Biography:

MARDELLE KLAUS, RHIA, CCS, CPC, CHC, CHIAP
SENIOR ASSOCIATE

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Industries
Construction
Healthcare
Logistics/Wholesale
Media
Restaurants

Specialties
Compliance Programs
Corporate Integrity Agreements
Denials Management
Documentation, Coding, Billing and Claim Reviews
End-to-End Revenue Cycle Optimization
Enterprise Risk Management & Internal Audit
Forensic Analytics & Investigations
Healthcare Fraud
HIPAA Privacy & Security
Independent Review Organization (IRO)- Claim & Arrangement Reviews
Litigation Support
Payer Special Investigation Unit (SIU) Support
Provider/Payer Audit and Recoupment Defense
Reimbursement Model Analysis
Technology Assessments & Implementations

Mardelle Klaus brings a diverse background of healthcare experience including auditing, regulatory compliance and healthcare operations to GlassRatner. Her areas of expertise include providers and health plans with proficiency in Medicare, Medicaid and Commercial lines of business. She has successfully assisted clients in optimizing work flows, identifying and mitigating risks, analyzing and managing complex reimbursement issues and achieving peak revenue cycle performance. She possesses strengths in both pre-service insurance mechanics (i.e., authorizations, referrals, ABNs, etc.) as well as post-service coding, billing and claim adjudication processes. Ms. Klaus has served in project management and leadership roles. Most recently, Ms. Klaus has served as an expert providing litigation support on behalf of physician facing criminal indictment. She has conducted independent and objective investigation of allegations of fraud. Her efforts have uncovered critical findings key to the defense effort. She has also identified risk mitigation strategies and areas of operational improvement for implementation of stronger safeguards and controls with respect to documentation, coding and billing practices.

Ms. Klaus conducted retrospective payment audits on behalf of a Pacific NW-based health plan to ensure compliance with payer coverage guidelines. In addition, she has assisted the Special Investigation Unit ("SIU") with complex auditing and investigation of claims, medical and payment policies for suspect fraud, waste and abuse.

Ms. Klaus has served as interim Manager of Compliance and Coding Audit for one of the nation's largest multi-institutional Catholic health care delivery systems delivering the full spectrum of preventive, acute, and post-acute care services. Oversight included 4 acute hospitals, a licensed in-patient rehabilitation hospital, $1.6 billion in annual revenue, 1,642 beds, 837 employed providers and 1,500 affiliated partners.

Ms. Klaus also led the Patient Access Authorization Center for a Truven Top 15 Health System whose operations included 7 hospitals, 1,000 staffed beds; 150+ clinics; 1,300+ physicians. She managed the team through design and implementation of Epic go-live, supervised central authorization department staff, consulted on projects related to a health partners network benefit plan design and implementation, coordinated technology build needs between provider and payor systems and conducted root cause analysis on revenue cycle failures. She also designed and conducted audits for quality assurance and compliance.

Ms. Klaus is a Registered Health Information Administrator, Certified Coding Specialist, Certified Professional Coder, is board Certified in Healthcare Compliance, and is also a Certified Healthcare Internal Audit Professional. She is a member of the American Health Information Management Association, American Academy of Professional Coders and the Health Care Compliance Association. She has also completed training and holds certification in project management.

Selected Engagements & Experience:

- Served as interim Compliance and Coding Audit Manager for one of the nation's largest multi-institutional Catholic health care delivery systems. Oversight included $1.6 billion annual revenue, four (4) acute hospitals, a licensed

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in-patient rehabilitation hospital, 1,642 beds, 837 employed providers and 1,500 affiliated partners. Conducted internal auditing for compliance and coding related matters to detect and mitigate regulatory risk. Assisted in the investigation of government audit activity, response preparation, and identification of safeguards and controls to prevent future scrutiny. Reviewed Epic workflows and worked with development team to ascertain and implement best practices to ensure accuracy, efficiency and compliance. Developed and conducted compliance, documentation and coding related education across departments, including physician stakeholders.

- Served as a risk adjustment subject matter expert for a multi-specialty clinic. Performed review of population health management, clinical workflows, documentation, coding and billing functions. Developed best practice policy and procedures for risk adjustment data capture and reporting.
- Provided investigation and audit support to Special Investigation Unit (SIU) team related to suspected fraud, waste and abuse. Conducted research and audits related to data outliers indicative of inappropriate billing practices. Reviewed medical record documentation, claims data, scope of practice, specialty specific guidelines, local and national coverage determinations, commercial reimbursement policies and other related regulatory sources. Drafted reports summarizing findings and provided support for recoveries of identified overpayments.
- Developed an audit program for health plan contract compliance. Implemented a plan to ensure accurate claim adjudication according to plan benefits and coverage guidelines. Conducted claim audits and analysis of identified deficiencies. Coordinated resolution efforts between provider5s and health plans. Provided education and training related to patterns and trends.
- Served as key subject matter expert/lead for a turnaround "SWAT" committee. Played a lead role in the review of revenue cycle operations for a practice facing significant financial distress due to revenue cycle inefficiency and non-compliance with regulatory guidelines. Analyzed compliance risk in coding, billing and claim adjudication processes. Conducted audits to identify revenue cycle deficiencies. Designed and implemented optimized department structures, policies and procedures from patient access through claim adjudication.
- Led the Patient Access Authorization Center for a Truven Top 15 Health System. Operations included 7 hospitals, 1,000 staffed beds; 150+ clinics; 1,300+ physicians. Managed team through design and implementation of Epic go-live. Supervised central authorization department staff. Consulted on projects related to a health partners network benefit plan design and implementation; coordinated technology build needs between provider and payor systems. Conducted root cause analysis on revenue cycle failures. Designed and conducted audits for quality assurance and compliance. Collaborated with insurance recovery, billing and health plans to resolve claim issues and manage complex appeals.

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- Served as the lead investigator of revenue cycle integrity and optimization for an outpatient practice under government investigation of which the efforts culminated in the successful resolution of allegations resulting in the civil and criminal indictments being dropped and an extended payment suspension being lifted. Procurement of a new third-party billing and EHR vender was performed to improve patient care and increase revenue. Documentation improvement education was provided to clinicians which included suggestion for template design and ICD-10-CM basics.
- Assisted internal review in response to a government investigation to proactively identify risk to develop a remediation plan in collaboration with council. Execution of an audit of clinical documentation and claims to development specialized clinical documentation and coding education for clinicians.
- Conducted an investigation on the legitimacy of hospital receivables previously leveraged as collateral for secured line of credit. Allegations prompting the review included concerns that hospital owners promptly withdrew the maximum allotment of credit which coincided with the closure of the hospital operations despite of the previous claim of hospital's profitability. Provided independent and objective analyses of the collectability of the receivables to be used in the negotiation of a settlement to resolve the outstanding debt.