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How to Battle Coding Denial Trends

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Check Yourself

Internal revenue cycle audits gain importance

By Mary Butler

How to Battle Coding Denial Trends

Creating a proactive appeal strategy

By Malissa Powers, BS, RHIT, CCS, CICA, and Sabrena Gregrich, MBA, RHIA, CHPS, CPEHR

IFHIMA Prepares for 19th Congress as Health Information Goes Global and Digital

By Lorraine Fernandes, RHIA; Kerryn Butler Henderson, PhD; Carol Lewis, MPH, RHIA; Marci MacDonald, CHIM; Margaret Skurka, MS, RHIA, CCS, FAHIMA; Hussein AlBishi; and Kylie Axford

As healthcare moves toward value-based reimbursement, provider organizations are experiencing a new level of complexity in coding denial trends, which requires effective strategies for managing denials and appeals.
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#### Tips for Improving Payer Audit Management

Millions of records are requested annually for payer reviews. As the workload and costs climb, new best practices have emerged.

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  There's a right way and a wrong way to audit your revenue cycle—take it from the experts.

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  Facilitated by AHIMA subject matter experts, Documentation Detective’s monthly posts discuss components of quality clinical documentation and CDI.
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President's Message

Running Toward AHIMA’s Mission, Vision, Values, and Long-Term Strategy

By Valerie Watzlaf, PhD, MPH, RHIA, FAHIMA

THE PROCESS FOR preparing to run a marathon is similar to that of building strategy. Both begin with asking a seemingly simple question: “Why?” We may decide to run a marathon for personal achievement, to support charity, or to assist in a specific community initiative. When taking on such a commitment, it’s important to understand our motivations.

The AHIMA Board of Directors and association staff, under the facilitation of the THRUUE consulting group, convened in January to begin work on AHIMA’s new mission, vision, and values, along with our direction for long-term strategy. While building the mission statement, the AHIMA Board continued to ask important questions to guide us through the process, such as “Why is AHIMA here?” and “What would happen if AHIMA did not exist?” Continuing to ask “why” helped to define and clarify AHIMA’s purpose.

When preparing for this strategy session, the AHIMA Board of Directors examined large amounts of data from focus groups, interviews, and surveys of our members, stakeholders, and industry experts starting in July 2018 to the present. Re-examining the past helped us to re-energize and newly imagine our future.

The importance of the mission and vision of an organization—and defining and understanding why it matters—is key to effectively guiding strategy and providing direction. Understanding this also improves our ability to communicate our role in the industry. Great mission and vision statements of other organizations in healthcare and beyond were examined by the group. The mission needed to be clear, concise, memorable, fearless, and bold. It was important to remember that no one piece of what we were developing should stand alone, but that all parts must be presented in concert for better clarity.

Next, we formed three break-out groups to write drafts of the mission statement, which were then presented to our larger group and discussed in more detail. We then brainstormed on vision, which focuses on looking toward the future. For this step in the process, we examined types of vision, visioning questions, and trends in the industry that are important to note as we move into our future. There were many trends that emerged in our discussion, such as artificial intelligence, precision medicine, consumer-driven care, cybersecurity, and more.

We were told to constantly push ourselves to “imagine the unimaginable” as far as the role that information will play in our future world. The AHIMA proposed values tended to pop out as we discussed these areas. All of this information has been given to the AHIMA staff and THRUUE consulting group. We will meet again in March to further discuss and assist in the development of a strategic plan that will encompass our long-term strategy from 2020 to 2023. We will also continue to solicit member input. Be ready—your voice is invaluable.

It takes preparation, dedication, education, and training to run a great marathon—and the same can be said for building a great mission, vision, values, and long-term strategy for AHIMA. Once completed, they both provide a true sense of accomplishment, direction for achievement, and motivation for the future—well worth the effort!

Valerie Watzlaf (Valerie.watzlaf@ahima.org) is vice chair and associate professor of the HIM department at the University of Pittsburgh.
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HIM Reimagined (HIMR) initiative to build a framework for health information management (HIM) transformation and to position professionals for the future, the Council for Excellence in Education (CEE) Curricula Workgroup has developed and released the 2018 AHIMA Health Information Management Curricula Competencies. The new curricula competencies, developed following analysis of a draft open comment period in 2018, addresses the HIMR recommendation to “increase the opportunities for specialization across all levels of the HIM academic spectrum through curricula revision, while retaining a broad foundation in HIM and analytics.”

Full details on the updated HIM Curricula Competencies, which are used by Commission on Accreditation for Health Informatics and Information Management Educators (CAHIIM)-accredited HIM educators to structure educational programs, can be found at www.ahima.org/education/academic-affairs/academic-curricula.

As part of the new competencies, the associate’s-level degree has been revamped with a specialty track requirement added to all future degrees. Associate’s degree-level educational programs can choose one or both specialty tracks to offer students, which include Data Management and Revenue Management—skills that were identified in a 2016 survey of healthcare employers to be required of HIM professionals in the next five to 10 years. This change will better position HIM professionals graduating with associate’s degrees in the workforce, according to a statement from the CEE published in AHIMA’s Academic Advisor newsletter. “The transition to associate degree tracks will allow the technical HIM professional level to be specialized, bringing awareness to employers that associate degree-educated HIM professionals have a deep knowledge in a specific area of HIM practice grounded by a solid foundation of knowledge and skills that all HIM professionals possess,” the statement

HHS Cybersecurity Guidelines Overlook Mobile Phishing Attacks

At the end of 2018, the US Department of Health and Human Services (HHS) released a guide to public-private cyberattack prevention strategies. However, the document—“Health Industry Cybersecurity Practices (HICP): Managing Threats and Protecting Patients”—doesn’t go far enough in addressing the threat of cyberattacks on mobile devices brought in by patients, according to one expert.

The report, released by HHS and the Healthcare and Public Health Sector Coordinating Councils, is organized around 10 of the most efficient technical cybersecurity practices: email protection systems, endpoint protection systems, access management, data protection and loss prevention, asset management, network management, vulnerability management, incident response, medical device security, and cybersecurity policies. The document was written in response to a requirement in the Cybersecurity Act of 2015, according to an HHS press release.

But Bob Stevens, vice president of federal systems for the mobile security research and advisory firm Lookout, said the report is far too focused on desktop and laptop devices. In an interview with Health Data Management, Stevens points out that the report fails to address deadly phishing attacks that exclusively target mobile devices.

Stevens claims that hackers can easily manipulate patients and the contacts on their phone by leveraging the high stress situation of a hospital visit. He said hackers could send text messages to individuals who have a friend or family member in the hospital, and 99 percent of those targeted individuals will open the message out of concern, which allows malware to infect their device.

“Mobile is different from desktops; a hacker can steal a mobile user’s two-factor authentication and log-in credentials, and medical records, turn speakers and cameras on and off, or listen to a conversation,” Stevens said.

Survey: Doctors Unsure on Data Analytics Benefits

A new survey shows that the “Physician Misery Index” is rising, in part due to burnout from electronic health record system demands and a lack of faith in data analytics tools to help improve care. Healthcare analytics solutions company Geneia surveyed 300 physicians to create the index. The report found that 86 percent “agree” and 51 percent “strongly agree” that “the heightened demand for data reporting to support quality metrics and the business-side of healthcare has diminished my joy in practicing medicine,” according to an article on the study in Healthcare Informatics. Doctors were mixed on whether data analytics tools brought value to their practice, with 57 percent saying the introduction of the tools has brought positive and negative developments. Eighty percent of physicians said they are at risk of burnout, with 96 percent saying the amount of time they spend on data input and reporting has increased in the last 10 years.
New Report Finds Internet of Things Security Lacking

Roughly half of companies that use Internet of Things (IoT) devices in the workplace lack any mechanism to detect whether the devices have been hacked, according to a report from security company Gemalto. Despite the proliferation of IoT devices and technologies, companies continue to spend comparatively small amounts of their budgets on IoT security, at 15 percent. And although 62 percent of users believe that IoT security needs to improve, according to Fast Company, only 14 percent of companies that responded to Gemalto’s survey reported that they viewed IoT security as an ethical responsibility.

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IN BRIEF

Long-time US Senator Lamar Alexander (R-Tenn), chairman of the influential Senate Health, Education, Labor and Pensions Committee, announced he will not seek re-election in 2020.

Walgreens and Microsoft announced a new partnership that will combine the software company’s cloud and artificial intelligence (AI) platform with Walgreens’ outpatient healthcare and retail services in order to build new solutions that leverage health information and data science.

Researchers at University of Chicago Medicine found that using new electronic “nudges” in the electronic health record to schedule vitals recordings and medications instead of routinely waking up patients led to less inpatient sleep deprivation.

Though the Centers for Medicare and Medicaid Services has started reimbursing healthcare providers for certain virtual care visits regardless of the patient’s location, a survey by Reaction Data found 67 percent of 283 physicians and health IT leaders were not aware of the expanded benefit.

The three most common risks found during HIPAA risk analyses using IRM|Analysis software were user authentication deficiencies, endpoint leakage, and excessive user permissions, according to a study done by Clearwater Compliance.

AHIMA CEO Wylecia Wiggs Harris was named one of the “30 Leading HIT Experts to Watch in 2019” by Health Data Management.

Showing advancement in the use of AI, a new study published in The Lancet found deep-learning algorithms were able to accurately identify nine different abnormalities in CT head scans.

The Anonymous-linked hacker who was found guilty of carrying out a cyberattack on Boston Children’s Hospital was recently sentenced to 10 years in prison.
ONC Report Identifies Barriers to Healthcare Interoperability

There are six main barriers to achieving effective interoperability for US healthcare providers through the electronic exchange of their health information, according to a Congressional report from the Office of the National Coordinator for Health IT (ONC).

The Department of Health and Human Services (HHS) is “committed to maximizing the promise of health information technology (health IT) as a critical component in our efforts to accelerate value-based transformation in health care,” according to the 2018 report, which is required by Congress annually to track ONC’s progress on issues. “HHS is committed to the use of health IT to support the free flow of health information for patients, health care providers, and payers.” The report also notes that improved data flow will help to address a range of national health priorities, such as the opioid epidemic.

The six barriers to interoperability identified in the report are:
1. Technical barriers
2. Financial barriers
3. Trust barriers
4. Administrative requirements
5. Reporting requirements
6. IT usability

As interoperability continues to pose challenges to the industry, providers are electronically exchanging more information than ever. A recent Data Brief from ONC found that 78 percent of hospitals use more than one method to routinely send summary of care records electronically, compared to 61 percent of providers that regularly receive them electronically. The brief also reports that while health data exchange rates were high in 2017, small, rural, and critical access hospitals continue to lag behind.

Health IT Executives Feel Unprepared for Value-Based Care Shift

As private and government payers continue their march toward value-based care (VBC), providers are worried they won’t have the technical systems in place to provide it, according to a new survey conducted by Health Data Management (HDM). The survey of provider organizations’ IT executives found that while the majority believe VBC is “a requirement for their future survival,” only half said they are ready for VBC’s successful adoption. “That lack of preparedness comes despite the fact that nearly three out of four respondents who participated in the study believe that the ability to effectively deliver value-based care will be either very important or extremely important to the viability of their organizations. The contrasting data points serve as a powerful reminder of the technological commitment required to adopt VBC,” according to a HDM article.

Of the 160 responses, only 42 percent said their organizations are “only somewhat effective in providing VBC.” Barriers in the VBC transition were identified as both technological and cultural. While fee-for-service contracts pay providers based on the volume of services rendered, VBC pays based on the quality of care provided and patient outcomes. Achieving VBC relies on increased use of data analytics, accessible patient records, and a revamped culture that focuses on proactive treatment of patients, HDM reported. The overall lack of health IT interoperability in healthcare is another barrier for providers, the article noted, as is the ability to effectively use data—53 percent said data use was either very or extremely challenging.
Reports: ONC Must Help Standardize Patient ID Methods

The Government Accountability Office (GAO) and the Pew Charitable Trusts both released reports on the current status and future recommendations of patient identity matching. At press time, health IT stakeholders are anxiously awaiting the Office of the National Coordinator for Health IT’s (ONC’s) Trusted Exchange Framework and Common Agreement (TEFCA) guidance—the release of which stalled due to the early 2019 government shutdown. TEFCA is expected to address patient matching.

The GAO’s report, “Approaches and Challenges to Electronically Matching Patients’ Records across Providers,” offers takeaways based on interviews with stakeholders, a review of vendors, and a review of existing ONC documents.

“Stakeholders’ views varied on the roles ONC and others should play in these efforts and the extent to which the efforts would improve matching. For example, some said that ONC could require demographic data standards as part of its responsibility for certifying EHR systems, while other stakeholders said that ONC could facilitate the voluntary adoption of such standards...” the GAO authors wrote.

The Pew Charitable Trusts agreed with the GAO’s findings in the article “GAO Highlights Need to Better Match Patient Records,” and strongly urged ONC to take the lead in developing and implementing standards and promoting new technology.

“Many participants noted they already use fingerprints or facial scans to unlock smartphones and move through security checkpoints at airports. Given the increasing prevalence of these technologies, people recognize the potential of biometrics to assist with record matches, especially when patients may be unconscious or unable to identify themselves,” wrote Ben Moscovitch, Pew’s health IT project director.

OIG: Security Weaknesses Permeate Department of Defense Health Systems

Medical records stored by systems in the US Department of Defense (DoD) remain vulnerable to cybersecurity attacks, according to a DoD Office of Inspector General (OIG) report.

The Department of Defense Health Agency (DHA) needs to continue focusing on managing cybersecurity risks related to governance, asset management, information protection processes and procedures, identity management and access control, security continuous monitoring, detection processes, and communications, the OIG noted in its January report. Army officials failed to implement security protocols to protect systems that stored, processed, and transmitted electronic health record (EHR) and patient health information. Specifically, DHA and Army officials did not enforce the use of Common Access Cards (CACs) to access the three DoD EHR systems and two Army-specific systems because system administrators stated that the CAC software was incompatible with older system software or did not allow multiple users to log in and out of the systems without rebooting local terminals. Nor did it comply with DoD password complexity requirements for the Clinical Information System/Essentris Inpatient System (Essentris) and two Army-specific systems because system administrators considered existing network authentication requirements sufficient to control access.

The report stated: “The DoD must... ensure that cybersecurity risks are effectively managed to safeguard its reliance on cyberspace to support its operations and... improve the overall cybersecurity.”

Tools

NEW PHYSICIAN SERVICE REIMBURSEMENT BOOK RELEASED
https://my.ahima.org/store/product?id=65591

The new AHIMA Press book Procedural Coding and Reimbursement for Physician Services: Applying Current Procedural Terminology and HCPCS, 2019 introduces the basic principles and conventions of CPT and HCPCS coding while delivering the experience-based knowledge needed to code confidently and efficiently. The book features an expanded test bank with more than 80 case-based coding scenarios for readers to apply coding knowledge and skills.

2019 INTEROPERABILITY STANDARDS OFFER INDUSTRY DIRECTION

The Office of the National Coordinator for Health IT (ONC) has released the 2019 reference edition of its interoperability standards advisory. The advisory serves as ONC’s official direction to the healthcare industry regarding standards development, and provides a “snapshot” view of recommended interoperability standards. New updates include added standards and characteristics, as well as a call for better interoperability in e-prescribing.

ONC’S ANNUAL CONGRESSIONAL REPORT DETAILS DATA EXCHANGE FLAWS

ONC’s annual report to the US Congress delivered at the end of 2018 states that while progress has been made in getting providers to adopt health IT systems—96 percent of non-federal acute care hospitals and 78 percent of office-based physicians adopted certified health IT, ONC reported—work still remains in getting providers to share that information with patients, payers, and other providers. The problem has led to electronic health information failing to meet potential, the report says.
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Inside Look

Keeping Our Eye on the Revenue Cycle Ball

BY WYLECIA WIGGS HARRIS, PhD, CAE, CHPS, CICA, CPEHR

HOW WOULD YOU spend $262 billion? It’s an eye-popping number, but according to a 2017 report by Change Healthcare, that’s how much in claims are initially denied every year due to insufficient clinical documentation. The report also says that denials totaling $28 billion are directly linked to a lack of clinical documentation.1

These statistics—as well as the complexities of a value-based reimbursement environment and a host of other changes happening in healthcare—are one reason why HIM professionals need to have their eye on the revenue cycle ball.

The stakes are high. Our organizations need to maintain healthy revenue cycle processes to stay in business and to provide care. And for patients, billing and insurance are perennial pain points. As an industry, we have a long way to go toward solving our own problems—as the figures above demonstrate. But as HIM professionals we have the tools, skills, and abilities to make progress.

The articles in this month’s Journal of AHIMA reflect the importance of becoming experts in your own internal processes and audits—to be ready for the certain challenges ahead. In “Check Yourself,” Mary Butler consults with HIM professionals on internal audit best practices and what to do when creating an internal audit program that covers the entire revenue cycle. Butler notes, “As external quality, billing, and coding audits continue to increase from payers and regulators, such as Medicare’s Recovery Audit Contractors, the need for a thorough internal audit program has never been greater for healthcare providers.” Because of their clinical documentation and billing expertise, HIM professionals should be leading these audits, Butler notes.

Coding denials are creating new levels of complexity in the process. As denials increase, the best strategy is a proactive one, writes Malissa Powers, BS, RHIT, CCS, CICA, and Sabrena Gregrich, MBA, RHIA, CHPS, CPEHR, in “How to Battle Coding Denial Trends.” They recommend best practices to address denials, including working in a multidisciplinary and collaborative fashion with all stakeholders, building awareness and training, crafting an appeal strategy, and using a skeptical eye. “Do not assume that a denial is correct,” they write.

The stakes are high. Our organizations need to maintain healthy revenue cycle processes to stay in business and to provide care.

AHIMA offers a number of training tools to help HIM professionals showcase their expertise in revenue cycle management, including a revenue cycle trainer virtual workshop that prepares students to train others in best practices in this area. By honing our knowledge and training others, we can ensure that HIM best practices and interdisciplinary collaboration thrive… as well as our bottom lines.

Note

Check YOURSELF
INTERNAL REVENUE CYCLE AUDITS GAIN IMPORTANCE

By Mary Butler

BEING TOLD “THERE’S going to be an audit” triggers a fight or flight reaction of sorts. Visions of G-men in suits and ties, ominously wielding briefcases and calculators, spring to mind before the bearer of the bad news can clarify the context or minimize the impact. Health information management (HIM) leaders must keep this in mind when they tell their staff a revenue cycle audit is in their future.

When Tammy Ree, RHIT, CCS-P, PCS, CHC, CPC, senior HIM consultant at UASI, worked as an external HIM auditor, it was corporate policy not to use the word “audit” when they went on-site. Instead, they simply said they were doing a “review and assessment” to counter the defensiveness that kicks in at the onset of an audit.

“If I were to come in automatically in a power suit saying ‘We’re here to audit you,’ who’s going to open their door to me? Would you? But if I came in wearing a sweater and a skirt and say ‘I’m here to assess and review and to provide education,’ do you think you’d be more open?” Ree says.

Yet, providers would be foolish not to interrogate the processes and procedures that feed into the revenue cycle. According to a 2017 Change Healthcare report, more than $262 billion in claims are initially denied every year due to insufficient clinical information.1 What’s more, denials totaling $28 billion were directly linked to a lack of clinical documentation, according to the report. Appealing denials is not without its own costs, either. The success rate for claim denial appeals dropped from a median of 56 percent to 45 percent for private payers, and from 51 percent to 41 percent for Medicaid in the past two years, according to an American Hospital Association study.2 This shows that its best to be proactive with internal audits in order to head off denials before the bill goes out the door.

Touching nearly every aspect of a healthcare operation, a revenue cycle’s audit program likely would include checks on authorizations and referrals, insurance verification and assignment, charging, coding, claims submission, accounts receivable, write-offs, payments and adjustments, and other areas. Audits help identify where education is needed among staff and helps HIM professionals get ahead of the curve on things that external auditors are looking for. The goal is to have fewer disputes and appeals to deal with on the back end and get out in front of external audits—the internal audits are done to help find gaps and holes in the revenue cycle. As external quality, billing, and coding audits continue to increase from payers and regulators, such as Medicare’s Recovery Audit Contractors (RACs), the need for a thorough internal audit program has never been greater for healthcare providers. The revenue cycle needs to be operating efficiently if an organization wants to ensure its financial viability. An audit should examine nearly every aspect of a healthcare operation, both before a claim is dropped and retrospectively, experts recommend.

Self-audits “can also help reduce fraud and other improper payments, improve patient care, lessen chances of an outside audit, and create a robust culture of compliance,” notes Stacy Upton, RHIT, CCS, quality assurance manager at TrustHCS.

She adds that because ICD-10-CM/PCS and CPT, including evaluation and management, coding is always evolving it can be difficult to stay current on all the guidelines and Coding Clinic publications—plus, coding professionals routinely indicate a lack of time to stay on top of guidelines due to productivity demands and because of time spent on discharge not final billed (DNFB) accounts. Audits don’t just protect revenue, they also can pinpoint problems in an electronic health record (EHR), encourage strong communication between coding and clinical documentation improvement (CDI) staff, and inform the development of internal processes and procedures to ensure accurate and consistent coding.

Due to their clinical documentation and billing expertise, HIM professionals are ideal candidates to lead these wide-reaching revenue cycle audits. They know best which charts to reach for an audit and have the best sense of which DRGs, CCs, and MCCs result in the most denials. HIM also understands how errors at the start of an encounter at the registration desk can trickle down into the clinical documents and, eventually, the bill.

Internal audits don’t stop within the HIM department, but should be conducted throughout the entire revenue cycle. Areas of the revenue cycle that should be audited internally include coding and claims submission, CDI processes (review to ensure documentation is at the highest quality level to support claims), overall data quality and integrity (start with how many duplicates there are in the master patient index since this affects everything in the record downstream), and document management and release of information (anything feeding into the EHR needs to have its documentation quality checked).

This article checks in with HIM auditing experts on internal audit best practices before and after a bill goes out the door, the role of CDI and data analytics, aspects of a strong audit program, and how to get team members on board.

Coding as the First Line of Defense
As much as it might seem obvious, the best way for a provider to protect itself from denials and ensure its compliance with regulations is to audit its coding practices.

Felisha Bochantin, MS, CPC, CPCH, CPC-I, a population
health analyst at 3M who has also worked extensively as a coder and coding auditor, says she still sees far too many coding mistakes, either due to bad habits, out of date coding software, or a lack of ICD-10 training.

"From a training perspective I’m not sure the totality of the industry got what they needed. I’ve done some post-payment audits recently and I’ve seen a lot of codes that were miscoded based on documentation in the medical record—a lot of retrospective payment data that’s less than desirable," Bochantin says. “They’re not capitalizing on money that’s on the table because they’re either not able to decipher what’s in the medical record, or they’re not able to decipher or extrapolate that data into working measures. So I think training is always key.”

Bochantin says that progressive, proactive providers ask themselves whether they have weaknesses in AP-DRG and MS-DRG coding, or codes that are crucial to value-based care. Or, for example, they know they need to take a closer look at charts for every patient with septicemia in order to drill down into every payer classification to see if it was coded appropriately—reviewing the secondary and tertiary diagnoses and whether they were coded accurately.

Of course, close collaboration between coding departments and CDI teams is one of the best ways a provider can help ensure their coding is up to snuff.

“When I first started working 28 years ago, the revenue cycle started at the point of scheduling. Now it really starts at the point of care when the patient walks in the door and the provider starts charging for all that they’re doing for them,” Ree says. “What I see CDI as is the body of people that help support medical necessity and that gets the detail into the record so we can code it accurately for appropriate payment.”

For years, physicians have been underpaid for services they’re providing because they don’t write it all down, Ree says. CDI is a key part of changing that. “The downside that I see consistently across the board is that CDI and coding [staff] do not talk to each other,” Ree says. “What I’ve seen work really well is when CDI and coding meet, however frequently they need to, to talk through some of the difficult issues, to talk through some of the DRG issues, to talk through medical necessity in relation to the coding process versus the medical process.”

Communication between coding and CDI teams doesn’t just need to be face-to-face—some facilities are forging effective communication by having coding and CDI communicate through a shared software platform. That’s one element of the process Rochester Regional Health used when it implemented a process improvement program focused on decreasing payer denials for five key diagnosis codes—sepsis, acute respiratory failure, encephalopathy, acute kidney injury, and malnutrition.

The process at Rochester was led by Judy Kelly, MS, RHIA, CCS, CCS-P, CHDA, CPHI, senior director of HIM; Karen Linder, BS, RHIA, CCS, CCS-P, CHDA, coding director; and Kalena Britt, BSN, RN, CCM, CCDS, director of CDI—all of whom were acting in response to their facility’s chief financial officer who wanted answers as to why the health system was seeing so many denials. In addition to RAC audits, commercial payers had begun aggressive chart audits leading to an increase in denials. And whereas RAC audits limited the number of charts they requested and the DRGs they looked at, commercial payer audits were much broader and engaged in “unfettered denials activity.” Judy Kelly says. The coding and CDI teams knew it would be too difficult to study every denial and the reasons for it, so they selected inpatient diagnoses that had the highest financial impact and worked to reverse the tide.

Their process for tackling denials was multi-pronged and included forming an interdisciplinary team, reassessing all of their payer contracts, standardizing the denial tracking process, implementing software to raise awareness of internal red flags; and retraining mailroom, business office, and HIM staff to prevent missed deadlines and communications with payers.

Judy Kelly says that when she, Linder, and Britt started their denials management program, they thought the core problem was coding. In actuality, they ultimately realized it wasn’t just coding—it was about validating the codes with a “supercharged” CDI team. When they looked back at their denials, claims weren’t denied because they were coded incorrectly, they were being denied because there wasn’t enough clinical documentation to support the diagnosis. This led to much closer collaboration between coding teams and CDI teams.

The two teams met frequently to discuss process flow maps, physician performance, DRG mismatch trends, denial trends and case examples, and opportunities to provide service line training to the hospital departments affected by the new focus on the five diagnosis codes. They utilized health system consensus clinical criteria that was developed by the physician advisor team about what needed to be documented for validation of each of the five diagnosis codes. The CDI team began writing clinical validation queries to physicians—a step physicians hadn’t seen before. CDI and coding teams created notes on a shared software platform so that coding and CDI teams could interact on cases and determine when diagnoses were clinically valid.

“I went through many of our facilities and talked about the consensus criteria we use for those five big diagnoses, what a clinical validation query was. I emphasized that we’re not questioning their judgement, we just need what’s in their [doctors’] brains to be put on paper because we’re getting a lot of denials based on those diagnoses,” Britt explains.

The shared software program does an excellent job of showing, from the coding team’s perspective, what the CDI team is doing on the clinical validation side, according to Rochester staff. It provides the sense that all parties are closing the feedback loop.

“We still have coding audits for stated purposes. But I guess I’ll say once again this is well beyond coding,” Judy Kelly says. “Even when I have a coding audit, it’s going to be by a person with a coding background usually, maybe a nurse, but they can only code what’s in the record.”

Auditing the Whole Cycle

How a chart is coded and documented is the part of the billing
process that brings in reimbursement, but money can be lost at many parts of a patient’s encounter, including registration, which encompasses validating a patient’s identity and their insurance information.

“I think it’s good to have an overall process review,” Ree says. “Just to have someone come in and work through your entire revenue cycle to see if there’s any breakdowns in communications or policies or procedures that may or may not exist. That means making sure that the insurance is entered correctly, which sometimes doesn’t get done and you’re essentially giving away free services.”

Even if a HIM director doesn’t directly oversee the registration or billing areas, they can still collaborate with other leaders to shepherd an end-to-end audit along from a project management perspective. A good audit also includes checking for coding accuracy, physician documentation, and checking to see that the chargemaster has been set up correctly. Internal audits can also use the US Department of Health and Human Services’ Office of Inspector General (OIG) work plan to guide their focus. The OIG work plan can offer clues about which data sets Medicare and Medicaid auditors will be paying attention to.

“When you have a topic it’s easy to go and say, ‘Run me a bunch of data on this particular code set and let’s see if we have any outliers or issues.’ Then you sample that and do your reviews. I think with data analytics you can get much more detailed down into the data,” Ree says. But, she cautions, “when I say data analytics from an auditing perspective, I think it’s useful once you identify an issue to drill down into what’s going on. I don’t think it’s useful using it to understand on a broad spectrum where you may have issues. From a quality perspective I think differently. The more detailed data you have you can better understand the quality of the care you’re providing.”

Audits are useless unless they’re repeated, meaning internal audits should be routinely scheduled and planned at intervals, experts say. “I think a good internal audit program is one of the most critical things in an HIM department,” says Cassandra Kelly, RHIA, vice president of client services and operations at Mindseeker. “There needs to be ongoing, regularly scheduled audits, regularly scheduled feedback with coders and auditors working hand in hand. There has to be open communication in the relationship—that’s something that the most successful audits have. Mutual respect between auditor and coder. That’s critical.”

According to Cassandra Kelly, to do the most thorough audit even the auditors should be audited.

“Many times, facilities overlook auditing the auditors. I think that knowing that your audit team is doing the job that they should be, you want to make sure they’re doing accurate work. If you have auditors that are not performing top notch audits on your coders, then it kind of defeats the purpose of auditing your coders within an organization,” Cassandra Kelly says.

### Engaging Auditees

When an organization determines that an internal audit is necessary, Bochantin recommends outlining a clear set of standard operating procedures—including details such as who on the HIM staff will oversee them, the number and types of charts that will be scrutinized, and an outline of expectations.

To get staff engaged with an audit, two conversations need to take place, according to Bochantin—one with coding professionals and other HIM staff and one with physicians. Coding professionals should understand that compliance is in their job description—it comes with the territory. Bochantin recommends emphasizing this fact at the start of an audit. They should expect coding audits to come as often as on a quarterly or monthly basis. Physicians need to be told that audits are important to verify that quality care is being delivered and help understand how much money is being left on the table due to inadequate reimbursement. Physicians often have a harder time understanding that more training is needed on an ongoing basis.

Ree says that whether she’s conducting an internal audit or an external audit, she uses the same approach.

“I still try to understand emotionally what’s going on at the facility—what are they concerned about? I always go to the client and say, ‘Are we doing this review to discover opportunities for education, to discover opportunities to improve process, or will this be used in a punitive nature?’” Ree says. “What I’ve found especially when you audit coders or CDI people, if you’re going into the audit and they have a feeling they’re going to get in trouble if they have errors, their defense is automatically up, they won’t like you, they won’t listen to you. But if you go in and say, ‘There are no punitive damages that will occur because of it, it’s an opportunity to find out what’s going on, to improve processes and patient care,’ then people buy into it more.”

### Notes


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**Journal of AHIMA Continuing Education Quiz**

**Quiz ID:** Q1919003  |  **EXPIRATION DATE:** MARCH 1, 2020  
**HIM Domain Area:** Clinical Data Management  
**Article—**“Check Yourself—Internal Revenue Cycle Audits Gain Importance”

**Review Quiz Questions and Take the Quiz Based on this Article** Online at [https://my.ahima.org/store](https://my.ahima.org/store)

**Note:** AHIMA CE quizzes have moved to an online-only format.
How to **Battle** Coding Denial Trends

CREATING A PROACTIVE APPEAL STRATEGY

By Malissa Powers, BS, RHIT, CCS, CICA, and Sabrena Gregrich, MBA, RHIA, CHPS, CPEHR
AS HEALTHCARE MOVES toward value-based reimbursement, provider organizations are experiencing a new level of complexity in coding denial trends, which requires effective strategies for managing denials and appeals. Though denial prevention is the ultimate goal, denials remain a reality for health information management (HIM) directors and dedicated staff.

Among recent trends, claim denials from Medicare, Medicaid, and commercial payers are on the rise, with a steady increase in commercial denials. In fact, 80 percent of denials are now from commercial payers. Furthermore, the median for successful appeals for hospitals fell to 45 percent for commercial payers and 41 percent for Medicaid, according to an Advisory Board report.\(^1\) Awareness and understanding of emerging trends is the first step toward creating a proactive appeal strategy that promotes optimal outcomes and most effectively battles denials.
There seems to be a fallacy that minimal effort is involved in producing health records within an electronic environment.

**Heightened Focus on Clinical Validation**

Distinguishing coding denials from clinical validation denials is an ongoing challenge. HIM professionals are seeing more clinical validation denials, especially where payers use a combination of clinical and coding references, making it hard to determine the type of denial. In some cases, a coding reference may be used inappropriately to support a clinical validation. This is a growing issue that demands a dual approach to writing appeals. Coding experts—who specialize in coding rules and regulations—and clinicians—nurses, physicians, nurse practitioners, physician assistants—should work together to appropriately respond to denials. Collaboration between coding and clinical documentation improvement (CDI) professionals is essential.

Even when provider documentation clearly states a diagnosis, it will be challenged if the payer determines there are insufficient clinical indicators or discussion points to support the diagnosis.

**Shift from Inpatient to Outpatient Denials**

As more and more hospitals acquire and manage physician practices, the shift toward increased outpatient denials is a new and challenging trend. In these cases, there’s virtually nothing regulating payers, and the lack of oversight results in inconsistent timelines, difficulty getting responses, and overall ambiguity about the denial. The lack of clarity regarding what specifically is being denied makes the appeal process more difficult.

On the inpatient side, the cost to appeal—typically hundreds of dollars—is nominal compared with what could be recouped. Moving into the outpatient realm, at the physician practice level, for example, the recoupment amount may be relatively low—less than $150. For this reason, it is important to consider the value of pursuing an appeal and to establish criteria around the process. Is it worth the time and effort? Regardless of the cost and potential gain, tracking all denials is important in order to understand what payers are targeting and to leverage that information to educate physicians and allow coding and CDI professionals to focus on high-risk areas.

**Higher Volume of HEDIS and Risk Adjustment Requests**

Payers are requesting larger volumes of records for Healthcare Effectiveness Data and Information Set (HEDIS) and risk adjustment purposes, placing unprecedented demands on HIM staff. There seems to be a fallacy that minimal effort is involved in producing health records within an electronic environment. Furthermore, many payers are now requesting direct access to the electronic health record (EHR), a controversial issue from both a data management and privacy/security perspective.

From an HIM perspective, managed care contracts should include language that limits the number and types of medical record requests at no charge—and requires accountability on the part of the payer. For example, if the payer says a claim is not substantiated based on the DRG submitted, then timelines should be in place to ensure clarity about what is being denied and why. Support from senior leadership is critical.

**Queries and Review Dates Subject to Payer Scrutiny**

In an effort to identify gaps in documentation where an additional physician query may be necessary, payers have heightened their scrutiny of queries. It’s important to make sure the queries are complete and appropriate. Here are three recommendations:
- Create templates to ensure queries are standardized and not leading.
- Include queries and the physician response in the designated record set/legal health record.
- Follow appropriate guidelines that were applicable to the date of the claim.

In some cases when there are post-payment reviews, the payer may erroneously reference guidelines effective at the time of review but not in effect at the time of service. If appropriate guidelines are not applicable to the claim date, the findings should be challenged as part of the appeal process.

**Technology, People, and Processes Protect Revenue**

Data collection and reporting are critical to an effective denial management program. At Yale New Haven Health, a large hospital and physician network based in Connecticut, denial management and appeal technology has been implemented and combined with a team of experts to manage the volume of denials and pursue the appeal process across the system. This dual approach is designed to help the organization eventually move from payer denial management to proactive denial prevention. Yale New Haven Health has made substantial progress through comprehensive reporting capabilities that enable tracking and monitoring of essential metrics via a centralized dashboard, including:
- Number of denied cases—how many appeals for each
• Top denied reasons by payer for fiscal year
• Payer outliers—supports conversations with payers regarding issues
• Overturned cases by last level of appeal
• Upheld cases by last level of appeal—keep fighting to the last level
• Top DRGs targeted whether upheld or overturned—identifies key issues
• Recovery Audit Contractor (RAC) appeal summary—audit dashboard showing dollars recovered
• Open cases—indicates new appeal volumes by payer for trending purposes
• Volume by appeal level—current cases in progress
• Percentage of upheld versus overturned appeals

These reports identify initial dollars at risk, dollars recovered, problem payers and DRGs, and more. In addition to standard reports, the system provides unlimited ad hoc reporting based on specific filters to produce customized reports. It is a data-rich system that captures critical data. One of the most important benefits is the ability to identify the root causes and frequency of payer denials and provide education on the front end of the revenue cycle.

Implementing a Proactive Appeal Strategy
With the increased volume of denials from all payers, health systems need strategies to proactively address and appeal denials. Here are six proven practices to consider:

Establish a multidisciplinary team approach. Include representatives from critical areas—HIM, physicians, coding, CDI, managed care contracts, revenue cycle, legal, financial, audits, and compliance. Hold regular meetings to review reports, discuss issues, track trends, and monitor outcomes. For example, look at the top 10 DRGs targeted. Identify opportunities to improve education. Knowledge sharing is necessary to achieve clinical and financial goals.

Work closely with the managed care contract department. Managed care contractual provisions affect payment, departmental organization, billing procedures, and clinical decision-making. Providers need to understand contract language and exercise their rights in the appeal process. Initiate conversations about opportunities to change some of the language in contracts with payers. Given the traditional structure of contracts, the focus on medical records has been lacking. Contracts are usually written in favor of payers. Meet with contracting to revise the language to support the appeal process.

Promote communication among all stakeholders in the denial and appeal process. This includes HIM, coding, CDI, contracting, compliance, finance, and clinicians. Transparency of data and trends is critical as the impact of denials affects all aspects of the revenue cycle. In addition, with the growing volume of denials involving a combination of clinical and coding issues, CDI and coding must collaborate to ensure correct coding and clinical documentation on the front end and proactively educate physicians.

Consider engaging a physician advisor to support the appeal process. A physician advisor is a valuable partner who can help with many aspects of the appeal process, particularly clinical validation, and also provide education for other physicians on documentation best practices that help prevent denials and pursue appeals.

Do not assume that a denial is correct. An appropriate credentialed individual should be involved in the denial process. Check for a signature by a clinician or certified coder. Investigate the rationale for the denial. Make sure coders are up to date on all coding resources. Verify all references including AHA Coding Clinics and other resources and ensure each reference is applicable to your case. Note any discrepancies in your appeal.

Provide periodic training for all stakeholders. Conduct ongoing training and provide educational resources related to denials and appeals. Use reports to develop educational opportunities aligned with tracking and monitoring trends. Continually evaluate your appeal process and revise educational efforts accordingly. Build on strengths and identify any weaknesses that need to be addressed.

Awareness of coding denial trends helps ensure best practices to address denials and pursue appeals. The claims appeal process is costly, time consuming, and increasingly complex. Ideally, healthcare providers will implement strategies to successfully manage the process and move toward prevention.

Note

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IFHIMA Prepares for 19th Congress as Health Information Goes Global and Digital

By Lorraine Fernandes, RHIA; Kerryn Butler Henderson, PhD; Carol Lewis, MPH, RHIA; Marci MacDonal, CHIM; Margaret Skurka, MS, RHIA, CCS, FAHIMA; Hussein AlBishi; and Kylie Axford
HEALTHCARE, LIKE MANY other segments of society and the economy, has become truly global.

The impact of healthcare on national economies is evident in the 2018 Organization for Economic Cooperation and Development (OECD) study, which revealed the average amount spent on healthcare across OEDC nations is six percent of the Gross Domestic Product (GDP), with healthcare in the US accounting for as much as 18 percent of GDP. In addition to its financial impact, healthcare is increasingly being built into our lives and our livelihoods via mobile technology that allows quick access to vital health information. Thus, health information and its management couldn’t be more important than it is today.

Healthcare is also a big international industry fueled by medical tourism, expatriation of healthcare workers, and an imperative to have quality healthcare on the “home front” by advanced societies. Large healthcare organizations, including the Hospital for Sick Kids (Toronto), Cleveland Clinic, and Mayo Clinic, operate facilities or conduct global research not only in cities around the US and Canada, but also in countries around the world.

Healthcare is also an increasingly high-tech industry where health information management (HIM) plays a crucial role in the governance and the safe sharing of health records and patient information. This is why the International Federation of Health Information Management Associations (IFHIMA), which will hold its 19th Congress in Dubai, United Arab Emirates from November 17 to November 21, sees its role in the globalization of the healthcare industry as so very important.

IFHIMA, a non-profit organization affiliated with the World Health Organization (WHO) as a non-governmental organization (NGO), is acutely aware of how rapidly healthcare delivery and policy is changing. Accordingly, the organization works with its members to ensure the HIM workforce is trained to manage the privacy and security of paper and digital data in any country. The challenge of this work is evident, given that healthcare data is predicted to double every 73 days by the year 2020.

IFHIMA has an executive board that is made up of elected officials, the president, the president-elect, and six regional directors representing Europe, the Americas, South East Asia, Western Pacific, Eastern Mediterranean, and Africa. Attendees from various IFHIMA regions will converge in Dubai in November to attend educational sessions, hear speakers discuss globally relevant HIM topics, and network with other HIM professionals.

IFHIMA Congress Celebrates Its Golden Jubilee

Last year marked IFHIMA’s Golden Jubilee Celebration—50 years since the organization was founded in 1968 as an opportunity for the global exchange of HIM-related information, education, and networking.

In a series of articles posted on the IFHIMA.org website, members shared their reflections about what 50 years of the international association has meant to them. Sue Walker from Australia wrote in her article, “What a wonderful organization IFHIMA is—seeking to unite health information professionals from across the world, helping us to understand that many of the issues and problems we think are unique to our own experiences are actually common, working together to promote best practices.” Dr. G.W. Mogli from India wrote, “IFHIMA has transformed the HIM profession excellently with limited resources.”

Since the IFHIMA Congress is held every three years in one of the 23 IFHIMA member countries, this year’s 19th Congress will mark the first chance for the organization to celebrate the golden jubilee milestone in person. Themed “Empowering HIM Professionals Through a Global Voice,” the 19th Congress will convene HIM colleagues from around the world to explore how the HIM global voice is changing and how IFHIMA is advancing core practice areas. Dr. Robert Jacob, director of standards, terminology, and classification at the World Health Organization, will be a keynote speaker at the event and address the release of ICD-11. Dr. AbdulElah M. Alhasawi, director general of the Saudi Patient Safety Institute, is also slated to discuss key elements to improving patient safety, including HIM and clinical documentation, in his keynote address.

The 19th Congress Scientific Program will reflect the diverse practice areas for HIM including clinical coding/classifications, health informatics, healthcare finance/value-based...
Board Activities Advancing IFHIMA

IFHIMA Board members regularly promote topics expanding global HIM perspectives at association conferences around the world. Here are some of the most recent board activities:

- **September 2018 AHIMA Convention, Miami, FL.**
  Lorraine Fernandes presented “Information Governance: New Perspectives and Global Experiences”

- **September 2018 CHIMA Convention, Niagara Falls, Ontario, Canada.**
  Marci MacDonald presented “International Perspectives in HIM”

- **October 2018 Klasifikon, Prague, Czech Republic.**
  Angelika Haendel presented “IFHIMA, DVMD, Clinical Documentation and Coding in Germany”

- **April 2018 Medical Informatics Europe MIE 2018 Convention, Gothenburg, Sweden.**
  Angelika Haendel with Angela Kennedy, Grace Kennedy, Mervat Abdelhak, Marion Ball, and Ursula Huebner presented “Ask the Patient! What can TIGER, AHIMA/IFHIMA and CAHIM do to ensure patient safety through better health informatics/health information education?”

- **November 2018 HIMAA Convention, Hobart, Tasmania.**
  Vera Dimitropoulos presented “Transition to Implementation of ICD-11—What do we need to consider?”

Advancing Collaboration and Knowledge in Developing Nations

The 18th IFHIMA Congress held in 2016 in Tokyo, Japan had unprecedented attendance from developing nations, thanks to the generosity of the Japan Hospital Association. To sustain this momentum and keep advancing HIM practice in developing nations, the Japan Hospital Association has graciously endowed a new IFHIMA Japan Scholarship. Additionally, the IFHIMA Ulli Hoffman Scholarship—Hoffman was IFHIMA President from 1992-1996—endowed by Hoffman’s friends and family will also be given for the 19th Congress. Scholarship applications and details can be found on the 19th IFHIMA Congress website, IFHIMA2019.com. Scholarship recipients for the 19th Congress will be determined in mid-2019 by the IFHIMA Board.

IFHIMA in Action

At the core of every IFHIMA Board discussion is a commitment to its mission, vision, and values and member nations. “Looking back over the long period I have followed IFHIMA, I find great pleasure in seeing how IFHIMA has developed and now embraces all WHO Regions,” says Darley Peterson from Denmark, a 30-year IFHIMA member. Developing nations are routinely highlighted since the IFHIMA Board believes raising a tide for all is critical to improving health and wellness around the globe. Some of IFHIMA’s activities over the past year include:

Learning Modules

IFHIMA recently updated nine Learning Modules designed as educational resources to assist in communicating core healthcare and HIM-specific practices between people working in the field of health records/information management around the world. The modules are not formal curriculum or training guides; rather, they are resources to assist practitioners in communicating core principles and practices.

ICD-11 Advocacy

Change in the healthcare ecosystem will be coming in the next decade in the form of ICD-11. While the US may feel that they’ve just caught their breath after ICD-10 was implemented in 2015, much of the world implemented ICD-10 one or two decades ago. Thus, WHO has been working for over a decade on the International Classification of Diseases, Eleventh Revision, which will be officially adopted by the WHO for implementation in May 2019. ICD-11’s new structure reflects a diversity of data needs given the vast use of health data, new information technologies, and the advancements in medicine. IFHIMA, through US member Margaret Skurka, MS, RHIA, CCS, FAHIMA, has an official voice and vote on the WHO Education and Implementation Committee, with fellow HIM professionals including Yukiko Yokobori (Japan), Vera Dimitropoulos (Western Pacific), and Sue Walker (Aus-
Mortality Examination and Certification
The World Health Organization Family of International Classifications (WHO-FIC) Education and Implementation Committee conducts examinations for underlying cause of death coders, and IFHIMA awards a certificate to those who achieve a score of 80 percent or better. The first mortality exams were conducted in 2007. In 2018, following a survey of recertification practice in IFHIMA member countries, a recertification examination was developed and conducted in the Republic of Korea. A recertification cycle of five years is now established. An examination for morbidity coders has been developed and conducted but, given that morbidity coding rules vary among countries, no certificate is awarded.

Implementing Membership Expansion
IFHIMA membership has traditionally been open to individuals, nations, and corporations. As of the 2016 Congress, IFHIMA added a new membership category, Educational Institutions. IFHIMA anticipates the new institutional members will engage in better collaboration to serve students and educators around the globe.

Global Workforce Challenges of the Future
As HIM has evolved over the decades, IFHIMA members are mindful that the profession must continue to address workforce challenges and changing regulations. The rapid development of new technologies and the impetus for data-driven decision-making has carried health information out of the shadows and to the forefront of supporting the safe delivery of care. But with this comes a shift in challenges for the HIM professional.

The profession will need to transform or risk becoming obsolete along with the paper health record. The need for high-level operational management within a paper or hybrid system is now reduced in a digital environment. A 2013 Oxford white paper reported that the role of medical records and health information technicians are 91 percent susceptible to automation. Yet, this will increase the need for data quality audits, clinical documentation improvement, and data analytics. As such, the role of the health information manager should evolve from operational managers to information strategists. And with exciting emerging roles accompanying innovations such as artificial intelligence, automation, and data strategy, the transformation of the profession seen globally places HIM central to digital health. That said, workforce development is slated to be a key topic and an important track at the 19th Congress.

In the words of past IFHIMA President, honorary member, and Australian leader in HIM, Professor Phyllis Watson, AM, “Over the years changes, and at times incredible challenges, have dominated our history and been an important part of the work of the medical record/health information professional, and we should not expect it to be different in the future.”

Change is once again upon the HIM profession and workforce. This will require a system approach, including peak bodies advocating for the profession, educators preparing graduates for future capabilities, and practitioners joining the journey associated with workforce transformation.

These are topics that will be explored at the 2019 Congress in Dubai as IFHIMA works to advance the HIM profession and celebrate 50 years of global collaboration in support of a healthy world enabled by quality health information.

Notes
2. Corish, Breda. “Medical knowledge doubles every few months; how can clinicians keep up?” Elsevier. April 23, 2018. www.elsevier.com/locate/medical-knowledge-doubles-every-few-months-how-can-clinicians-keep-up.

Reference

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ONE OF THE critical information governance (IG) functions is successful execution of an organization’s privacy and security responsibilities. Chief among these responsibilities is to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). This assessment is a foundation upon which other security processes will depend. Poor or non-existent risk analysis processes have been a finding in 89 percent of settlement agreements and civil money penalties imposed by the US Department of Health and Human Services’ Office for Civil Rights (OCR). In 2018 alone, the cost was over $24 million for organizations that failed to implement effective risk analysis or risk management processes.

The intent of this article is to help healthcare entities consider a strategy for a security risk analysis process, considering current requirements and industry best practices for protecting ePHI. Depending on the risk profile and resources, some recommendations and decisions will require significant research, analysis, policy development, investments, and approvals.

It is critical to understand that a risk analysis is not a non-technical evaluation required by HIPAA’s Evaluation Standard. Risk analysis is required by HIPAA’s Security Management Process Standard and is a process of identifying the vulnerabilities in the entity’s networks, computer systems, personnel processes, physical security, and environment that could be exploited by a threat agent (whether human or environmental). A risk analysis also considers the likelihood and impact to the organization if the vulnerability were exploited.

OCR’s guidance on risk analysis requirements under the HIPAA Security Rule describes nine essential elements of a risk analysis, regardless of the methodology:

1. Scope: All ePHI that an organization creates, receives, maintains, or transmits must be included.
2. Data collection: The data on ePHI gathered using these methods must be documented.
3. Identify potential threats and vulnerabilities: Reasonably anticipated threats to ePHI must be identified and documented.
4. Assess current security measures: The security measures used to safeguard ePHI must be included.
5. Determine the likelihood of threat occurrence: Consider the probability a threat will occur.
6. Determine the potential impact of threat occurrence: Address the impact to confidentiality, integrity, and availability of ePHI.
7. Determine the level of risk: The level could be determined by combining the values assigned to the likelihood and resulting impact of threat occurrence.
8. Finalize documentation: The risk analysis must be documented, but no specific format is required.
9. Periodic review and updates to the risk analysis: Update and document security measures “as needed.”

A risk analysis project should establish the scope and required actions (i.e., what the project will entail) and the end goal and desired state. Once addressed, a timeline based on resources and end goals can be established. AHIMA suggests the following risk analysis framework.
**Risk Analysis Framework**

Start with a system characterization. Create an inventory of applications and systems that involve ePHI. Then group assets as applications (electronic health records (EHRs), lab or radiology information systems (LIS/RIS), enterprise content management, etc.) or systems (workstations, laptops, networks, etc.).

Next, identify reasonably anticipated threats. Consider:
- Environmental factors (i.e., power failures, chemicals, or liquid leakage)
- Acts of man (i.e., intentional or unintentional actions causing loss of ePHI)
- Acts of nature (i.e., wildfires or flooding)

Then conduct a vulnerability assessment. Organizations should assess:
- Missing controls. Examples:
  - Use of mobile devices without a mobile device management solution
  - No encryption methodology
  - No reviews of activity in information systems
- Identify how applications or systems could be exploited. Examples:
  - Unpatched applications could be exploited
  - ePHI on a stolen device could be accessed by an outsider

When conducting a control assessment, organizations should assess what controls are in place currently. Is there protection of a data center from flooding and fire threats? Malware protections? Daily backup of all ePHI systems?

Next step in a risk assessment is the risk likelihood determination. Decide the probability of each threat occurring. For example, the likelihood of a staff member clicking on a link within an email, or a laptop being stolen from a vehicle.

Conduct an impact analysis. Rate possible impacts from low to very high and evaluate what the risk would do to the organization. For example:
- The EHR goes down and cannot be restored for three days—Risk: high
- The billing system is attacked by ransomware and payment demanded for a decryption key—Risk: medium

See the sidebar above that lists AHIMA’s impact definitions based on magnitude and definitions of exploitation.

Risk determination should be factored as part of the risk assessment, and can be calculated using the formula: Risk = Likelihood * Impact. A high impact (16) multiplied by a high likelihood (4), yields a risk score of 64, whereas a low impact (2) multiplied by a high likelihood (4) yields a risk score of 8.

This calculation allows placing of limited resources to target the high risks first. Also, recommended controls should be determined. Provide recommendations to manage risks appropriately. For example: Implement training on how malware can be introduced through email links; encrypt

---

**AHIMA’s Impact Definitions**

<table>
<thead>
<tr>
<th>Magnitude</th>
<th>Definitions of exploitation of the vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High (16)</td>
<td>(1) May result in the high costly loss of major tangible assets or resources; (2) May violate, harm, or impede an organization's mission, reputation, or interest significantly, or (3) May result in human death or serious injury.</td>
</tr>
<tr>
<td>High (8)</td>
<td>(1) May result in the costly loss of major tangible assets or resources; (2) May violate, harm, or impede an organization's mission, reputation, or interest significantly; or (3) May result in serious human injury.</td>
</tr>
<tr>
<td>Medium (4)</td>
<td>(1) May result in the costly loss of tangible assets or resources; (2) May violate, harm, or impede an organization’s mission, reputation, or interest; or (3) May result in human injury.</td>
</tr>
<tr>
<td>Low (2)</td>
<td>(1) May result in the loss of some tangible assets or resources; or (2) May affect an organization’s mission, reputation, or interest noticeably.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likelihood of occurrence</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Certain (5)</td>
<td>Constant or frequent</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>May happen once a year</td>
</tr>
<tr>
<td>Moderate (3)</td>
<td>May happen once in 5 years</td>
</tr>
<tr>
<td>Rare or unlikely (1 or 2)</td>
<td>May happen once in 10 years</td>
</tr>
</tbody>
</table>

Continued on page 51
AS WITH ANY journey, understanding where you started is the key to understanding where you are going. Those who have been in the health information management (HIM) industry for many years have seen rapid change in how the HIM department functions. There has been a transition from filing hard copy records and reports to indexing and analyzing documentation through the electronic health record (EHR) “system.” On a surface level, there seems to be great strides taken in the implementation of EHRs and other health IT systems. But a deeper dive into these changes can leave one wondering: just how much has changed? There is still the legal health record, and HIM is still responsible for its completeness. HIM professionals are still charged with basic HIM functions, such as checking to make sure every inpatient has a history and physical report on the record within 24 hours of admission; checking that every surgery record has an operative note within 24 hours of the procedure; and noting whether the discharge summary is completed within 30 days of discharge. This review task has not changed, nor has the management of this data.

There is more data now at our fingertips than ever before. Written reports are easily generated with the click of a button. Physician letters are no longer manually written, and paper charts no longer need to be “checked out” to do chart reviews. Ten people can review a chart at one time, all looking at different information. The fact that the record can be used by many people at the same time is truly an amazing feat, and makes abstracting information more efficient than the old process.

Staff are still required to index documents that are generated without barcodes, track releases, destruction dates, reports, and amendments. New tasks driven by technology have emerged that have eliminated tasks, but many basic HIM functions remain. A colored flag used in the paper days to indicate where a signature was required can now be completed in one easy click by scanning a fingerprint.

Technology has advanced and so has HIM. Table 1 on page 27 and page 28 illustrates how core HIM functions look different with the adoption of complex technology, and compares HIM functions pre-EHRs and post-EHRs.

Evolving Roles of HIT and HIA Professionals
The changes in methodology of HIM functions require a different or advanced skill set for entry-level HIM staff. In the past, it was not uncommon to hire an untrained or unskilled person for an entry-level clerk position. Often, entry-level positions listed the qualification as “some high school” or “some college,” and unfortunately the pay grade reflected the lack of advanced skills. Today, it is essential for HIM professionals to understand data and how systems work together to be successful. Unfortunately, salary surveys have not kept up with the changes in the required skill set of the HIM professional.

The HIM profession is continuously changing and will continue to do so in the future. The foundation of the HIM department and the profession has not changed with time—to manage the information that makes up a patient’s health record. Technological advances have changed the way HIM professionals work, but the bottom line continues to focus on confidential, effective, efficient, trustworthy, and secure management of health information.

Julie Wulf Plimpton (julie.wulfplimpton@dsu.edu) is an assistant professor at Dakota State University. Amanda Wickard (wickarda@woodcountyhospital.org) is the director of HIM services at Wood County Hospital.
Table 1: HIM Functions “Then” (Pre-EHR) and “Now” (Post-EHR)

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Filing and Storage</strong></td>
<td><strong>Scanning</strong></td>
</tr>
<tr>
<td>Documents were filed within the patient record</td>
<td>Loose documents are scanned using a document imaging software</td>
</tr>
<tr>
<td>Stored in the file room</td>
<td>Images are stored electronically</td>
</tr>
<tr>
<td>Eventually transferred to different storage medium (microfilm,</td>
<td>Paper is destroyed after scanning</td>
</tr>
<tr>
<td>microfiche, or CD)</td>
<td></td>
</tr>
<tr>
<td>Destruction of the paper record</td>
<td></td>
</tr>
</tbody>
</table>

| **Release of Information**                                           |                                                                      |
| Staff physically pulled charts                                      | Patients, payers, providers, and other healthcare entities have     |
| Paper-based process required staff to spend hours standing at a      | online access to the electronic patient record                      |
| copy machine reproducing paper documents                            | Health Information Exchanges (HIE) are exchanging records            |
| Invoices were created                                               | Release of information requests may be transmitted entirely         |
| Copy of the records and invoices were mailed via US Postal Service  | electronically                                                       |
| Paper, and then electronic, logs were developed to improve the      | Invoices can be generated electronically                            |
| process                                                             |                                                                      |

| **Coding**                                                          |                                                                      |
| Move the chart to the coding department                             | Place chart in coding work queue                                     |
| Review paper record                                                 | Send an electronic query to providers                                |
| Send a query to the provider                                        | Input codes and move to Patient Financial Services work queues for  |
| Input codes on paper or in a software program                       | billing                                                             |
| Send codes to Patient Financial Services                            |                                                                      |

| **Deficiency Analysis**                                             |                                                                      |
| Review discharge chart to make sure all reports are present         | Scan documents into patient’s record                                 |
| Review every page of medical record for missing information (       | Send deficiency notice to the physician through electronic work     |
| signature, date, and time)                                          | queue for electronic signature                                       |
| Use color coded flags to identify the owner of the missing item(s)  |                                                                      |
| Send a note to the physician regarding incomplete charts           |                                                                      |
| Delay in completion if multiple physicians need to complete the     |                                                                      |
| record                                                             |                                                                      |

| **Deficiency Tracking**                                             |                                                                      |
| Record the location of incomplete charts either by using an outguide| The system generates the deficiency list                            |
| or electronic tracking system                                       | Deficiency list is sent to provider work queues for completion      |
| Move the chart to the incomplete chart area                         | Provider returns completed record to HIM work queue                 |

| **Audit Process**                                                   |                                                                      |
| Obtain the list of records to be audited                            | Run report of records to be audited                                 |
| Pull chart from the file room                                       | Place the required record in a work queue                           |
| Sort through hundreds of pages of paper                             | Auditor can review the charts at the facility or can dial-in        |
| Complete the required audit form                                    | remotely                                                            |
| Charts are refiled in the file room                                 |                                                                      |

| **Transcription**                                                   |                                                                      |
| Retrieve voice from a cassette or microcassette                     | Automatically interface into the patient’s record                   |
| Transcribe and print report                                         | Copies can be autofaxed to physicians who do not have access to     |
| Deliver paper to the patient record on the nursing floor, or        | the EHR                                                             |
| Deliver report to the provider via fax, autofax, mail and/or manual| Providers may use voice recognition and templates to create         |
| distribution                                                        | documentation                                                       |
| Make the necessary corrections and return to the provider for       |                                                                      |
| signature                                                           |                                                                      |

Continued on page 28
### Table 1: HIM Functions “Then” (Pre-EHR) and “Now” (Post-EHR) (Continued from page 27)

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forms Management</strong></td>
<td><strong>Forms Management</strong></td>
</tr>
<tr>
<td>• Draft the form</td>
<td>• Draft a form</td>
</tr>
<tr>
<td>• Take to committee for approval</td>
<td>• Take to committee for approval</td>
</tr>
<tr>
<td>• Have form printed</td>
<td>• Build form in EHR</td>
</tr>
<tr>
<td>• Use paper form for documentation</td>
<td>• Build barcode for scanning</td>
</tr>
<tr>
<td></td>
<td>• Maintain a paper copy for downtime purposes</td>
</tr>
<tr>
<td><strong>Content Management</strong></td>
<td><strong>Content Management</strong></td>
</tr>
<tr>
<td>Content management—much of the information that was created for documentation was done so with the paper form. Copies were made, ordered, and added to the record. Any time a change was made, HIM was involved. HIM also often chaired the forms committee and/or medical records committee.</td>
<td>Enterprise content management—much of the information that is built in the system is designed by IT or nursing that was moved to the production environment by IT. HIM is sometimes not even involved in the content that is built or that comes with the system implementation. While in many organizations much of this has been moved to IT, HIM should still be involved in the approval process.</td>
</tr>
<tr>
<td><strong>Chart Correction</strong></td>
<td><strong>Chart Correction</strong></td>
</tr>
<tr>
<td>• Place a single line through the error</td>
<td>• Some EHR systems allow the user to draw a line through the information and add the new information. Both are visible.</td>
</tr>
<tr>
<td>• Make the correction to the entry</td>
<td>• Others hide the information that was corrected “behind the scenes” but viewable in an audit report</td>
</tr>
<tr>
<td>• Write the initials and the date of the person correcting the error</td>
<td></td>
</tr>
</tbody>
</table>

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How to Use Patient Data to Boost Acquisition and Retention Numbers

By Gary Druckenmiller Jr.

CONSIDER THESE THREE statistics: Acquiring a new patient is six to seven times costlier than retaining an existing one.¹ A five percent increase in patient retention produces a 25 percent increase in profit.² Additionally, the volume of healthcare data is expected to grow to 25,000 petabytes by 2020.³ Together, these statistics paint a broad picture of the current healthcare landscape—and the keys to organizational growth. Due to the high cost of patient acquisition, healthcare organizations need to be more strategic and targeted in their efforts. They need to align patient marketing campaigns and initiatives with organizational goals, in particular identifying high-value service lines and high-value commercial payers.

Because of the potential for return on investment (ROI), organizations need to focus on connecting with patients on a deep level and being more proactive in communication and outreach regarding the services they need to improve their unique long-term health goals.

Finally, as health information professionals know all too well, there’s an incredible amount of data produced by the healthcare sector. While there are regulations governing much of this data, with proper care taken and technology in place health systems can leverage it to provide better patient care that inspires lifelong relationships.

This article will outline four best practices for developing actionable patient data to influence organizational growth.

Leverage Technology to Better Understand Patient Data

It wasn’t that long ago that patient records were file folders full of paper. With the advent of electronic health records (EHRs) those papers are now digital files. It’s been a revolutionary transformation, but many organizations still have patient data in multiple different databases and no central technology platform to gather, store, and analyze this information for the purposes of marketing or business development.

There are five technologies available now that are critical to effective healthcare marketing: EHRs, healthcare customer relationship management systems, content management systems (CMS), marketing automation, and call centers, whether they be in-house or outsourced.

Each one of these technologies plays an important role in understanding patients, engaging them effectively, and enabling the smarter growth strategies necessary to boost revenue in the current healthcare marketplace.

Implementing and integrating these technologies requires a shift across an organization to a more data-driven culture that works to build a comprehensive database, and an investment in cross-departmental collaboration.

Build Complete Customer Profiles

It can be argued that the most reliable data available to hospitals and health systems is the data they collect on patients. Through implementation of guidelines that yield consistent customer and patient data, and an integrated technology platform to support that initiative, health organizations can build up a customer database that can be used to engage more effectively with patients.

With the integration of third-party consumer data, which may include demographic, psychographic, and geographic data, organizations have an even more complete picture of the communities they serve. However, even more importantly, representatives of the hospital, whether they be within the...
marketing department or contracted partners such as call center agents, have greater insight into a customer’s past interactions, interests, and current health needs.

With connected technology platforms, interactions with patients can be more informed and effective. Let’s walk through an example: A customer contacts the call center to express interest in an upcoming wellness seminar. The agent asks for a few identifying details and pulls up a detailed caller profile. They see that this caller was previously targeted with a pre-diabetic campaign. Using this information, the agent further personalizes the discussion. The agent asks if the caller is willing to answer a few health-related questions to see if they qualify for a new pre-diabetes program.

With this level of visibility into an individual customer, the agent re-engages a potential customer while demonstrating care for the individual and the organization’s efficiency.

**Develop Target Audiences with Propensity Models**

Within a healthcare customer relationship management system, multiple data sets from disparate sources (patient demographic data, select clinical data, and third-party consumer data) are brought together to fuel advanced segmentation and clinical modeling.

In particular, propensity models, an analytical tool that derives insights from patterns and relationships within multiple data sets, help marketing teams hone in on the best targets for patient outreach. The tool also helps build smarter patient acquisition and retention campaigns by offering directional insights on the most effective channels and messages for those targeted audiences.

Consider how this can be used to drive patient acquisition for bariatric care to manage weight, such as gastric bypass surgery and recovery. For example: An analysis of data from past bariatric patients reveals the priority targets for this initiative are living in middle-density population urban environments and ages 55-65. Further analysis shows the outreach channels, lead times, and type(s) of content that resonate with this particular model. Together, these insights provide a framework for a precision marketing patient acquisition campaign.

A separate propensity model could be built to identify existing patients with propensity for bariatric care. Using a combination of clinical data and consumer data, marketers create an existing patient segment for the bariatric campaign and engage those customers with relevant and personalized messaging concerning their health and well-being.

Through these data-driven efforts, marketers optimize resources and deliver return on investment.

**Use Data to Map the Patient Journey**

Today’s healthcare consumers seek out and engage with hospitals and health systems across many digital platforms, including email, social media, websites, and mobile apps, and even more traditional channels, such as direct mail and the call center. Modern marketing campaigns need to not only utilize multiple channels, but also draw connections across those interactions.

In order to optimize these engagements, marketing teams need a centralized software system to collect and make sense of all of the customer’s interactions with the organization to develop a streamlined, continuous patient journey.

A patient journey map outlines all of the patient touch points—when and how they interact with marketers, physicians, administrators, and more—during each stage of the care journey, from awareness to ongoing care/proactive health. Healthcare marketers create journey maps to detail how a customer interacts with the organization and develop a blueprint for engaging patients throughout their care journeys. It also ensures every step in the journey has a clear next action.

By analyzing campaign data, marketers create more strategic opportunities, identify gaps in engagement, and proactively communicate with individual patients in an ongoing effort to create patients for life.

**Dig Into the Data Gold Mine**

With growing volumes of data, healthcare organizations need to not only get a handle on patient data, they need to use it to inform their growth strategy. Patients are demanding more personalized, convenient, and effective service, not just from providers, but also from healthcare organizations as a whole.

The healthcare marketplace is a shifting space and HIM professionals are sitting on a data gold mine. By aligning with marketing, HIM professionals can play an integral role in driving patient acquisition and retention to reach organization-wide growth goals, while also providing enhanced, personalized patient care. With the implementation and integration of technology platforms and analytics capabilities, HIM professionals and their healthcare organizations can realize the full potential of data.

**Notes**


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Gary Druckenmiller Jr. ([gary.drunkenmiller@evariant.com](mailto:gary.drunkenmiller@evariant.com)) is vice president, customer success at Evariant.
Addressing Privacy and Security Risks in Today’s Healthcare Ecosystem

By Ann Meehan, RHIA

INFORMATION IS A healthcare organization’s most strategic asset and requires enterprise-wide management to ensure that it is protected and secured in the most compliant way—for patient care and other business purposes. More than ever, healthcare organizations face growing challenges in managing information due to the ever-growing volume of information, evolving regulatory requirements, and increasing risks associated with security threats.

A recent survey of 100 healthcare compliance leaders by Iron Mountain resulted in insights that health information management (HIM) professionals can leverage to better prepare their organizations to address privacy and security risks in this challenging ecosystem.

The key goals of the study were to:
1. Identify compliance leaders’ most pressing priorities over the next three to five years.
2. Review industry trends hindering progress.
3. Explore how information governance (IG) can help advance identified priorities and improve privacy and security enterprise-wide.
4. Assess the current state of IG across three high-impact areas that are indicative of an organization’s risk profile and IG program maturity. These areas include:
   - Information Inventory and Integrity
   - Retention Policy Management and Defensible Disposition
   - Privacy and Security
5. Explore best practices that can help compliance leaders address common gaps to advance IG, support strategic priorities, and enable enterprise-wide compliance.

Interviews were conducted from December 2017 through February 2018 and included hospital compliance and privacy leaders across a range of bed sizes (see Table 1 on page 33). Survey results were published in a white paper.

Healthcare Compliance: Goals and Priorities

When asked what their top three compliance priorities are, respondents indicated:
1. Standardize policies and processes governing the management, use, security, and release of protected health information (PHI) across the organization and/or newly acquired/recently merged facilities (75 percent)
2. Employee compliance training and education (62 percent)
3. Enable HIPAA compliance and prepare for OCR audits (41 percent)

Interestingly, these three priorities are very much interconnected. The need to standardize is at the heart of ensuring consistency in how information is managed and secured. Without a standardized approach, it would be virtually impossible to effectively manage hardcopy records and electronic records and information in today’s complex, ever-changing healthcare ecosystem. Without workforce training and education, a standardized approach is not possible. Additionally, lack of employee awareness or adoption of standardized processes inhibits an organization’s ability to be compliant and meet audit requirements.

Barriers to Success

Survey respondents were also asked to identify the biggest barriers to success. The top barrier at 33 percent was accelerat-
ing employee understanding and acceptance of compliance, which ties back to the previously reported need to provide employee training and education. Along with that comes the need to monitor adherence to role-specific compliance requirements learned and reinforced during training and the ability to hold staff accountable.

The second-biggest barrier to compliance identified by the survey, at 29 percent, are the challenges associated with convincing the medical staff to embrace change. The medical staff is an important audience for education around privacy and security policies and procedures. Organizational silos impeding visibility into facility or department processes represents another barrier. While this was reported by only 16 percent of respondents, it’s a very real challenge across all healthcare organizations where decisions and management of information are driven at the department or business unit level, resulting in disjointed and non-compliant processes. All this increases the risks associated with the protection and security of information.

Table 2 on page 34 outlines the next set of insights gained in the white paper. The table speaks to the continued growth of information due to merger and acquisition (M&A) activity. Fifty percent of hospitals noted that the growth of information due to M&A activity makes it very challenging to protect PHI and other critical information. As noted by 59 percent of organizations, this is due to the difficulty in understanding where information is, how it’s used, and how it’s managed. The lack of information visibility increases the risk around information protection and security, as indicated by 79 percent of respondents. These insights indicate that healthcare organizations need a way to know exactly what information is captured, generated, used, reported on, and stored. In other words, healthcare organizations need to manage the lifecycle of their information.

Could Information Governance Be the Answer?
Standardization and education are consistently identified as mission-critical priorities throughout the white paper. These initiatives are also foundational components of an enterprise-wide IG program. Let’s quickly recap what IG is.

AHIMA defines information governance as: “An organization-wide framework for managing information throughout its lifecycle and for supporting an organization’s strategy, operations, regulatory, legal, risk, and environmental requirements.” It is strategic in nature and includes policies, procedures, and education that are enterprise-wide and that address all types of information in all formats.

High Impact Areas of IG
As it relates to addressing privacy and security risks, industry experts believe there are three sub-components of IG that are high-impact areas. These include: Information Inventory and
Integrity; Retention Policy Management and Defensible Disposition; and Privacy and Security. HIM professionals work in these areas every day, making HIM subject matter experts for each area and providing the perfect opportunity to lead these initiatives or provide consultative advice.

Beginning with Information Inventory and Integrity, protecting information is based on knowing what you have and where it resides. Healthcare organizations should capture basic data elements of its information in an Information Inventory. Equally important is the integrity of the information that the healthcare organization maintains.

An example that all HIM professionals can relate to is the accuracy of the enterprise master patient index (eMPI). Does your organization proactively prevent duplicate eMPI creation? Does your organization consistently monitor for and address any duplicates or overlays that are created and correct any downstream systems affected? Are trends captured to identify why duplicates are created, and is education provided to ensure duplicates are eliminated or at least minimized? Additionally, does your organization calculate the percentage of duplicates created? HIM professionals know the ramifications of duplicate MPI, including patient care errors and inadvertent disclosures.

Moving onto the second-highest impact area, Retention Policy Management and Defensible Disposition, each healthcare organization needs a record retention schedule and policy that is consistently updated, readily understood, and easily enforced, and which addresses all types of records across the organization—including electronic data.

Table 3 on page 35 provides a summary of survey results indicating that 74 percent of organizations have an enterprise-wide record retention schedule but it is not updated frequently. HIM professionals are the guardians of the patient medical record and have an obligation to not only ensure that the record is accurate and complete, but that it is retained for the timeframe required by federal and state regulations. Equally important is that HIM professionals ensure patient medical records are destroyed when they meet the timelines in those regulations and no longer serve a business purpose. Defensible disposition is the defined processes around the appropriate disposition of paper and electronic data to prevent the legal discoverability of that information, reducing the risk of breaches.

This brings us to the last of the high-impact areas, Privacy and Security. Physical safeguards and access management are vital to ensuring that information is protected and classified appropriately. Many healthcare organizations have paper records that were created prior to implementing an electronic health record (EHR). Until those records can be effectively secured through access controls, and accessed by only those with a legitimate need to do so. Another area that falls into this high-impact area is release of information (ROI) practices. HIM professionals should know: Who is performing ROI? What training is provided to ROI staff to ensure the appropriate handling of PHI?

HIM professionals are at the center of disclosure management. Many HIM directors serve as privacy officers as well and have a crucial role in compliance by ensuring that approved policies and procedures are in place and followed to identify data breaches, reporting requirements, and follow-up, including sanctions.

HIM and IG Strengthen Privacy and Security
HIM professionals play a key role in ensuring compliance to address privacy and security risks. Information governance practices facilitate compliance requirements through enterprise-wide policies and procedures around all workflows and tasks, including MPI management, ROI, and defensible disposition.
“Information governance provides a sustainable, foundational framework that drives the cross-functional awareness and the accountability required to proactively identify and remediate policy gaps and emerging risk across the organization,” wrote the authors of the white paper.¹

Using information governance practices, HIM professionals can work to ensure that the healthcare organization’s most valuable asset is protected and secured and that the organization can get strategic value from its information. ²

Notes

Ann Meehan (ann.meehan@ironmountain.com) is a senior consultant at Iron Mountain. This article is copyrighted (owned) by Iron Mountain and cannot be used or reproduced without the express permission of Iron Mountain. The Journal of AHIMA is reprinting this article with permission. To request permission for its use contact Iron Mountain at michelle.urban@ironmountain.com.
THE DIRECT FISCAL impact of ever-increasing claim denials spans the healthcare continuum, including large health systems, independent hospitals, physician group practices, solo providers, and post-acute care facilities. A 2017 analysis of 850 hospitals’ payment transactions revealed that initial denial rates among five national payers varied from 7.5 percent to 11.1 percent of net patient service revenue (NPSR)—meaning $1 of every $10 of revenue is at risk for nonpayment. Nearly $3.5 trillion was spent on healthcare in the US in 2017, and that spending is projected to grow to $5.7 trillion by 2026. Extrapolation of this data clearly illustrates the significant financial impact of claim denials on US healthcare providers.

A best practice for mitigating financial risk is a proactive and preventative—not reactive—approach to denials management using claims data for denials prevention. This approach will enhance revenue by minimizing the number of denials, reducing the amount of uncollected revenue, and lowering the associated staff costs required for the appeals process.

The path to long-term successful denials prevention begins with a clear vision that is articulated in a formal denials prevention plan that includes stakeholders from across the healthcare continuum.

Role of Claims Data and Analytics in Denials Prevention

Claims data provides a comprehensive snapshot of a patient’s encounter. This data is valuable in identifying accounts for further review that may be at risk for denials based on current patterns.

Key elements of claims data include:

- Patient demographics
- Diagnoses
- Procedures
- Modifiers appended to outpatient procedure codes
- Date(s) of service
- Service provider/national provider identifier (NPI)
- Revenue codes
- Occurrence codes
- Status codes
- Plan and payer information
- Charges and reimbursement for episode of care

Claims data is rich with information that can be measured at the individual level and can aid in treatment decisions, as well as generalized data that can be extrapolated and applied to a broader population. To ensure all these quantitative and qualitative elements are measurable, the data must be accurate and clean from the source.

Data analytics can be employed to proactively minimize claim denials and improve coding accuracy, thereby contributing to an overall denials prevention strategy. Many healthcare organizations use a case-by-case auditing approach once a denial is received. However, a more global strategy is the analysis of an organization’s claims database which allows for the identification of denial-prone codes as well as potential denial trends. This allows an organization to proactively identify and correct potential sources of coding-related denials on a much broader scale and to craft education surrounding the findings to prevent future errors.

The Office of Inspector General (OIG) Monthly Updates Work Plan is a valuable industry resource that identifies projects such as OIG audits and evaluations that are underway or planned. There is no longer an annual work plan, but instead individual issues on a monthly basis. Other industry resources include the Recovery Audit Contractors’ (RACs) focus areas, as well as the American Hospital Association’s Coding Clinic, the American Medical Association’s CPT Assistant, the National Correct Coding Initiative Edits (NCCI), and various trade journals, newsletters, and blogs that discuss coding issues. Internal resources that can be used to develop claims database analytics include internal and external coding audit results, root causes of previous claim denials, and the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER is a comparative data report that summarizes a hospital’s Medicare claims data statistics for areas prone to abuse/improper Medicare payments.

Based on the volume of potential coding issues to be analyzed, an organization should prioritize issues that represent common diagnoses and procedures, high-dollar cases, and issues that relate to quality and safety measures and value-based purchasing.

Life Cycle of Claims

The life cycle of a claim begins from the moment a patient is seen by a provider and ends when all outstanding payments from clean claims are received. Administrative, clinical, and health information management (HIM) and coding staff must follow specific processes to help ensure correct and timely reimbursement. Omission of any step in the process may cause the claim to be ineligible for payment, resulting in a claim denial. Patient demographics collected by registration and/or patient admitting representatives is key and critical to the coding process.
Healthcare organizations should keep the following basic steps in mind for effective results-oriented claim processing:

- Efficient scheduling and pre-registration data collection
- Health record documentation
- Charge capture and coding
- Claim submission
- Claim follow-up
- Timely claim payment posting
- Timely denials, appeals, and collections processing

Provider documentation is the basis of coding diagnoses and procedures for an encounter. The accurate collection and appending of coded data to a claim form initiates the reimbursement process. Once internal billing edits are resolved, a claim is generated and submitted to the payer. The claim is then tracked for payment. Should the payer issue a denial, the appropriate entity within an organization is responsible for the correction.

There is a shared responsibility for review of claims denials among HIM, clinical documentation improvement (CDI), patient accounts, and the department originating the charge. The HIM department may be the preferred entity to lead denials management by validating that provider documentation supports the correct code assignment.

Appeals Process

Organizations that view coding denials as learning opportunities strategically empower themselves to strengthen their ability to successfully appeal and ultimately reduce future denials through an improved clean claim rate. Although a trend of rogue denials is on the rise, methods exist that allow providers to take legitimate denials and use analytics to craft effective defense strategies. The best defense against denials is a singular organizational vision of revenue integrity wherein all stakeholders collaborate to achieve this goal. After determining a claim denial is legitimate, the specific issue(s) that prompted the denial must be carefully examined from all angles:

- **Step 1 – Clinical Documentation Analysis:** Perform a thorough review to ensure that consistent and complete clinical documentation was present in the health record at the time of coding. If documentation gaps or inconsistencies are identified, a collaborative effort between CDI and HIM should be undertaken to identify problematic documentation trends in order to create better documentation strategies. Robust dialogue among clinicians, CDI staff, and HIM staff can help improve disconnects between medical language and coding language—thereby reducing impediments to correct coding.

- **Step 2 – Coding Analysis:** Coding denials offer stellar opportunities to identify knowledge gaps in an organization's coding staff. Focused internal audits, based on identified denial patterns, are an important and proactive component of denials prevention. Audit results not only illuminate erroneous coding patterns but also provide an understanding of the logic that underlies them. It is important to remember that coding professionals are faced with time constraints due to the complex and ever-expanding nature of ICD-10 and CPT coding coupled with productivity expectations. Coding professional time constraints may result in missed query opportunities, imprecise coding, lack of attention to coding guidelines and conventions, and incorrectly assigned present on admission indicators. The method of efficient coding, without sacrificing quality, should be taught to all coding professionals whose efforts will, in turn, positively impact denial rates.

- **Step 3 – Create a Long-Term Denials Prevention Plan:**

  Each new round of coding denials offers the opportunity to take legitimate denials and use analytics to craft effective defense strategies. The best defense against denials is a singular organizational vision of revenue integrity wherein all stakeholders collaborate to achieve this goal. After determining a claim denial is legitimate, the specific issue(s) that prompted the denial must be carefully examined from all angles:

  - **Step 1 – Clinical Documentation Analysis:** Perform a thorough review to ensure that consistent and complete clinical documentation was present in the health record at the time of coding. If documentation gaps or inconsistencies are identified, a collaborative effort between CDI and HIM should be undertaken to identify problematic documentation trends in order to create better documentation strategies. Robust dialogue among clinicians, CDI staff, and HIM staff can help improve disconnects between medical language and coding language—thereby reducing impediments to correct coding.

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  - **Step 3 – Create a Long-Term Denials Prevention Plan:**

    Each new round of coding denials offers the opportunity
to perform clinical documentation integrity and coding quality analyses. Providing continuous education to correct the knowledge deficits for the CDI and coding staff will result in greater accuracy in coding and claims submission and a reduction in appeals for the long-term.

Regulatory Considerations

The impact of regulatory oversight in claims processing cannot be overemphasized. Lack of competency in this area is a consistent reason for claims denials and delays of payment. This problem extends to coders, auditors, and coding managers. There are thousands of pages of regulatory guidance that may lead to quick resolution of edits and denials, but staff members must be aware of how to access these resources and then how to correctly apply the guidance. For many coding professionals, the edit resolution process is more a matter of guesswork. This is not due to a coding professional’s lack of consideration about these issues; rather, it is more a matter of a failure to understand what resources may be used to assist them. This can be easily corrected by sharing with staff members the valuable resources created by the Centers for Medicare and Medicaid Services (CMS) to guide edit resolution actions.

For outpatient coding and auditing of facility and professional fees, the regulatory resources in the sidebar on page 37 are available to assist in ensuring correct coding. These resources, and the guidance found within, may potentially affect codes on every claim and many times follow and support coding directives as found in the CPT Manual. CMS does have some directives that are not found in CPT, and vice versa. When coding for claims for Medicare and Medicare Advantage Plans, follow the regulatory guidance. Individual commercial payers may have their own directives in this regard.

Benchmarking Overview

Benchmarking is the process of comparing and contrasting an individual facility’s or organization’s business process and performance metrics with industry best practices.

An organization may have multiple data sources against which analyses can be performed to help improve coding accuracy. These data sources include registries and individual departmental databases. The types of analyses can be very specific to organizational needs.

For example, a hospital with a pattern of failure to code and report tracheostomies when performed can use the respiratory therapy department’s database to identify all tracheostomy cases for analysis. Similarly, an orthopedic department’s joint replacement database could be used to identify all bilateral joint replacement and revision cases for review.

Data analytics techniques can be a powerful tool when developing and analyzing benchmark data. Consideration must be given to the following factors:
- Timeframe in which data was compiled
- Appropriateness of benchmark providers or organizations selected
- Specific measures used (e.g., procedure code, DRG, charges, costs, LOS) for comparison

Table 1: Example of Benchmarking MS-DRG Hospital Data with CMS National Data

<table>
<thead>
<tr>
<th>DRG</th>
<th>DRG Title</th>
<th>Hospital Data Example</th>
<th>Variance</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>291</td>
<td>Heart Failure &amp; Shock W MCC</td>
<td>10.01%</td>
<td>Over National Benchmark</td>
<td>Denial Risk</td>
</tr>
<tr>
<td>292</td>
<td>Heart Failure &amp; Shock W CC</td>
<td>6.37%</td>
<td>Under National Benchmark</td>
<td></td>
</tr>
<tr>
<td>293</td>
<td>Heart Failure &amp; Shock W/O CC/MCC</td>
<td>3.64%</td>
<td>Under National Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Considerations to take into account include:
- Does my facility’s CC/MCC capture rate for a given principal diagnosis align with the CMS mean?
- Is my facility potentially under-reporting or over-reporting CCs or MCCs for a given MS-DRG?
- What is the value of conducting an internal review of CC/MCC capture rates based on CMS MS-DRG benchmarks?
How can I use this data analysis model to positively impact my facility’s data quality and overall financial health?

To find the CMS benchmark data, follow these steps:

1. Navigate to www.cms.gov
2. Search for Fiscal Year Final Rule Tables
3. Table 5: List of Final MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
4. Tables 7A and 7B contain the number of discharges, and selected percentile lengths of stay

The formula for utilizing Tables 7A and 7B is as follows:

- Add the total number of discharges per MS-DRG set
- Divide the MS-DRG volume by the MS-DRG set total volume
- The results equal the percent of MS-DRG set total volume per MS-DRG

Example of MS-DRG Benchmarking

For illustrative purposes, consider the heart failure MS-DRG set (DRGs 291, 292, 293). According to the Centers for Disease Control and Prevention, the national estimated cost to treat heart failure annually is $31 billion. Fiscal Year (FY) 2018 ICD-10-CM code changes included numerous new and revised heart failure codes that allow more granular categorization and capture of heart failure data. It can take time for documentation and coder knowledge to catch up with the ever-expanding ICD-10-CM code set. As such, it is wise to benchmark your facility’s DRG reporting against the national benchmarks with data found in Tables 7A and 7B. Table 1 on page 38 illustrates a facility wherein DRG 291 exceeds the national benchmark and DRGs 292 and 293 fall below the national benchmarks. Focused audits of this MS-DRG set could potentially reveal both under- and over-reporting of heart failure data and their accompanying MCCs and/or CCs.

While it is possible to benchmark code edits, delays of payment, and/or denials without having full regulatory competency, there is greater understanding of the issues involved if the data is more than just a number. An understanding of the deeper issues underlying the reasons for edits and denials is essential to a successful revenue cycle. For example, the grid in Table 1 contains insightful data into potential over-reporting and under-reporting of MCCs and CCs for a given DRG family. A next step would be to perform quality audits surrounding documentation and coding for cases that group to DRG 291 to determine the legitimacy of the MCC capture rate. The same logic could be applied to cases that group to DRGs 292 and 293 to determine if missed revenue opportunities exist. The audit findings can be used to identify erroneous documentation and coding trends which can then translate into best practice education for all stakeholders. All HIM staff members performing data analytics would benefit from expanding their knowledge and competency in this area.

Denials Prevention and Management Programs Offer Value

Programs to prevent and manage denials not only bring tangible fiscal value to organizations, but also enhance the skillsets of the HIM professionals who create and manage them. The financial value of denials prevention and management programs varies directly with the amount of strategic global thinking, time, and effort invested in the process. The implementation of a proactive denials management strategy often requires an additional investment of time on the front end, while continuing to process retrospective cases and meet appeal deadlines. The result, however, often yields a significant reduction in initial denials through analysis of coding targets, concurrent audits, and education of coding staff. Once a proactive denials management program is in place, a culture of continuous quality improvement takes root, involving stakeholders across the healthcare continuum.

HIM professionals are uniquely positioned to take leadership roles in their healthcare organization to successfully navigate the complex issue of payer denials, as thorough knowledge of coding and clinical documentation integrity is essential to the process. A positive impact on an organization’s bottom line from a reduction in denials will help ensure a place at the table for HIM professionals with other revenue integrity stakeholders. Most importantly, a reduction in denial rates directly translates into more available revenue for patient care.

Notes


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CALENDAR YEAR (CY) 2019 brings robust changes to the CPT code set with 212 new codes, 73 deleted codes, and 50 revised codes. This puts the total number of CPT codes at an all-time high of 10,294. This article will highlight some of the CPT changes, focusing on the surgical CPT codes.

The tables on page 41 and page 42 offer a breakdown of the overall changes, as well as a breakdown of the body system subsection changes for the surgery subsection.

Overview of Changes in Surgery Subsections
The 2019 update saw several CPT code changes in the surgery subsections. Below are some of the highlights.

Integumentary System
Most of the changes in the surgery subsections have to do with the integumentary system. There are two new sets of biopsy codes. The first set involves updates to fine needle aspiration (FNA) biopsy codes. The old code of 10022 for FNA with imaging guidance was deleted. Code 10021 was updated to describe FNA without imaging guidance of the first lesion. Code +10004 was added for FNA without imaging guidance of each additional lesion. Imaging may not always be needed if the mass or lesion is clearly visible. There are eight more new codes (10005-10012) that describe FNA by type of imaging guidance with add-on for each additional lesion. The imaging guidance in the codes include ultrasound, fluoroscopic, CT, and MRI. Coding professionals will now have to really study the procedure note to determine what type of guidance was used, if any, and if additional lesions were biopsied. Coders may also want to review the difference between FNA and core needle biopsies. FNA biopsy is performed when material is aspirated with a fine needle, percutaneously, and the cells are examined cytologically. A CORE needle biopsy is typically performed with a larger bore needle to obtain a core sample of tissue for histopathologic evaluation. CORE needle biopsies are coded within the body system subsections and are not fine needle aspirations.

The real challenge to the FNA biopsy codes come into play when there are multiple types of imaging used on different lesions, or if there is both a FNA and CORE biopsy done of the same lesion—leaving many coders unsure how to proceed. In such an instance, the coder should follow these guidelines:

- If FNA and CORE biopsies are done on the same lesion, same session, same day, same type of imaging guidance, do not separately report the imaging guidance for the CORE biopsy code, but report the “without imaging guidance” code with modifier -59. For example:
  - 10007, FNA biopsy including fluoroscopic imaging first lesion
  - 19100-59, Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure). Report this code without guidance. The same imaging guidance should not be reported twice.

- If FNA and CORE biopsies are done on separate lesions, same session, same day, same type of imaging guidance, report both types of biopsies with imaging guidance, with modifier -59 on the second.
The next set of biopsy codes added were six new codes (11102-11107) that depict the type of biopsy, each type with an add-on code. There are three types of skin biopsies. The first is tangential, which is a scoop, saucerize, shave, or curette type of biopsy removal. The second type is a punch biopsy, which uses a punch tool, and the last type is incisional biopsy of skin using some type of sharp blade. There is a hierarchy with incisional biopsy being the most involved, followed by punch, and finally by tangential. If a coder has a case where there are two lesions biopsied by different means, one tangential and one incisional, then the primary code for the incisional biopsy would be assigned, followed by the “add-on” code for the tangential skin biopsy. Coders will also need to read the operative report carefully so that they do not confuse a punch skin biopsy with an actual full lesion removal via a punch excision. A punch excision takes a small margin around the lesion. This is not a biopsy, but a lesion removal. Also, coders should not confuse a “tangential shave” biopsy with an actual shave removal of the entire lesion (codes 11300-11313).

New Category III codes 0512T-0513T were created for extracorporeal shock wave therapy for integumentary wound healing.

**Musculoskeletal**

New add-on codes were developed for osteoarticular, hemicortical intercalary, partial and intercalary, complete (+20932-34) allografts. These are usually cadaver bone and will typically be used with codes for radical resections of bone tumors, such as osteosarcomas. Osteoarticular includes articular surface and contiguous bone. Intercalary is cylindrical and hemicortical intercalary, partial, is hemicylindrical. Other new codes include injection for contrast knee arthrography or contrast-enhanced CT/MRI knee arthrography and insertion or removal or both of sinus tarsi implant, which treats over-pronation and mobile flat foot.

**Cardiovascular**

The first group of additions in the cardiovascular subsection involves new codes for a leadless pacemaker. The leadless pacemaker is placed directly in the heart in the right ventricle, which eliminates the need for a subcutaneous pocket. The codes are 33274 for insertion or replacement of leadless pacemaker and 33275 for removal. These had been Category III codes 0387T-0388T last year, so the procedure is not new.

There are two new codes for insertion and removal of cardiac rhythm monitor. This is also known as a cardiac event monitor...
Coding Notes

Surgery Subsections

<table>
<thead>
<tr>
<th>CPT Surgery Subsections</th>
<th>Codes Added</th>
<th>Codes Deleted</th>
<th>Codes Revised</th>
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<td>1</td>
<td>0</td>
</tr>
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<td>Cardiovascular</td>
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<td>3</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Digestive</td>
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<td>3</td>
<td>0</td>
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<tr>
<td>Urinary &amp; Male Reproductive</td>
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<td>1</td>
<td>0</td>
</tr>
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<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Eye or Endocrine</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Totals for Codes</td>
<td>34</td>
<td>20</td>
<td>6</td>
</tr>
</tbody>
</table>

or insertable loop recorder. It continuously records rhythms triggered by irregular heart rates.

One new code was created for transcatheter implantation of wireless pulmonary artery pressure sensor. This monitor is for patients with class III heart failure. There is now a code for replacement of aortic valve with the patient’s own pulmonary valve (33440). The patient then receives a pig valve in the place of the pulmonary valve. This is because the native pulmonary valve gets less “traffic” than the aortic valve, so a pig valve works well in its place. The patient’s own pulmonary valve is better suited to take on the workload of the aortic valve it is replacing. This is also known as the Ross-Konno procedure. One new add-on code, +33866, was added to report hemiarch graft that is used in ascending aortic graft replacement surgery, which is coded separately.

Peripheral inserted central venous catheter codes 36568-36584 were revised or created for “without imaging guidance” and “including all imaging guidance, image documentation.” The imaging guidance used is usually fluoroscopy and ultrasound. All supervision and interpretation (S&I) with the guidance is also included in the codes.

New Category III codes were created for insertion and removal of various components of a wireless cardiac stimulation device. The WiSE CRT system from EBR is one example. This device is used for left ventricular pacing and resynchronization of the heart. The stimulation is accomplished using components from a previously implanted conventional device such as a pacemaker that are activated by the wireless cardiac stimulation system.

One new Category III code, 0505T, was created for endovascular femoral-popliteal artery revascularization, or bypass stent graft. In this procedure, the stent graft exits the artery and then is placed in the adjacent vein—usually the femoral vein—until it is around the arterial blockage. Then the stent graft is brought into the artery again. If the stent graft does not enter the adjacent vein, then it is not coded to 0505T.

There are also new Category III codes for coronary fractional flow reserve, endovenous catheter-directed chemical ablation with balloon isolation of incompetent extremity vein, and insertion removal, programming and interrogation of an intracardiac ischemia monitoring device.

Digestive

Two new codes (43762, 43763) were added to distinguish replacement of gastrostomy tube, percutaneous, without imaging, either not requiring revision of gastrostomy tract, or requiring revision of gastrostomy tract. There are other existing codes for gastrostomy tube replacement under fluoroscopic guidance and for endoscopically placed gastrostomy tube. So, the coder is cautioned to pay attention to the method used to replace a gastrostomy tube. Old code 43760 was deleted.

Urinary

Two new codes were created to help clear up confusion regarding dilation of a nephrostomy tract or creation of a new tract. One new code, 50436, is for dilation of an existing nephrostomy tract for the purpose of inserting larger instruments for an endourological procedure. It includes post-procedure nephrostomy tube placement, all imaging guidance, and S&I. The second code, 50437, is for creation of a new access, and includes all the elements of 50436. Code 50395 was deleted. These changes will help the coder better understand what is included in these procedures.

New code 53854 replaces HCPCS code C9748 for transurethral destruction of prostate tissue by radiofrequency-generated water vapor therapy.

Coding professionals must fully review the CPT code book instructional and code notes, as well as documentation and reimbursement requirements, in order to be fully proficient in assigning these new codes.

Category III Code Changes

Some of the new surgical Category III codes have been covered above. Many of the new codes have to do with diagnostic testing or non-surgical procedures. Hospitals may report
some of these codes via chargemaster charging at the departmental level. Examples include 0533T-0536T, Continuous recording of movement disorder symptoms and 0537T-0542T, Chimeric antigen receptor T-cell (CAR-T) therapy. Coders are urged to peruse the Category III code section of CPT to look for procedures that are performed at their facilities. Work with hospital departments on how these codes will flow to the claim. Many can be placed on the chargemaster.

**Radiology, Laboratory, Medicine Changes**

Since many of these codes are chargemaster-driven, this section won’t go into detail regarding the changes. For Radiology there are 10 new codes, six deleted, and four revised. Changes include six new ultrasound and ultrasound with elastography codes and four new magnetic resonance imaging of breast codes.

For the Medicine section there are 29 new codes, 13 deleted, and 17 revised. This includes one new code, 93264, for remote monitoring of wireless pulmonary artery pressure sensor and seven new or revised neurostimulator monitoring codes. A new “Adaptive Behaviour Services - Assessments – Treatment” subsection is new along with other central nervous system testing codes.

For Laboratory and Pathology sections, there are 95 new codes, five deleted codes, and 15 revised codes. Most of the new codes encompass molecular pathology codes, a growing area in pathology.

**Evaluation and Management Changes**

For Evaluation and Management, the term “Electronic Health Record” was added to the subsection “Interprofessional Telephone/Internet Consultations” and notes to denote the increased use of the online electronic health record “visits.” Two new codes, 99451-99452 were created to denote various times for “Interprofessional telephone/internet/electronic health record assessment and management service” provided by a consultative physician or referral services provided by a treating/requesting physician.

New subsections for “Digitally Stored Data Services/Remote Physiologic Monitoring” and “Remote Physiologic Monitoring Treatment Management Services” have been created to include four new codes and one revised code. This is a much-needed area for CPT as more and more patient data becomes digitized and is managed and assessed by the physician after download.

One new code has been created, 99491, Chronic care management services provided personally by a physician or other QHCP at least 30 minutes of physician/QHCP time, per calendar month. There are required elements for this code.

The coder who assigns the above evaluation and management codes should read the extensive notes included in the CPT introduction to this subsection. It is mandatory to follow these instructional notes.

**Appendix L Expansion**

Coders will find that the American Medical Association has expanded Appendix L, Vascular Families to include detailed diagrams of vessels and the appropriate order for normal anatomy.

**Further Review of Changes**

In summary, this article was a brief overview of the CPT changes for CY 2019. Coding professionals must fully review the CPT code book instructional and code notes, as well as documentation and reimbursement requirements, to be fully proficient in assigning these new codes.

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ACCORDING TO THE Agency for Healthcare Research and Quality (AHRQ), more than 10 million patients undergo surgical procedures as inpatients each year, accounting for over 25 percent of all hospital stays. The most common types of inpatient surgical procedures include cesarean section, hip and knee replacement, hip fracture repair, spinal fusion, laminectomy, cholecystectomy, and colorectal resections.

Surgical site infection (SSI) is defined by the Centers for Disease Control and Prevention (CDC) as infection related to an operative procedure that occurs at or near the surgical incision within 30 days of the procedure, or within 90 days if prosthetic material is implanted at surgery. This is among the most common preventable complications after surgery. SSIs occur in two to four percent of all patients undergoing inpatient surgical procedures. Although most infections are treatable, SSIs remain a significant cause of morbidity and mortality after surgery. They are the leading cause of readmissions to the hospital following surgery, and approximately three percent of patients who contract an SSI will die.

Risk factors for SSI include patient attributions (such as age, tobacco use, diabetes, and malnutrition) and procedure-specific risk factors (including emergency surgery and the degree of bacterial contamination of the surgical wound at the time of the procedure). While many of these risk factors are not modifiable, the majority of SSIs are considered preventable, and recent advances have improved insights as to how hospitals can systematically prevent these infections.

International Classification and Official Guideline Update

For Federal Fiscal Year (FFY) 2019 the International Classification of Diseases 10th Edition, Clinical Modification (ICD-10-CM) expanded code subcategories T81.4, Infection following a procedure, and O86.0, Infection of obstetrical surgical wound, to identify the depth of the post-procedural infection and a separate code to identify post-procedural sepsis. This was done at the request of the Patient Assessment and Outcome Committee of the American Association for Surgery and Trauma to better align the ICD-10-CM classification with categories for SSI as defined by the CDC.

Codes T81.41- and O86.01 classify those post-procedural infections that have a superficial SSI at the incision site. This includes subcutaneous abscess following a procedure and stitch abscess following a procedure. Codes T81.42- and O86.02 classify those post-procedural infections that are designated as deep in the surgical incision site, including intra-muscular abscesses. Codes T81.43- and O86.03 classify post-procedural infections that go into organ and space surgical sites, including but not limited to intra-abdominal abscess and sub-phrenic abscess. Codes T81.44 and O86.04 are used to identify sepsis following a procedure.

With the expansion of these code subcategories, a code sequencing issue arose; if a patient has sepsis due to an intra-muscular abscess at a prior procedural incision, which code should be sequenced first: T81.42- for the post-operative wound infection or code T81.44 for the sepsis from the post-procedural wound infection?
Prior to the FFY 2019 expansion of subcategory T81.4-, a post-procedural wound infection and post-procedural sepsis were assigned to the same ICD-10-CM code T81.4-, Infection following a procedure with a code for the infection (sepsis, cellulitis, etc.) assigned as secondary diagnoses, if specified, so there was no sequencing issue. In order to address this sequencing issue, the FFY 2019 Official Guidelines for Coding and Reporting were also updated to delineate how codes from subcategory T81.4- should be sequenced. Per the 2019 Official Coding Guidelines I.C.1.d.(5).(b):

For infections following a procedure, a code from T81.40 to T81.43, Infection following a procedure, or a code from O86.00 to O86.03, Infection of obstetric surgical wound, that identifies the site of the infection should be coded first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

When comparing the FFY 2018 Official Coding Guidelines to the FFY 2019 Official Coding Guidelines on this topic, it can get confusing with all of the additions, deletions, and modifications. Simplified, the new rule states that when a patient has sepsis due to a post-procedural wound infection, a code for the wound infection is sequenced first followed by a code for the post-procedural sepsis. This may seem counterintuitive to some coding professionals who are used to sequencing sepsis first when it is associated with a localized infection (the wound infection in this case).

For comparison, see Table 1 at right for the 2018 and 2019 diagnosis-related group (DRG), relative weight, and code sequencing for sepsis from a post-procedural wound infection that includes intramuscular abscess.

Under code T81.44- there is an instructional note that states “use additional code to identify the sepsis.” Per the coding guidelines, this instructional note is found in the Tabular List with codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. In this example, assigning code A41.9, Sepsis, unspecified organism, does not provide any additional information that is not already included in code T81.44-. Therefore, no additional code is assigned for an unspecified sepsis. This is noted on page 25 of the first quarter 2017 issue of the American Hospital Association’s Coding Clinic, which states that an unspecified code should not be assigned as an additional code when it does not provide any additional information. In order to maintain the major comorbid condition (MCC) status in this case, the provider must specify the organism associated with the sepsis so that a code from categories A40-A41 can be assigned that specifies the organism.

**Addressing Public Health Issues with Coding**

SSIs are persistent and preventable healthcare-associated infections. There is increasing demand for evidence-based interventions for the prevention of SSI. Prior to the 2017 update, the last version of the CDC Guideline for Prevention of Surgical Site Infection was published in 1999. While the guideline was informed by evidence, most recommendations were based on expert opinion, in the era before evidence-based guideline methods. CDC updated that version of the guideline with an evidence-based method. Most of these data points, recommendations, guidelines, and definitions are born of coded data that is abstracted from healthcare claims. Without codes that are specific and descriptive and in alignment with clinical language it can be near impossible to monitor such public health issues.

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**Table 1**

<table>
<thead>
<tr>
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<tr>
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<td>T81.42XA</td>
</tr>
<tr>
<td>Infection Following Procedure, initial</td>
<td>Infection Following a Procedure, deep</td>
</tr>
<tr>
<td>encounter</td>
<td>incisional surgical site, initial</td>
</tr>
<tr>
<td></td>
<td>encounter</td>
</tr>
<tr>
<td>Secondary Diagnoses</td>
<td>Secondary Diagnoses</td>
</tr>
<tr>
<td>A41.9</td>
<td>T81.44XA</td>
</tr>
<tr>
<td>Sepsis, unspecified organism</td>
<td>Sepsis Following a Procedure, intial</td>
</tr>
<tr>
<td></td>
<td>encounter</td>
</tr>
<tr>
<td>M60.08</td>
<td>M60.08</td>
</tr>
<tr>
<td>Infective Myositis, other site</td>
<td>Infective Myositis, other site</td>
</tr>
</tbody>
</table>

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*Continued on page 50*
A Look Ahead
Upcoming AHIMA Institutes, Seminars, Workshops, and Webinars

APRIL
3–4  CSA Meeting: Missouri, Branson, MO
3–5  CSA Meeting: Arkansas, Little Rock, AR
4    CSA Meeting: Alaska, Anchorage, AK
4–5  CSA Meeting: Idaho, Boise, ID
8–9  CSA Meeting: Indiana, Noblesville, IN
8–9  CSA Meeting: Iowa, Des Moines, IA
9    AHIMA Foundation Webinar: Apprenticeships: An Effective Workforce Planning Model for Employers
10–12 CSA Meeting: Nebraska, Kearney, NE
11–12 CSA Meeting: Oklahoma, Catoosa, OK
11–12 CSA Meeting: New Mexico, Albuquerque, NM
12    Student Open House, Chicago, IL
15–16 CAHIIM Accreditation Process Conference, Chicago, IL
16    Faculty Development Webinar: CourseShare and Educator Resources
17–18 CSA Meeting: Maryland and Washington, DC, Baltimore, MD
18–19 CSA Meeting: Kansas, Wichita, KS
23–25 CSA Meeting: West Virginia, Bridgeport, WV
24–25 CSA Meeting: Montana, Great Falls, MT
24–25 CSA Meeting: South Dakota, Mitchell, SD
25    Career Assist: Virtual Career Fair
25–26 CSA Meeting: Illinois, Normal, IL

UPCOMING INSTITUTES, SEMINARS, WORKSHOPS, AND WEBINARS
May 1–3  CSA Meeting: Minnesota, Duluth, MN
May 2–3  CSA Meeting: Colorado, Lone Tree, CO
May 5–8  CSA Meeting: Alabama, Georgia, North Carolina, and South Carolina, Myrtle Beach, SC
May 7–9  CSA Meeting: Wisconsin, Green Bay, WI
May 10   CSA Meeting: Rhode Island, Warwick, RI
May 14   AHIMA Foundation Webinar: Apprenticeships: A Tool for Career Seekers
May 15–16 CSA Meeting: Virginia, Richmond, VA
May 15–17 CSA Meeting: Hawaii, Honolulu, HI

Check www.ahima.org/events for the latest schedule of institutes, seminars, and workshops.

Keep Informed
Resources and News from AHIMA

New On-Demand Webinars Now Available
Available and ready any time you are, new AHIMA on-demand webinars are now in the AHIMA Store. Ranging in topics from coding to revenue cycle management to privacy and security, AHIMA’s on-demand webinars offer the latest education on important health information topics.

On-Demand Webinar: Professional Coding Audits: It’s More Than Just Compliance
Gain an understanding of an incredibly important benefit of auditing professional services: the ability to analyze the accuracy of physician productivity models. Organizations or physicians wanting to understand the accuracy of their physician productivity data can perform a self-initiated audit of coding and billing.

On-Demand Webinar: Improving Revenue Integrity: The New Frontier for HIM Professionals
With the challenges of ICD-10 behind the healthcare industry and many new regulatory opportunities on the horizon, there is more focus and opportunity for HIM professionals in the area of revenue integrity. This presentation explores the regulatory climate impacting healthcare, provides definitions for “revenue integrity” and “denials management,” and discusses how they are linked to health information management.

On-Demand Outpatient Clinical Documentation Improvement (CDI) Workshop Recordings
With this workshop, attendees will gain the knowledge and skills to apply CDI principles to outpatient settings; analyze the benefits, drivers, and structure of outpatient CDI; develop outpatient CDI policies and procedures; examine outpatient documentation scenarios to determine opportunities for improvement; and evaluate the impact of high-quality documentation on coded data.

Visit https://my.ahima.org/search/webinars for a full list of on-demand webinars.
AHIMA Volunteer Leaders

Email changes to your listing to sarah.sheber@ahima.org

Journal of AHIMA March 19/49
AHIMA Thanks Its Loyalty Program Members

The AHIMA Loyalty Program offers organizations the opportunity to better align their marketing outreach with AHIMA’s print, content, and information channels while delivering year-long exposure to AHIMA’s 103,000+ health information professionals.

To learn more about the AHIMA Loyalty Media Program and position your organization for success, contact: Jeff Rhodes, 410-584-1940, jeff.rhodes@mci-group.com or Allison Zippert, 410-584-1941, allison.zippert@mci-group.com

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References


Melissa Minski (Melissa.minski@stonybrookmedicine.edu) is associate director, staff development, revenue integrity department at Stony Brook University Hospital and an AHIMA-approved ICD-10-CM/PCS trainer.

Continued from page 45 ("Surgical Site Infection Coding Update")
laptops to minimize access in case of theft; limit access to server rooms and secure areas.

After the analysis is complete the results should be documented. Create a summary of key findings, recommendations, and estimates. The documentation should include a timeframe to implement needed changes as well as an assessment of financial and personnel resources needed to mitigate the identified risks.

For each documented risk a decision should be made to either:
- Reduce risk by implementing additional controls
- Transfer the risk
- Avoid the risk by removing the process or system
- Accept the risk

Multiple benefits come from an effective risk assessment. When completed and acted upon, the assessment can plug security holes, prevent security breaches, and protect patient care capabilities.

Risk Assessment Timeline
Contingent on the size and complexity of the healthcare entity, some of the following risk assessment actions can be done concurrently:
- One year to do an inventory of all organizational computer systems, applications, and networks
- One year to organize a digital asset function and to staff it
- One month to create a security assessment taskforce
- Two months to review existing HIPAA compliance provisions and to review new HIPAA requirements
- Six months to create an organizational risk assessment tool and questionnaire and distribute throughout the organization; development of a database to collect results of the questionnaires
- Two months to assemble, summarize, and analyze reported risk assessments from the components of the organization
- IG steering committee reviews threats, gaps, and recommendations and makes the decisions on organizational actions. IG committee provides funding and human resources to implement needed actions.
- One month: Security risk assessment taskforce transitions to ongoing security incident response group. Security policy and procedures developed through the stakeholder group listed below in conjunction with the IG committee.
- Ongoing workforce education and training on security management policies
- Ongoing auditing/monitoring of workforce adherence to policies and procedures

End Goal and Desired State
The end goal and desired state is to ensure availability and access to ePHI for optimal patient care while simultaneously protecting ePHI from impermissible access and disclosure. The stakeholders required to complete a risk assessment include: legal, privacy/security, risk management, compliance, IT, health information management, business unit leaders, and enterprise information management leaders or executives.

Benefits of Risk Assessments
Multiple benefits come from an effective risk assessment. When completed and acted upon, the assessment can plug security holes, prevent security breaches, and protect patient care capabilities.

Other benefits include:
- Enhance planning capabilities
- Justify spending based on potential recovery costs required due to breaches, failed audits, etc.
- Cost-effective compliance that meets multiple legal requirements, including HIPAA
- Accurate and controlled digital asset management
- Accurate and controlled management of IT licensing requirements
- Documentation of due diligence maintained

Patients, clinical teams, the breach response team, and IT staff all benefit from risk assessments since they prevent incidents. The entity’s reputation, financial wellbeing, and continuous ability to provide acceptable access to PHI all benefit as well. ☺

Note

Wes Morris (wes.morris@clearwatercompliance.com) is senior principal consultant for Clearwater Compliance. Sandra Nunn (casand74@msn.com) is principal at KAMC Consulting.
Digital Assistants Record First Privacy Breaches
Incidents Create Questions About the Emerging Tech’s Use in Healthcare

UNQUESTIONABLY, ARTIFICIAL INTELLIGENCE (AI) is destined to revolutionize healthcare. It’s also highly likely that in the near future, lawmakers in the United States will pursue legislation to strengthen privacy laws in the wake of data breaches and scandals that have rocked tech giants such as Google and Facebook. In the meantime, American healthcare and technology companies might want to take some cues from what Europeans have learned in the relatively brief length of time that the European Union’s General Data Protection Regulation (GDPR) has been in effect.

One proposed use of AI in healthcare has been the adoption of digital voice assistants—such as Apple’s Siri, Amazon’s Alexa, and Google’s Home—in intensive care units, which a pilot program at Boston Children’s Hospital has been testing. Across the pond, Europeans have been taking advantage of the GDPR’s ability to let tech and social media users request to review data that companies like Google and Facebook have collected on them. According to NPR, one user in Germany asked Amazon for his data through GDPR only to realize that what Amazon sent back was 1,700 audio recordings by Alexa that were generated by another person.

“Suddenly, we found ourselves in the intimate sphere of strangers without their knowledge,” the user told the German magazine c’t.

Using the recordings and public Twitter and Facebook data, the magazine was able to piece together the identities of the Alexa users whose data were sent to the wrong person. Similar cases have happened in the US—for example, an Oregon couple discovered their digital assistant device sent a conversation to the husband’s employee, NPR reported. The incidents highlight the potential for privacy breaches of personal health information should use of this technology become widespread in healthcare.

As Katie McInnis, policy counsel for Consumer Reports, told NPR, “My concern as a result of what happened...is that a big corporation with sensitive information on individuals hasn’t figured out how to keep those sensitive conversations very secure.”

Clearly there is time for companies to work out the kinks before digital assistants become mainstream applications in healthcare. And hopefully hospital privacy officers will do their due diligence before patients are left saying, “Alexa, call my attorney.”

Notes
3. Ibid.

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CASE OF THE SENSITIVE ROI REQUEST

Magnum PHI and SureLook Holmes are called to the case when Danielle Disclosure, an ROI Specialist at a local hospital, is processing a sensitive ROI request. The two investigators swoop in to remind Danielle that MRO’s ROI Online® platform includes a built-in knowledgebase, intelligent guidance, and access to a specialized User Support team — all to help her process the request compliantly.

“The support doesn’t stop there,” says SureLook. “A second team of disclosure integrity specialists will review the request and use optical character recognition technology to ensure PHI accuracy. And, another team will validate the requester information, so you don’t need to worry about the records getting into the wrong hands!”

Read episode summaries and watch behind-the-scenes footage here: www.mrocorp.com/TwoPrivateEyes

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DON HARDWICK,
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