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PRESENTS

CERINI & ASSOCIATES LLP
CERTIFIED PUBLIC ACCOUNTANTS

BEST PRACTICES

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FROM THE EDITOR - EDWARD McWILLIAMS, CPA

Hard to believe, but it's already time for the Fall 2019 edition of Best Practices.

In this issue, our focus was driven by real challenges our clients have faced in the past six months. If these are issues that they are facing in their practices, surely other practices must be facing some of the same challenges, and we wanted to share advice on how our clients tackled these issues.

With a renewed emphasis on work-life balance, one area that clients always ask for our guidance on is crafting a Paid-Time Off policy. The policy must be attractive to the staff to motivate and retain them, compliant with the law, and serve the needs of the practice. Many times, these forces are opposed to each other, and we provide some tips to help get these opposite forces synergized to improve your practice.

As reimbursement & insurance models change, one of the more significant shifts has been toward increasing patient financial responsibility, which now makes up a larger percentage of net service revenue than in the past. Developing a patient collection strategy is, therefore, now more important than ever. It starts with an education of the staff and an increase in communication with patients. Along with making sure your practice has multiple methods of payment and a system for monitoring, this change should not be a burden to your practice but rather an opportunity.

Finally, we address recent developments in Medicare Fraud by healthcare providers. Understanding what regulatory bodies are doing and what happens during the investigation process is vital for providers and practices so that they can be prepared if a routine inquiry ever occurs or if their practices require an update in order to be able to comply with regulations. It also provides a reminder to practices that there are always people watching to make sure you operate with integrity.

These are just a sampling of a few key issues we have helped practices with this year. Our industry knowledge allows us to gain a deep insight into your operations and consult on a variety of topics. If you have questions regarding these topics or other areas that you are not getting the support you need, feel free to give us a call.

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CRAFTING AN EFFECTIVE PAID TIME OFF POLICY

As the importance of work-life balance and flexible scheduling increases for employees, it becomes important for practices to have an effective **Paid Time Off (PTO)** policy that both provides the benefits employees seek but also meets the needs of the practice staffing. When discussing PTO, we are generally referring to the complete amount of time a practice will offer as compensated days off to its staff, including vacation, personal, holidays and sick time. The employer and the employee will have an adverse interest here; the employee will look to have the most PTO days as possible and the employer will look to limit. As a result, striking a compromise between these interests is the best way craft an effective PTO policy.

Many employers look toward traditional methods and standards when it comes to setting a PTO policy. The number of days (*or hours*) granted is typically commiserate with experience, position and the marketplace that they operate in. These policies are typically setup with 2 weeks (*10 days or 80 hours*) vacation for entry level and early experience employees, 3 weeks (*15 days or 120 hours*) for front-line supervisors, team leads and experienced staff, 4 weeks (*20 days or 160 hours*) for managers and 5 weeks (*25 days or 200 hours*) for executives. Some healthcare practices may normally find themselves closer to the high end of these ranges even for entry level or experienced professionals, as the specialization leads itself to an expectation of more time off. Firms also will generally offer a fixed number of sick days, typically between 5-10. Many employees view these as just additional PTO that can be used generally, and as a result will use them more frequently.

As counterintuitive as it may seem, an *"unlimited"* vacation and sick time policy is often a great tool in both offering employees the ultimate in flexibility and benefits and may reduce the overall number of PTO time taken by staff. Many studies have shown these policies can reduce the number of PTO days by up to 13-15% over the year. The general logic behind this is that is employees are given a fixed number of days, they are going to make sure to use each day (*both vacation and "sick"*) days each year, rather than as they need. Further, this flexibility is very much attractive to younger talent and also empowers the employee to make decisions and fosters a sense of trust, and the policy is much easier to implement and maintain than traditional polices. As part of this, it is important to stress to employees that the work must still be completed.

Another feature of an effective PTO policy is something that is not necessarily part of the policy itself but is very important is the workplace culture around PTO. As companies and employees become more connected, there has been an implicit expectation that employees will always be available to respond to requests immediately. Further, many workplace cultures have (*unfortunately*) organically developed a competitive, workaholic culture that can discourage many employees from taking PTO. Studies have shown that using of PTO and disconnecting can overall increase productivity and reduce burnout. As an employer you should work to develop a culture that encourages employees to disconnect and respects the boundaries of their time away; your company as a whole will benefit as will the staff.

Having a strong PTO policy can also attract potential employees to your company. People strongly value having personal time to spend with their families, or however they see fit, so potential candidates can be drawn into a company based off their PTO policy. This could allow the company to have many options to choose from to fill an opening with the best possible candidate. An effective policy is one that both allows the employee to feel satisfied but meets the needs of the practice.

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CULTIVATING A PATIENT COLLECTION STRATEGY

With the shift in more insurance plans to High Deductible Health Plans with larger deductibles and higher Out-Of-Pocket amounts, patient financial responsibility is accounting for a greater portion of net healthcare revenue. Additionally, with declining reimbursements, many practitioners have moved to provide more niche and specialty services that are generally private pay. These factors, combined with rising costs and more aggressive coding standards, make monitoring and optimizing collection procedures now matter more than ever. Practices need to develop a strong patient collection strategy in response to these changes in order to sustain their success.

EDUCATION OF STAFF

Most staff can easily communicate their specific specialty, but many still fall short in understanding the basics of the revenue cycle for practices. By educating the staff on how the revenue cycle works they will feel more at ease in talking to patients about their financial responsibility at all points of service. A general primer should be held annually for all staff that helps to explain key principles on patient responsibility, such as deductibles, co-pays, out of pocket and the patient's overall financial responsibility. During this education, it should be emphasized to staff the importance of collection of these payments and communicating what the practices overall strategies and procedures are for the collection of payment.

COMMUNICATION WITH PATIENTS

As noted above, once your staff is educated on the basics of patient responsibility, they will feel more comfortable communicating this point with patients. Staff should look to start a courteous and professional conversation with patients from the point of scheduling and prior to the provision of care by providers. Many patients find medical service fees to be confusing and will appreciate the transparency upfront regarding potential fees due. Setting expectations early in the process and consistent communication of these expectations will make patients feel more at ease with their responsibility.

PAYMENT COLLECTION

This goes together with the communication with patients. After communicating fees and expectations to the patient, it is important for practices to focus on collection. The best time for these patient fee collections will be at the point of service. Many patients are apprehensive in a provider's office, with their concerns (*and hopefully the providers*) being their health and welfare. It should be stressed to all staff that payment should ideally occur prior to service, such as at check-in.

In addition to optimizing when payment for patient responsibility is collected, it is also important that practices have a variety of payment options. These should include cash, checks and credit cards on site, as well as having an option for installment plans. These payment plans are best served via a third-party vendor or solution to assist in the management, collection and underwriting of these plans. While these solutions may have a fee, the alternative of stalled or non-existent collections is far worse.

Many practices are turning to different industry models and new technologies in order to help with these collections. Electronic statements are becoming more popular, allowing the practice to send a statement to the patient (*if the collection was not done upfront*) aftercare is provided and allows for automated reminders of the balance due. The electronic systems also give patients more detailed records of their care that they can access at any time, and this sense of empowerment can often help with collections. Practices with re-occurring patients also have found that keeping payment details on file (*such as credit cards*) improve collections as they allow the practice to charge patients automatically for services provided.

DEVELOP AND MONITOR COLLECTION KEY PERFORMANCE INDICATORS (KPIS)

Using KPIs to help monitor collections can help practices, owners and administrators on judging the effectiveness of patient collections, if their plan is working and if the plan requires more communication or education. Some common KPIs for collection include Days Receivables Outstanding and Adjusted Collection Rate.

DAYS RECEIVABLES OUTSTANDING	**ACCOUNTS RECEIVABLE** *(6 Months Charges/183)*
40 to 50 days is considered standard	
ADJUSTED COLLECTION RATE	**NET COLLECTIONS** *Net Allowable Charges*
95-99% is considered average	
PATIENT COLLECTION RATE	**DAILY POINT OF SERVICE COLLECTIONS** *Daily Patient Responsibility*
Monitors how much patient responsibility is collected	
POINT OF SERVICE COLLECTIONS	**DAILY POINT OF SERVICE COLLECTIONS** *Total Patient Cash Collected*
Monitors efficiency of collections at point of service	

Like it or not, the old models of healthcare reimbursement are being phased out, even beyond the changes from fee-for-service to more value-based models. In the past, third party payors accounted for nearly all revenue of a practice, however, there has been a noticeable change in patient responsibility in plans in the past 10 years. One study found that practices saw an 88 percent increase in revenue from patient payments between 2012 and 2017. With the source of the revenue collections changing, your practice needs to have a strong patient collection strategy for continued success.

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THE PRESCRIPTION FOR FRAUD

You see it in the movies, you see it on the news, one day you might see it at the physician's office down the street – a raid by the men in black. No, not Will and Tommy-Lee, but a combined task force by the **Department of Justice (DOJ)** and the FBI. They're there for Medicare fraud, not extraterrestrials. In June 2018 alone, the DOJ announced a national health care fraud scheme that took down 601 individuals responsible for over $2 billion in fraudulent claims. That's *"billion"* with a *"b!"* The defendants allegedly participated in multiple schemes to submit claims to Medicare and private insurance companies for treatments that were medically unnecessary and often never provided.

RECENT DEVELOPMENTS

The U.S. recovered $4 billion last year through healthcare fraud prevention and enforcement efforts, according to a report released by Attorney General Eric Holder and Health and **Human Services (HHS)** Secretary Kathleen Sebelius. The report says that the **Health Care Fraud and Abuse Control Act (HCFAC)** recovered more than $8 for every $1 it spent on healthcare fraud investigations over the last three years, the best ratio in the 17-year history of the program. According to the DOJ Health Care Fraud and Abuse Control Program Annual report for 2018, the DOJ convicted 1,503 individuals or entities for fraud and patient abuse or neglect with an estimated $314 million in criminal recoveries and $545 million civil recoveries through these convictions.

EXAMINING THE DATA

Healthcare fraud can take many forms among the various types of healthcare providers. These include clinics, home health providers, nursing homes, emergency transportation services, and diagnostic companies, just to name a few. Although the services vary greatly, the techniques used to defraud are similar across these disciplines. The various techniques include:

- *Billing for services not rendered.*
- *Billing non-covered services as covered services.*
- *Misrepresenting dates and/or locations of service.*
- *Upcoding and/or unbundling.*
- *Corruption (kickbacks and/or bribery).*
- *False or unnecessary prescription of drugs.*

These schemes are important to understand, not just to catch fraudulent activity, but to prevent and increase awareness of potential abuse. Fraud examiners at the DOJ have many techniques to derive how, where, and when these activities take place, but for them to become involved they need the public to be mindful and alert to these activities. To trace these activities, fraud examiners will start by taking a close look at the bank statements.

The bank statements are often retrieved through a subpoena. This includes cancelled checks, deposit slips, and any other information supplied to or produced by the banks of the company or related entities. More specifically these records are reviewed and analyzed to identify health care fraud through:

- *Payment and expense trends.*
- *Flow of funds between related accounts.*
- *Indications of money laundering activities.*
- *Additional bank accounts and involved players not previously known.*
- *Significant cash inflows/outflows.*

Typically, individuals committing health care fraud use multiple accounts to shift money around — attempting to hide the initial origin of the funds and avoid a clear transaction trail. Analyzing the flow of funds between related accounts can facilitate the identification of the origin of the funds, which enables a fraud examiner to trace those funds between related accounts.

In addition to bank statements, fraud examiners can assist in conducting analyses of health care claims information. Claims data provides a profile of a patient's history, which might be gathered from Medicare, Medicaid, private insurance companies, and other sources. With this data, fraud examiners can assist in:

- *Verifying or refuting the source of deposits to the bank accounts of individual defendants.*
- *Analyzing Diagnostic Related Group code trends.*
- *Identifying instances of potential upcoding.*
- *Identifying instances of billing for un-rendered services and/or products.*

Applying data mining to claims data makes it possible to identify patterns and anomalies. For example, Doctor A and Doctor B work at the same office, and the claims history for year one was produced in litigation alleging improper upcoding by Doctor A. In the first year, Doctor A was associated with 1,000 of one particular claim (*claim 1*), and 500 claims that were of a different specific claim (*claim 2*).

In the same year, Doctor B was associated with 50 claims that included claim 1 and 1,450 claims that included claim 2. In this example, the contrast between the claims of the two doctors raises a red flag that should lead to additional investigation of the claims submitted by Doctor A.

If the prosecution alleges that the defendant improperly utilized the costlier claims, an analysis of the frequency of those claims as compared to the less expensive codes could be used to either support the prosecution or vindicate the defendant. Fraud examiners can't provide opinions relating to the legitimacy of the claims, but can inform the prosecution or defense of data trends, such as the vast differences between practitioners, which can lead to additional investigation and support for the legal argument.

FRAUD EXAMINERS DUTY

The fraud examiner relies on the public's trust in the ethical standards crucial to the profession. Without the belief that a fraud examiner is an ethical independent professional, the results of their investigations would not be trusted. Naturally, fraud examiners play a major role in health care fraud cases and this trust can save billions of dollars of fraudulent charges. Thanks to their code of ethics and pursuit of fraudulent activity we can rest easy knowing the men in black are on our side working to counteract the would-be fraudsters of the world.

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