most hospitals (and even many health systems) to invest in information systems that can monitor and trend billing data, allowing them to target specific types of bills for denials. It is clear that a good denials management program is a hugely important element in revenue cycle management and can pay significant dividends in the reduction of billing denials.

Denials Management: Fraud and Abuse Issues Related to Billing

Issues of fraud and abuse in billing for services are multifaceted and complex. The Medicare and Medicaid programs want to be sure that they are paying only for the services required and used by their beneficiaries. On an annual basis, the Office of Inspector General (OIG), which is an arm of the Department of Health and Human Services, creates a work plan of what it believes are the biggest areas of fraud and abuse in claims processing. The areas targeted for substantial review in 2013 are summarized in exhibit 5.1.

EXHIBIT 5.1. OFFICE OF INSPECTOR GENERAL WORK PLAN: SELECTED AREAS FOR REVIEW IN BILLING AND CLAIMS PROCESSING, FISCAL YEAR 2013

Area for Review	Action and Intent
Same-Day Readmissions	OIG will review Medicare claims to determine trends in the number of same-day hospital readmission cases. On the basis of prior OIG work, CMS implemented an edit (a special system control) in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. If a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one DRG payment and should combine the original and subsequent stays into a single claim. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100–04, ch. 3, § 40.2.5.) Providers are permitted to override the edit in certain situations. We will test the effectiveness of the edit. This work may also be helpful to CMS in implementing provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). *(OAS; W-00–13–35439; various reviews; expected issue date: FY 2013;* new start; *Affordable Care Act)*

Hospital-Owned Physician Practices Using Provider-Based Status	OIG will determine the impact of hospital-owned physician practices billing Medicare as provider-based physician practices. OIG will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. *(OEI; 04–12–00380; 04–12–00381; expected issue date: FY 2013; work in progress)*
Admissions with Conditions Coded Present on Admission	OIG will review Medicare claims to determine whether specific acute care hospitals are frequently transferring patients with certain diagnoses that were coded as being present when patients were admitted (referred to as "present on admission," POA) to another acute care hospital. Medicare requires acute care hospitals to report on their claims which diagnoses were present when patients were admitted. (Social Security Act, §1886(d)(4)(D), and CMS's *Change Request 5679*, Pub. 100–20, One-Time Notification, Transmittal 289.) *(OAS; W-00–12–35500; various reviews; expected issue date: FY 2013; work in progress)*
Inpatient and Outpatient Payments to Acute Care Hospitals	OIG will review Medicare payments to hospitals to determine compliance with selected billing requirements. Results of these reviews will be used to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations, and inspections have identified areas at risk for noncompliance with Medicare billing requirements. Using computer matching and data mining techniques, OIG will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same techniques, OIG will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. OIG will then review the hospitals' policies and procedures to compare the compliance practices

	of these two groups of hospitals. OIG will also survey or interview hospitals' leadership and compliance officers to provide contextual information related to hospitals' compliance programs. *(OAS; W-00–11–35538; W-00–12–35538; various reviews; expected issue date: FY 2013; work in progress)*
Inpatient Outlier Payments: Trends and Hospital Characteristics	OIG will review hospital inpatient outlier payments, examine trends of outlier payments nationally, and identify characteristics of hospitals with high or increasing rates of outlier payments. Medicare typically reimburses hospitals for inpatient services based on a predetermined per-discharge amount, regardless of the actual costs incurred. Medicare pays hospitals supplemental payments, called outlier payments, for patients incurring extraordinarily high costs. (Social Security Act, §1886(d)(5)(A)(ii).) In 2009, outlier payments represented about 5 percent of total Medicare inpatient payments, or about $6 billion per year. Recent whistleblower lawsuits have resulted in millions of dollars in settlements from hospitals charged with inflating Medicare claims to qualify for outlier payments. *(OEI; 06–10–00520; expected issue date: FY 2013; work in progress)*

It is pretty obvious that the government is serious about fraud and abuse in billing. The table is not comprehensive, and some of the areas listed are given more weight than others. It is not known which of these areas is considered most heavily weighted, but some supposition can be gleaned from the OIG's work in the recent past and the probability of a greater monetary return for the government (Gardner 1998). Since the appearance of Gardner's article, the OIG has continued to bring charges against many health care providers and contractors. In fact, on February 11, 2013, Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius released a new report showing that for every dollar spent on health care-related fraud and abuse investigations in the previous three years, the government recovered $7.90. This is the highest three-year average return on investment in the sixteen-year history of the Health Care Fraud and Abuse (HCFAC) Program.

The government's health care fraud prevention and enforcement efforts recovered a record $4.2 billion in taxpayer dollars in FY 2012, up from nearly $4.1 billion in FY 2011, from individuals and companies who attempted

- Employee satisfaction from the capacity of technology to help clinicians (nurses, technicians, therapists) record their observations (charting) into the clinical systems and have immediate access to their notes and those of others in a format that enhances good clinical decision making
- Clinical data access for all levels of management; in addition to access by the actual caregivers, new clinical technologies allow RHMC management and administration to access summarized and detailed clinical information for the purpose of improving the quality of care being performed as well as reducing costs, where appropriate

RHMC is currently in the process of implementing an enterprise-wide electronic medical records system at both the hospital and its various physician office practices and clinic sites. Also, as will be seen later in this chapter, many projected financial implications for clinical application are favorable as well.

Integrating Data and Reporting to Support Enhanced Decision Making

The second IT strategic initiative—integrating data and reporting to support enhanced decision making—is extremely important to the organization. Without effective reporting and analysis systems, it is not easy for administrators to maintain proper control over their managers or for managers to gain a proper understanding of their department's operations.

Turning data into useful information is critical to the financial and clinical health of RHMC. Several areas of decision support allow managers to optimize the resources of their departments at all times; anything less than this type of commitment leads to inefficiency, ineffectiveness, and inappropriateness.

Effective Decision Support System Tools and Techniques Needed by the Health Care Organization

- Daily administrative and management dashboards on the computer desktop
- Monthly balanced scorecard of financial, clinical, quality, and satisfaction indicators (metrics)
- Benchmarking
- Flexible budgeting and monitoring
- Labor management
- Nonlabor management
- Service line, physician, and patient-level reporting and analysis

- Cost accounting technology
- Contract management technology
- Denials management software (Berger 2007, 63)

RHMC has, in fact, performed due diligence in this area and has selected the top-of-the-line business intelligence system, giving it all of the tools enumerated above as well as the easiest to use end-user interface in the industry. Without a very clean GUI (graphical user interface) the end-user (often referred to as the clinical and operating department manager) is unable to easily access the data to turn it into useful and excellent information. RHMC leadership is pleased to know that several of its competitors have selected systems with much poorer GUIs. Because of this, those competitors will not be able to recognize and understand their outcomes as effectively, giving RHMC the advantage.

Maximizing the IT Infrastructure and Delivery Capabilities

RMHC made a great commitment to improving its infrastructure and delivery capabilities, first during Y2K upgrades thirteen years ago and again over the past one to two years, as part of bringing its infrastructure capabilities up to the current year's state of the art. Thus, over these thirteen years, additional capital was allocated to upgrading the IT capabilities so that the organization could remain competitive with its peers and meet its IT plans. Still, this is an area that is never finished. As technology gets increasingly faster, smaller, and more reliable, the organization's technology infrastructure has to be continually upgraded.

HIPAA Implementation Issues

While contemplating continued IT spending for all these items, RHMC is reminded of the costs it faced to implement a variety of new systems, both computerized and administrative, to comply with the Health Insurance Portability and Accountability Act (HIPAA). Many parts of the legislation directly affect health care providers, payers, and a variety of vendors with which they do business.

The federal law has five parts:

Title I: Health Insurance Access, Portability, and Renewal

Title II: Preventing Health Care Fraud and Abuse, and Administrative Simplification

Title III: Tax-Related Provisions