Magnolia Minutes

A Publication of MGMA of Mississippi

December 2009

A Message From the Out-Going President

John Moore

Thanksgiving has come and gone, Christmas is just around the corner and 2009 is about to close out! Where has the time gone?

It has been a very fast year – they do seem to get faster each year. So much to do and so little time to do it. That seems to be the theme in Washington these days. The House has passed HR 3962, their version of healthcare reform. Then they came back and passed HR 3961 to repeal the Medicare SGR. Too bad it has to go on from there to the Senate. Speaking of the Senate, they are getting ready to start their debate on healthcare reform. No telling what their bill will look like when it is finally passed. And then, of course, the mingling of the two bills by committee and the final outcome that will presented to both houses for votes. Don't blink or you might miss something.

The fall meeting was outstanding. In all my years in MGMA of MS, I can never recall having so many members remain through the entire meeting as we did this year. Bobbie Beard presented an agenda that truly hit the HOT spots in our industry. Starting with the upcoming coding changes to ICD-10 and ending with the latest word on healthcare reform, the topics were at the forefront of things to come and the speakers were all very dynamic in their presentation and knowledge.

Our profession is in an ever changing mode today. That is both good and bad. It's good that we are in the position to make changes happen but bad in that they sometimes happen so fast we get left behind. The ACMPE is growing each year in helping us become better leaders, more informed managers and more professional executives. We lead a large contingent of individuals throughout the nation that provide care, support and compassion to millions of patients and their families. It is an awesome responsibility we carry, but carry it we do, with pride and humility.

I would again like to thank all of you for your support this year. You are, as you have always been, a source of strength for me and I so sincerely appreciate each of you. I want to thank all the people that have helped this year, from committee chairs and assistants to you members that make up MGMA of MS – your efforts were untiring. To the Executive Board and the Advisory Board, I also say THANK YOU for all the work and time you gave to help lead our organization. Finally, a very big THANKS to Karen Stuart, our Executive Director, for her support and assistance throughout the year.
Lastly, Merry Christmas to all and God Bless you in the upcoming year.

A Message From the In-Coming President

Bobbie Beard

I want to take this opportunity to thank MGMA of MS membership for allowing me to serve as your 2010 President. I am excited about the broad knowledge base of our Board of Directors, Advisory Board, and Committee Chairpersons. Please allow me to introduce and thank them through this article:

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Neidra Brandenburg
Debbie Tipper
Janice Kay
Lynn Ross

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Education & Scholarship Asst.	Jeremy Pittman

As we plan for 2010 we are challenged with numerous "Hot Topics" in healthcare. I am confident that the leaders of our organization will work diligently to offer the most up-to-date healthcare information and strategies MGMA has to offer. I look forward to working with each of them as well as our membership.

With Healthcare Reform as one of major concern it was very exciting to have Dr. Randy Easterling, MSMA President, to speak at our November meeting. Dr. Easterling defined the stance of MSMA and the challenges physicians in our state are facing. He gave an in depth explanation of the health system debate in Washington. As we move forward in the New Year you can expect more information from MSMA and MGMA on healthcare reform and the stance of each organization.

Many of you have also expressed reimbursement concerns with our states major carriers. In an effort to address your concerns and create synergy we hope to offer a panel discussion in place of the traditional February meeting. Harold Ingram, President Elect, is currently working on the details. We will provide you with more information within the next month.

As we strive to offer additional education on a variety of health related topics our membership continues to be a focus for our organization. We consistently learn of individuals working in our field that have not heard of MGMA. I challenge our membership to contact at least one potential member and invite them to a meeting. We offer discount rates for students as well as discounts for organizations with multiple members. In addition, we waive the first time attendee registration fees. I would also like to challenge each of you to become more involved with MGMA. There are a number of opportunities available to our members. I encourage you to visit our website at www.mgmams.com. Lynn Ross, Past-President, once stated "This association is the sum of the work of all of the members, and it needs you, individually, to continue the success we have had."

In addition to your membership it is important to our organization that we not lose contact with you. Please notify us if you relocate or desire to have your newsletter sent to your home address. We will make every effort to maintain our membership roster and e-mail address log.

If you need to contact me, please don't hesitate to call me at 601-883-4373. Or you may e-mail me at bobbie.beard@riverregion.com. Thank you for your support of MGMA of MS and I look forward to an exciting and challenging year in 2010.

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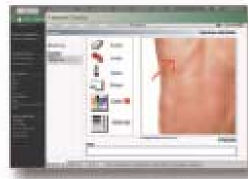

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MGMA of MS Awards first Scholarship!

At the recent MGMA of MS 2009 Fall meeting, MGMA of MS Scholarship Committee was proud to present a $1,000 scholarship to **Bree Spratlin**. Bree's mother, Regina Spratlin, is a member and was present at the meeting to receive the Scholarship on her daughter's behalf.

The MGMA of MS Board of Directors and the Education and Scholarship Committee are proud to announce an
MGMA of MS Scholarship

The MGMA (Medical Group Management Association) of Mississippi Scholarship Program is designed to financially assist qualified applicants in obtaining degrees from accredited academic institutions of higher learning, *located in Mississippi*, in the field of medical management or any field with any relation to medical management. The program is open to any student preparing to enter or already attending an accredited degree-granting *Mississippi* college or university and pursuing a bachelor, master's or doctoral degree.

The scholarships are awarded based on merit as measured by academic performance and extracurricular activities. The applicant's intended field of study is also considered in the evaluation process with preference given to those candidates pursuing a degree in medical management or a directly related field of study.

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FALLING THROUGH THE CRACKS

Harold Ingram, MBA, President-Elect, MGMA of MS

A patient is taken to an imaging center on a Friday afternoon for an MRI. The attendant knows that the radiologist is anxious to see the results. As soon as the scan is complete the attendant rushes the results to the radiologist. Later, Friday evening, it is discovered that the patient is missing. The police are called in. On Saturday, as they are retracing the patient's steps of the previous day, they enter the imaging center and hear a bumping noise coming from the MRI machine. After 29 hours, it is discovered that the patient had been left inside the MRI chamber.

In Germany, a tenant in an apartment complex receives a knock at his door. It seems he had not paid his rent. In fact, it had been several months since the landlord had received any correspondence or payment from him. When the tenant did not answer the door, the landlord enjoined the authorities to assist him in evicting the tenant. When the authorities entered the room, they found the tenant sitting in a chair with the television on and his Christmas lights blinking. Unfortunately, the tenant was dead. He apparently had been dead since Christmas, which was several months earlier.

As bizarre as they may seem, these incidences are real. If these things can happen what may be "falling through the cracks" in your office? A "real life" example of something falling through the cracks was discovered in a local office several months ago. Unfilled appointment slots are costly. To insure minimum slot vacancy, the clinic implemented a procedure where, in addition to sending out appointment reminder cards, the patient was to be called a couple of days prior to the visit. This would allow the clinic the opportunity to fill the slot if the patient knew he would be unable to make the scheduled visit. This seemed to work well since the patient slots were filled most of the time. As office activity became routine, other issues began to take precedence and the reminder calls stopped. This was unknown to the office manager who assumed that all the previously established procedures were being followed. It was only after the physician complained about empty appointment slots that it was discovered that the patients were not receiving reminder calls.

Unfortunately, routine frequently induces complacency. And, complacency often leads to laxity in performance. It seems to be human nature. Times of complacency are characterized by uneventful office activity, when everything seems to be working well. During these times employees may begin to focus on speed rather than accuracy. Shortcuts are found that may unintentionally subvert some of the procedures needed to insure effective office programs. Employees with limited vision may assume a decision-making role and curtail activities for which they see no benefit. Such action can easily cause a breakdown in effective office strategies. In the previous example, the employee responsible for calling the patients decided that other activities were more important and arbitrarily curtailed patient reminder calls. Since she was not looking at the end result, she did not realize the negative impact of her decision.

In another incident, a clinic discovered that patients were being charged for services but the supporting documentation was not being charted. This was uncovered during an audit of the clinic. The established policy was that the provider was to submit appropriate supporting documentation at least weekly since services were not rendered in the billing office but in a nearby facility. Initially this was monitored closely by the central office responsible for billing for the services. However, as things became routine, the scrutiny stopped. Without the gentle reminders from the billing office, the provider began to let the documentation slip. It began gradually and resulted in an undisciplined, haphazard process. The result was vulnerability on behalf of the clinic to fines and penalties should the carrier conduct an audit of the practice.

Problems such as those indicated in the previous examples are often not discovered until something such as an audit or a drop in income points them out. When things are going well, everyone has a tendency to relax. It is an interesting dichotomy that in a relaxed atmosphere it becomes easy to skirt the very details that helped create the opportunity to relax. Since much of the activity in today's medical offices is stressful, the office manager welcomes a break where everything seems to be running well. These breaks are nice but the manager must be ever vigilant.

Once the clinic has achieved a level of routine that is relatively comfortable and the clinic is performing well, it is important that the office manager or administrator does not let his/her guard down. It is important to monitor key activities to identify changes before they have a significant impact on the clinic. This will require monitoring tools and discipline.

Some of the areas to monitor include:

- Cash Collected At Time of Service
- Patient Visits (new and established)
- Missed Appointments (how often? why?)
- Documentation (periodic chart review)
- Insurance Problems (denials, reductions, turn-around time)
- Accounts Receivable Activity
- Expenses

The evolution of practice management systems has provided reports and tools to help monitor many critical areas. Other independent automated services have also emerged. These include services such as automated patient reminder calls and statistical analysis of electronically submitted insurance claims. If utilized, these can be of great benefit to a practice.

The availability of reporting and management tools, however, is not the answer. It is the consistent use of these tools that ultimately benefits the practice. The key is consistent use. Frequently, a reporting mechanism is established to monitor a diagnosed problem. This monitoring along with corrective action generally leads to improved performance. After a period of acceptable performance there is a tendency to relax the monitoring activity. It is when this happens that the practice regresses. Personnel are sensitive to review activity. Review of data provided by practice personnel is an indication that the process required to generate the data is important.

With all the problems practice managers face, periods of routine and stability are welcomed. Take a breather but don't relax too much. It is the consistent attention to the small things that prevent the big problems. Utilize your monitoring tools and react to abnormal fluctuations. Consider establishing quality control measures that allow you to quickly monitor activity and react only when the results are outside the parameters established as acceptable. Keep your focus and stay the course.

Magnolia Minutes
P.O. Box 186 Sumrall, MS 39482

Magnolia Minutes is published quarterly by The Medical Group Management Association of Mississippi and addresses both issues facing medical group managers practicing in Mississippi and broader issues facing medical practices nationwide.

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Submission of articles for publication is encouraged. Views of contributing authors do not necessarily represent the position of MGMA of MS.

To add names to our mailing list, or to submit an article for print, please email a request to Karen Stuart, Executive Director, at mgmaofms@msn.com or call 601.758.0244.

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Managing Your Revenue Cycle

Sheila M. Harkins, CMPE

Revenue Cycle management is the most complex area of medical practice management. It involves not merely filing a claim but decisions on Network participation, contract negotiations, and contact with your patient. The following graph lays out the steps we go through in a medical office to manage our Revenue Cycle.

The Revenue Cycle actually begins at the scheduling process where employees should collect or verify demographic and insurance information. Eligibility drives your payment. If verification cannot be done during the scheduling process it should be done prior to the patient's appointment. Real time insurance verification has simplified this process. Train employees about your major carrier's coverage policies. If you find that the patient should pre-certify their visit or a high deductible may require full payment at time of service, call the patient so they will understand their financial responsibility at the time of the visit. Nothing creates bad will quicker than a patient checking out to find the $300 visit they thought their insurance company would pay is denied.

All patients should understand the group's billing and payment policy. The "layaway (buy now pay later) tradition" should be a thing of the past. Have credit and debit card capabilities within your office. Develop payment plans to use for hardship cases. Consider discounts for self-pay patients who pay their bill in full at the time of service. (At some point in the process you will have to consider the cost to bill a patient month after month.)

During the registration process insurance should again be verified. Because of the volitile climate we face insurance coverage can change within a 30-day period due to employer changes in coverage, lay offs, and changes in employment. Employee training is probably an area we could all put more investment in because it is essential to the Revenue Cycle. Employees should know how to read insurance cards and understand what they mean. Role playing gives an opportunity for customer service training in dealing with patients whose insurance denies coverage or must pay a high deductible.

With proper training, employees will know reimbursement policies for your major carriers and when it would be necessary to pre-certify. Good rule of thumb: if you don't know, precertify. Training in this area should extend to the nursing staff since they are involved in the case management process.
We can't bill without a superbill! Completing the superbill for a patient encounter seems like an easy process but during days of heavy patient volume physicians often delay or even forget the superbill process. Uncertainty with proper coding for the visit can also create delays. A good EHR and/or practice management system will help track unbilled services. Upon request, the hospital may provide a list of patients the physicians saw in the hospital to ensure charge capture of all those charges as well. Don't lose charges or the opportunity to collect a payment. Even without a superbill check out personnel should be trained to estimate the patient's bill and collect for the estimated cost of services rendered.

Self-monitor coding and develop a training program for the staff and physicians. This can have a large impact on your Revenue Cycle.

Coding is a major factor in billing a carrier for services performed. Clinical and business office staff can be easily confused with this process: Was the correct Level of Service or Procedure code used? Was a modifier used and, if so, was it used correctly? Was the CPT code(s) properly linked to the diagnosis? If one of these factors is incorrect the claim is delayed and may be denied. Processing this claim can come to a hault because of improper coding.

More and more carriers have timely filing requirements. Every medical practice should have and enforce a policy about timely filing of claims, completion of charts/superbills, and submission of hospital charges.

Deposits should be made daily. Billing office phone calls, patient frustration, and the Revenue Cycle are all positively affected with timely posting of payments. Develop an internal policy that is reasonable and stick to it. Involve your accounts receivable department in the decision making process.

Work your denials! Track errors! Compare reimbursement with the agreed contract reimbursement amount! Improve your billing process by tracking denials and follow them back to the source. Maybe someone new in the office does not know how to verify insurance properly. The physician may not understand the use of modifiers. Follow rejection code patterns, find the weak spots, and resolve with the payer. Understand each carrier's appeal process. One failure point in our Revenue Cycle is inadequate follow-up on unpaid or underpaid claims. Encourage your employees to find that contact person with the major payer. This approach to managing claims will have a long lasting effect on your Revenue Cycle.

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FOR IMMEDIATE RELEASE

UNITEDHEALTHCARE BY AMERICHOICE TO SERVE MISSISIPPI CHILDREN'S HEALTH INSURANCE PROGRAM

JACKSON, Miss. (June 25, 2009) – UnitedHealthcare by AmeriChoice has been selected by Mississippi's State and School Employees Health Insurance Management Board to be the state's partner in its Children's Health Insurance Program (CHIP).

When the new policy begins in January 2010, UnitedHealthcare will be the exclusive health plan for approximately 65,000 children throughout Mississippi who are enrolled in CHIP.

"Particularly in these challenging times, we are keenly aware of the responsibilities that come in helping provide access to quality care statewide for the children of Mississippi," said Rick Jelinek, CEO of AmeriChoice, the state and public programs business of UnitedHealth Group. "We look forward to bringing our substantial resources and experience to the critical mission of improving the health status of Mississippi's CHIP beneficiaries."

For more than 20 years, the company has served as an innovative developer of public sector health care solutions. The AmeriChoice Personal Care Model™ features direct contact by clinical staff, who work to build a support network for chronically and acutely ill members involving family, physicians and government and community-based organizations.

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About AmeriChoice
Currently serving more than 2.5 million members in 21 states and the District of Columbia, AmeriChoice, a UnitedHealth Group [NYSE: UNH] company, is a diversified health services company dedicated to helping states, localities, and other government agencies facilitate care for the economically impoverished, the medically underserved and those without the benefit of employer-funded health care coverage. For more information, visit www.americhoice.com.

Forward-Looking Statements
This press release may contain statements, estimates, projections, guidance or outlook that constitute "forward-looking" statements as defined under U.S. federal securities laws. Generally the words "believe," "expect," "intend," "estimate," "anticipate," "plan," "project," "will" and similar expressions, identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions, trends and uncertainties and involve risks and uncertainties. We caution that actual results could differ materially from those that management expects, depending on the outcome of certain factors. We do not undertake to update or revise any forward-looking statements.

Our Commitment to the State of Mississippi

We remain committed and focused on the unique needs of the State of Mississippi CHIP plan, as well as the commercial business. The addition of CHIP members offers new opportunities for us to work with the State of Mississippi. The CHIP benefits are not changing. This benefit policy will now be managed by UnitedHealthcare in 2010, based on a set of clear advantages that were demonstrated in the state's selection process.

We have highlighted a few of these advantages below, illustrating how our local commitment, combined with the resources of UnitedHealthcare, will help this program succeed:

- **Local presence for plan leadership:** Our medical director, Dr. Joseph Blackston, is a Mississippi physician, enabling us to understand more fully the regional nuances of providing care in the market and implement solutions that will make sense for Mississippi physicians.
- **Local support system:** We will have resources available within Mississippi for member and provider service, further supporting the specific needs and challenges members and providers face within the market. Nurses and case management staff, customer care professionals and transaction specialists all will be located in Jackson, Mississippi. Provider relations advocates will be available to visit providers throughout the state.
- **Active community outreach**: We will have an active community outreach team who will promote wellness and preventive health services available in Mississippi.
- **Competitive payment:** We will be paying commercial rates to contracted providers for services provided to CHIP members, and FQHCs will receive PPS payments for services provided to CHIP members.
- We have put these measures in place to ensure that we are able to provide industry-leading benefits to the State and to fulfill our primary mission – to improve the health of children in Mississippi by employing our experience in serving this population and the underserved throughout America. We look forward to serving the State's needs on the commercial and CHIP business.

Claims Payment Reliability

Our current claims processing statistics demonstrate the ability of our company to use technology and innovation to provide timely and high-quality service to all of the parties involved. This is demonstrable through our timeliness, accuracy and service, which we carefully measure and monitor.

- **Timeliness**: Through August 2009, UnitedHealthcare averaged 96.1 percent of claims processed within 10 business days, which surpasses our goal of 95 percent and continues to rise month-to-month. This is a high level of accuracy, considering that the company processes over 300 million claims a year across our platforms.
- **Accuracy**: Through August 2009, we have averaged 99.5 percent claims payment accuracy. While a company standard is not published for claims payment accuracy, this measure is up from our full year 2008 average of 99.3 percent.
- **Service**: In 2009, our members indicated a notable improvement when responding to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 4.0H consumer satisfaction survey and the JD Powers Survey. In response to CAHPS questions regarding our ability to pay claims correctly and quickly, UnitedHealthcare's score by members increased over 1 percent year-over-year to 84.12 percent. Our result in the JD Powers survey improved 9 percent, 5 percent higher than the industry average.

UnitedHealthcare by AmeriChoice

AmeriChoice-specific data also show that we pay in a timely and accurate manner. Our claims processing timeliness, as of August 2009, is 99.6 percent in 30 days. On the FACETs platform, the platform that will be used for the Mississippi CHIP business, the turnaround is slightly higher at 99.7 percent in 30 days.

Our claims payment accuracy measure currently averages around 98.4 percent through August 2009.

Focus on Provider Satisfaction

From a provider relations perspective, we are committed to making it easier for physicians, hospitals and practice managers to do business with us. In 2008, we piloted an enhanced provider relations model in eight markets, adding new provider relations staff dedicated to improving provider satisfaction. Based on positive results and feedback from physicians, we are expanding the program to additional markets in 2009.

We are currently in the process of rolling out this new provider relations model in Mississippi. A director for the program covering the Gulf States is already on board. We intend to augment the provider relations staff in Mississippi through the remainder of the year, and, when fully staffed, the program will include two full-time employee (FTE) physician advocates (account managers), and a claims research and resolution position. This provider relations team will handle all lines of business, including AmeriChoice and UnitedHealthcare.

In addition, AmeriChoice is also in the process of building out their provider relations unit between now and the end of the year to include a manager, four provider advocates (account managers) and a claim research and resolution position.

Our enhanced provider relations model will promote open and continuous lines of communication around how providers and practice managers can best work with us using the robust suite of telephone and online tools that we make available. Equally important, through this model, we actively solicit feedback as to how we can become easier to work with and further assist providers in their interactions with us. In addition, the new provider relations program provides an improved issue resolution model, whereby if the issue is not easily resolved through the normal channels (e.g., a request for adjustment submitted via phone call, paper or online), the issue can then be quickly and easily escalated to a provider relations team whose focus is on issue resolution.

We continue to partner with our customers to identify areas of opportunity and leverage them to implement corporate-wide solutions. We are confident that the investment we are making in our programs will continue to positively impact our service in the future.