART or other purposeful goal structures)
- Monitoring of progress against strategic objectives
- Monitoring of key factors identified as opportunities and threats

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