

HEALTH CARE

POSSIBILITIES



inside

■ Fraud Perspectives

Health Care Under Siege

OVERVIEW

Fraud is becoming an increasing problem for many companies—including health care organizations. This article explains the causes, and how organizations can detect and mitigate their chances for fraud.

Just imagine an “extra” 8.4 percent of your total revenue available as an unbudgeted item. You get to decide how the funds are to be spent. In today’s economy, this may represent the difference between making it and not making it.

According to the Association of Certified Fraud Examiners (ACFE) in its 2008 Report to the Nation, 8.4 percent of total revenue in the health care industry is lost to fraud each year, with 75 percent of health care organizations victimized by fraudsters. In the health care industry alone, the median loss per event is \$150,000, and the fraud is often not discovered for 18 to 24 months.

How does fraud occur in clinics and hospitals? How can an organization detect fraud? What can be done to mitigate the occurrence of fraud? These are common questions posed by employees and management of many health care organizations.

Fraud occurs when there is an opportunity for it. The complex nature of health care lends itself to be a primary target for fraud. On one side, insurance companies and government agencies are dictating to health care providers what they will pay for services. On the other side are patients, needing medical care. Many of the patients have medical insurance, while many depend on government assistance and others have neither. In the middle are the health care providers whose job is to help patients in their time of need.

Opportunity for fraud surfaces as you follow the money. Health care providers interact with many complexities in the medical profession. Dealing with patients leads to support services from lab tests, ancillary and billing services, pharmaceutical companies and, ultimately, vendors who may be either disclosed or undisclosed to the parties. Money is transferred by payers, representing the patient, who may be from the public or private sector. This process results in a health care continuum that is segmented, fragmented, insulated, and lacking service and

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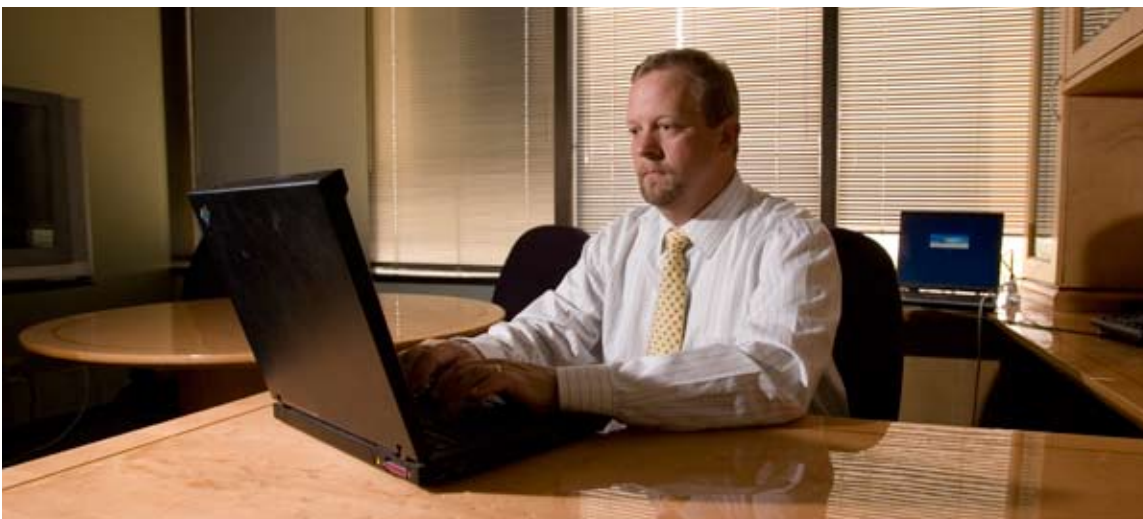
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Getting More Business Value from Information Technology

OVERVIEW

In these economic times, it is critical for all business functions to do more with less. This article reviews what some companies are doing to realize a greater business value from IT activities.



Companies are realizing extraordinary results by applying a strict discipline that focuses IT activities on business value.

In these economic times, it is critical for all business functions to do more with less. However, recent reviews of Information Technology functions have been less than favorable. Some of those reviews include:

- A recent study by Forrester found that 20 percent of technology spending is wasted.
- The Gartner Group identified that 40 percent of all IT initiatives fail.
- An IBM survey found that CIOs believe 40 percent of IT spending brings no return.
- Forrester revealed that less than half of executives have confidence in IT as a contributor to business success.

There are numerous reasons why confidence in a company's IT has diminished:

- Many organizations do not have an Information Technology plan that is actively followed. The IT strategy is often disconnected from the overall business strategy.
- IT organizations spend far too much time performing maintenance activities and far too little time on new business initiatives. On average, more than 80 percent of IT time is spent on maintaining existing systems. High performing organizations spend 60 percent of IT time on maintenance activities.
- Many IT organizations lack personnel with a clear understanding of business operational issues and processes. In addition, IT personnel may not be comfortable in asserting themselves as “thought leaders” and providing solutions to business problems.

There are no simple solutions to any of the problems we have identified. However, companies are realizing extraordinary results

by applying a strict discipline that focuses IT activities on business value. This includes:

- Conducting a “Value Analysis” on the company's IT organization to assess spending and the business value that is generated from that cost.
- Developing a clear definition of value—increasing revenue, reducing expenses, managing risk.
- Establishing IT priorities that are aligned with the overall business strategy.
- Requiring clear measures that demonstrate how IT-related spending contributes to improved business performance.
- Implementing initiatives focused on reducing IT time spent on maintenance activities.
- Recognizing that this is not just an IT issue, but a company issue. Business leaders from across the organization must take ownership of IT initiatives to ensure the expected benefits are delivered.

By focusing on these items, your Information Technology function can become a source of true business value and a significant competitive advantage. ■



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■ Coming January 1, 2010

Changes to the Home Health OASIS Data

The Outcome and Assessment Information Set (OASIS) is the standardized assessment tool utilized in home health since the inception of the home health prospective payment system (HH PPS) in 2000. Based on the scoring and coding of the data items within this assessment tool, which is completed by either a registered nurse or therapist, one of the results is the amount of reimbursement the home health agency (HHA) will receive for that patient episode. And since a patient episode is 60 days in length, it is important the reimbursement for that episode matches up with the amount of care to be provided. This entire process becomes critical for the overall financial viability of any HHA.

On January 1, 2010, the revised OASIS-C assessment tool will take effect. The new OASIS-C represents the most comprehensive revision to OASIS since its original release in 1999. Compared to the previous OASIS-B1 tool, there are approximately 40 changes to the updated assessment tool. Although there is to be no direct effect on the overall payment structure (i.e., budget neutral), the fact that there are several changes to the tool, including a totally new data item numbering system, could certainly have an initial effect on reimbursement during the learning curve period.

Based on this information, the most obvious question is, "What should we be doing right now?" The following is a list of items that can be started immediately if they haven't already been put in place.

1 Educate all staff on the new OASIS-C assessment form. There is already a considerable amount of information on the CMS website related to this. In addition, CMS will also be sponsoring a train-the-trainer session to educate as many people as possible about the new process.

2 Ensure your HHA director is fluent about the HHA reimbursement process, including how to manage each episode based on the specific HHRG, the new OASIS-C assessment tool and the new regulations related to this change.

3 Review your billing software system to be sure it has been updated to accommodate the new OASIS-C information. The cross-over will occur on January 1, 2010, without transition, so your billing system will be required to be updated by December 31, 2009, in order to bill any claims.

4 Incorporate the new grouper software into your current system. It is estimated the new grouper software (HAVEN 10.0) will be available on or about November 9, 2009.

5 Update all policies and procedures that may be affected by the conversion from OASIS-B1 to OASIS-C, including procedures on any assessment tools that will be used, any updates to billing processes and how the OASIS-C will be utilized for quality measures and risk adjustment purposes.

Meeting these five items initially should put you well on your way to a smooth transition to the revised OASIS-C process. To access an electronic version of the revised OASIS-C Guidance Manual, visit: http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. ■

OVERVIEW

The revised OASIS-C assessment tool will take effect January 1, 2010. This article provides an overview of what you can be doing now to prepare.



The new OASIS-C represents the most comprehensive revision to OASIS since its original release in 1999. Compared to the previous OASIS-B1 tool, there are approximately 40 changes to the updated assessment tool.



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■ 2009

AICPA National Health Care Industry Conference

OVERVIEW

The annual AICPA National Health Care Industry Conference was held in September. This article covers topics discussed and how the outcomes could affect the health care industry.



Regardless of the role of government, health care reform, as currently defined, will be very expensive. There are many dollar amounts being thrown around in the news, but a common figure is the establishment of a health care trust of \$630 to \$635 billion. Additional funds are expected to come through increased accountability, efficiencies and quality incentives.

The focus of this year's AICPA National Health Care Industry Conference was the changing face of health care, the forces causing those changes and the responses the industry is needing to make. Topics included the credit markets, health care reform, OIG Enforcement update and changes to accounting standards and tax exempt tax forms.

The credit markets remain tight, but there has been some improvement. The markets are predicted to continue to improve, but the change will be slow and deliberate. There have been several newsworthy bankruptcies of large hospitals and health systems which have put even more stress on the market. Unfortunately, the tightening of the credit market comes at a time when many hospitals are looking at needed upgrades of facilities and equipment and continued increases in the Medicare aged population. Also, there is even more of an increase in the need for capital as electronic health records become necessary both to compete in the market place and to not be penalized in Medicare reimbursement if an electronic health record has not been established.

Partly because of the problems with the credit markets, and partly because of the election of a new president, health care reform is a very hot topic. The general consensus is that something will be passed related to health care reform. Still, even with the knowledge that some legislative changes will be made, the pressing questions are:

1. **What is the role of the government in ongoing health care reform?**
2. **How will health care reform be paid for?**

The role of the government in health care reform has not yet been decided. The basic options are government run versus private sector. If health care reform will occur more in the private sector, it is likely that the government will regulate those organizations. In addition, the hope is that payment options, whether government or private sector, will not be tied to Medicare reimbursement. Regardless of the role of

government, health care reform, as currently defined, will be very expensive. There are many dollar amounts being thrown around in the news, but a common figure is the establishment of a health care trust of \$630 to \$635 billion. Additional funds are expected to come through increased accountability, efficiencies and quality incentives. When it comes down to the nuts and bolts of it, the cost of any health care plan that is passed will be funded through cuts to various programs and an increase in taxes.

One of the accountability items being closely monitored is in the area of health care fraud. The dollar amounts of identified health care frauds are staggering. The Office of the Inspector General (OIG) has invested increased personnel and dollars into identifying and prosecuting health care fraud. The problem is that often times the perpetrators are into and out of the system so quickly, they are never found and get away with millions of dollars. The OIG is trying to get more sophisticated systems to identify fraud by analyzing payment information. For example, if payments to a particular provider number began at \$10,000 per month and are now at \$1 million per month, it could be indicative of fraud and an investigation should be started. Unfortunately, for each case that is found and prosecuted, many more go undetected or if detected, are detected too late to recover any of the losses.

The past year has seen significant changes to the tax forms and accounting standards. The Federal Form 990 has undergone a significant change in format and the information that needs to be gathered. These changes have been introduced over time and have left providers and preparers looking for answers. In addition, the accounting standards have been newly codified, with the ultimate goal of making research into accounting standards more streamlined. As with any change, however, there are glitches and snags along the way. In addition, there have been continued talks of changing from United States accounting standards to International Financial Reporting Standards (IFRS). This change is currently more pressing to publicly-traded companies; however, all organizations in the United States could be impacted in the near future.

■ 2009

NRHA Critical Access Hospital Conference Highlights

The National Rural Health Association (NRHA) Critical Access Hospital Conference was held in Portland, Oregon, October 7-9, 2009. This year's conference provided an opportunity for providers, vendors and other industry experts to explore and discuss the opportunities and challenges facing Critical Access Hospitals (CAHs). Eide Bailly was represented by five staff members at this conference, and was also involved in a presentation on CAH reimbursement opportunities.

While discussions relating to regulatory compliance and reimbursement opportunities and risks will always be an integral part of this conference, there was also significant discussion in the area of Stimulus funding for health information technology and access to capital for facility replacement and/or renovation.

In the individual sessions, the discussion on health information technology focused on two areas. First, there was discussion about the

level of funding and how this funding would be accessed. Second, there were excellent presentations on managing the processes of working with the various information technology vendors in the acquisition and implementation of technology solutions. Individual sessions as well as discussions during the vendor fair focused on the current trends in the capital markets. Providers took advantage of this conference to pull together architects, financial representatives and accounting firms to discuss the possibility and planning of funding projects in their individual facilities.

Next year's conference is schedule for September 29 – October 1, 2010, in Kansas City. It looks to provide another opportunity to catch up on the latest trends affecting CAHs. ■



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We will need to stay tuned for what package or packages actually get passed for health care reform. As noted previously, the belief is that something will get passed, the unknown is what health care reform will look like in the end. The one thing that is certain—*The Times They Are A Changin* (Bob Dylan, 1964) could have been the theme song for this year's conference! ■



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MDS Update

The Centers for Medicare and Medicaid Services (CMS) released the much anticipated final revised MDS data set on October 29, giving long-term care providers approximately 11 months to prepare for the implementation of this revised assessment tool. With the final version complete, facilities can now move forward in every avenue of implementation.

Revenue Cycle Revisited

OVERVIEW

The revenue cycle is inherently complex. This article offers a new perspective on how promoting the value of health services can help ensure a smoother revenue cycle.

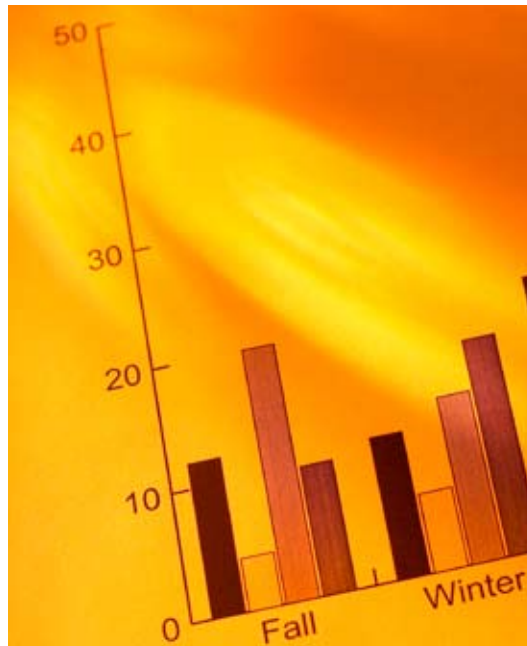


Promoting the value of our services to the health of our customers starts with physicians and ends with every individual who comes into contact with them. Customers need to know that you are there to help them, and that you will do everything within your abilities to do so.

I have a confession to make. I have been serving the health care industry for more than 25 years, starting as a staff accountant for a small western Minnesota accounting firm and eventually serving as CFO of a mid-size PPS hospital; yet, despite my health care experience, the last bill I pay each month is for my family's health care. As I reflect on this observation, it makes me wonder, why do I act this way? And what value do I put on my health care?

Life is full of priorities, and when it comes to health care, I have a feeling I'm not alone in my behavior. When it comes to our hard-earned dollars, where do our priorities lay? Certainly, when it comes to putting a value on our health, the simplest measure is what we are willing to pay for our health care. Taking a step further, how do we help our customers look at health care in this light?

The revenue cycle starts with a scheduled and/or unscheduled appointment and is completed with final payment for services rendered. Unfortunately, the work that needs to be done



from scheduling, registration, providing service, transcription, coding, billing and collecting have become anything but simple. In addition, where do you actually have points of contact with your patients and how are you utilizing these points of contact? First and foremost, the quality of care given to customers is number one. That being said, if you truly value the services you are providing customers, you must take every opportunity to share this with them and perform those back-office tasks that have nothing to do with the health of our customers.

Promoting the value of our services to the health of our customers starts with physicians and ends with every individual who comes into contact with them. Customers need to know that you are there to help them, and that you will do everything within your abilities to do so. Let them know that the services your health care facility provides will enable them to enjoy life's activities. Verifying insurance, collecting co-pays, financial counseling and accurate coding will not make our patients healthier, but all these steps will ensure the ability of health care organizations to serve our communities. Helping customers understand the value of their health care and collecting for those services must coexist with the quality of care provided.

Compassionate, sincere, and timely care of customers will be easy for passionate health care providers and employees. The complexities inherent in the revenue cycle are another matter. Fortunately, there are individuals dedicated to all aspects of the revenue cycle and they also have the passion, creativity and technological expertise to assist you in these matters. ■



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■ OPPS Final Rule

Physician Supervision Requirements

The 2010 OPPS Final Rule was released by CMS on October 30, 2009, and will go into effect on January 1, 2010. Of particular interest is the ruling on the physician supervision requirements. CMS has clarified that these regulations also pertain to Critical Access Hospitals (CAH) in addition to the PPS hospitals.

CMS has stated that, “in order to ensure that hospital outpatient services are appropriately supervised by qualified practitioners while not impeding beneficiary access to these services,” CMS will allow certain non-physician practitioners—specifically, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives and licensed clinical social workers, to provide direct supervision for all hospital outpatient therapeutic services that they are authorized to personally perform according to their state scope of practice rules and hospital-granted privileges. (Note: these rules do not apply to physical therapy, occupational therapy or speech therapy).

For on-campus hospital outpatient therapeutic services, CMS is defining “direct supervision” to mean the physician or non-physician practitioner must be present anywhere on the hospital campus and immediately available to furnish assistance and direction throughout the performance of the procedure. CMS will allow the physician or non-physician practitioner to be in an on-campus physician’s office, on-campus SNF, on-campus RHC, or other on-campus non-hospital space (provided he or she is immediately available).

For services furnished in an off-campus provider-based department, “direct supervision” would continue to mean the physician or non-physician practitioner must be present in the off-campus provider-based department (he or she does not need to be in the room when the procedure is being performed), and immediately available to furnish assistance and direction throughout the performance of the procedure.

The ability for certain non-physician practitioners to provide supervision for therapeutic services does not apply to cardiac rehab, pulmonary rehab or intensive cardiac rehabilitation services. These services will continue to require supervision by a doctor of medicine or osteopathy.

Although the final rule did offer some relief to hospitals, a close review of all of the supervision requirements must be done to ensure compliance. Non-compliance with the supervision rules could jeopardize a hospital’s Medicare payments. ■



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OVERVIEW

This article details the physician supervision requirements of the 2010 OPPS Final Rule, which will go into effect on January 1, 2010.



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Under Siege—from page 1

price transparency. This complex environment creates the true opportunity for fraud.

The opportunity for fraud stems from weak or nonexistent internal controls. Organizations should review the job responsibilities of its employees to determine if there are any incompatible duties (i.e., authorization, execution, recording and custody of assets). If there are incompatible duties, certain procedures should be implemented to review the procedures performed by the employee. By strengthening internal controls and implementing specific review processes, organizations can reduce the threat of fraud in the workplace. The following recommendations will promote effective antifraud activity:

- Conduct thorough background checks of individuals and entities who want to participate as providers or suppliers prior to their enrollment in health care programs.
- Adopt provider and supplier practices that promote compliance with program requirements, including quality and safety standards.
- Vigilantly monitor the programs for evidence of fraud, waste and abuse.

- Respond swiftly to detected fraud, impose sufficient punishment to deter others and promptly remedy program vulnerabilities.

How can a health care organization detect fraud? Having management actively participate in reviewing reports and supporting documentation for unusual trends or patterns can be a major step toward detecting fraud. If employees know that management is truly watching, the perception of detection will also become one of your best deterrents to fraud. If potential fraudsters think they will be caught, they most likely will not commit the fraud.

The key for health care organizations to mitigate their fraud risk is to identify weaknesses in internal controls, develop procedures to strengthen the controls and implement independent review processes to detect potential fraud schemes. To directly impact fraud in health care, you must limit the opportunity for fraud to occur, and increase the perception of detection. ■



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