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Message From The *President*

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When we try something different it can be very exciting but sometimes a little scary. That is the way I feel about the changes we've made to the 2013 Summer Conference. Mechelle, Kristina, and their team have put together a great program and I know all attendees will be glad they came… but it is out of state and that understandably bothers some people so I would like to give you a little background. We intended to have the conference at the Imperial Palace as we have done in years past. Over a year ago we agreed with them to hold the conference there for the next three years. Just as momentum was building in the planning process, we were informed that the IP was approached by a larger group that wanted the same dates we had reserved so we were told we had to move our conference dates. The dates they offered were not optimal and, not being able to find a venue that could accommodate the MGMA of MS Summer Conference, the Perdido Beach Resort was chosen as the best solution. Plus, we received rave reviews from members that had attended the Summer Conference there previously!

I really hope you will join us June 26 – 28, at the Perdido Beach Resort. We will learn about satisfying our patients, contracting with our payers, compliance strategies, the ever changing regulatory environment, and much more. There will be super heroes, super speakers, and super fun! But the best part of every conference is the friends you make and the networking which will pay long term dividends over your entire career. See you there!

FREE MGMA Mississippi Webinar

HIPAA FINAL OMBINUS RULE; What Medical Practices Need to Know

Date: Wednesday, June 12, 2013
Time: 12:00 pm - 1:00 pm CDT
Space is limited.
Reserve your Webinar seat now at: https://www1.gotomeeting.com/register/143518216

John Mulhollan has actively served a variety of business and healthcare clients in Ohio and California, with a particular emphasis on the healthcare industry, for nearly ten years. Prior to joining BakerHostetler, Mr. Mulhollan served as Senior Counsel to Catholic Healthcare West, a large integrated healthcare system located in California, Nevada and Arizona. He along with Jesse Webb, Senior Director of Information Security for McKesson Medical-Surgical, will be presenting "HIPAA FINAL OMBINUS RULE; What Medical Practices Need to Know."

Key Take Aways:

- Changes to HIPAA Breach Notification Rule
- Changes to HIPAA Privacy and Security Rules
- Enforcement and Audit Risks
- Basic Steps of How to Comply
- Business Associates Contracting
- Data Security – What Medical Groups Need to Know

Michael Jones
Administrator
Fort Wayne, Indiana

Stefanie Ardoin, RHIA
Practice Manager
Lafayette, Louisiana

Josephine Young, MD, MPH
Chief Operating Officer
Bellevue, Washington

Dr. Kevin Spencer
Physician
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Compliance Challenges For Your Practice – *From a Coder's Perspective*

Treasurer

Judy Stevens, CPC

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Regardless of the size of your practice or what your specialty might be, there are certain issues that raise concern for most medical offices as they consider their compliance plans. A good working knowledge of the requirements relating to these issues will go a long way in allowing you to develop a plan that will effectively address these concerns in your practice.

The number one concern for healthcare practices is the many governmental audit programs that are scrutinizing your practice. There are the RACs, contracted with CMS to recoup money from inappropriately-paid Medicare claims errors. The Medicaid Integrity Program (MIP) works much the same in reviewing the appropriateness of Medicaid payments, and Zone Program Integrity Contractors (ZPIC) also focus on reviewing claims paid to providers who submit more claims to Medicare than the majority of other providers in their community, looking for instances of fraud or abuse, which they report to the OIG (Office of the Inspector General). Lastly, the CERT (Comprehensive Error Rate Testing) programs look for inappropriate payment by carriers and MACs, calculating the Medicare fee-for-service error rates based on a review of records. Lack of documentation is one of the most frequent problems they identify. Their findings are also used to form OIG target issues lists and to identify "error-prone" providers.

The OIG uses CERT program data from the past 4 years to identify and "classify" error-prone providers and will scrutinize their claims more closely. Any provider with an identified billing error during the program period becomes defined as error-prone. Those errors could include:

- Wrong CPT code
- Wrong ICD-9 code
- Medical necessity errors
- Missing/incomplete documentation and non-response to documentation requests
- Incorrect date of service

Review documentation before you send it to CERT, if you receive a request. Challenge any CERT findings you feel are in error. A clean CERT report will take one issue off your plate.

Another issue currently under the microscope at the OIG is claims being billed with Place of Service errors. Of particular concern are services being billed as office visits (POS 11), when the actual services were performed in hospital out-patient locations (POS 22). This is under particular scrutiny since physicians are reimbursed at a higher rate for services performed in their offices. For hospitals, the big POS issue is related to medical necessity for admissions. Medicare has advised that if the patient can be treated and released within 48 hours, observation status should be billed, rather than in-patient care.

Next on the list to consider is the billing of E/M services that fall within global surgical periods. This may actually be a bigger potential problem for non-surgeons than for surgeons. A global package payment includes one E/M service on the day of, or day before, surgery; this includes the history and physical that is done prior to surgery, no matter when it is done. Even if it is performed by another physician, the service is not separately billable, unless medically-necessary clearance is required prior to surgery. It is imperative to document the medical necessity of pre-operative E/M services to avoid violation of the global package. Also included in the global package is all typical follow-up, and all care of complications that don't require a return to the operating room. Care of new, unrelated conditions that arise during the global period can be billed separately, but be certain that your documentation details these as separate conditions.

Also items of concern are certifying home health services and ordering DME. Ordering providers are now required to personally see the patient before certifying the need for home health care, as well as for ordering, or re-ordering DME. The ordering provider is required to maintain a copy of the order in the patient's medical record. For home health services, the provider who certifies must document a face-to-face encounter with the patient for the condition for which the home health services are being ordered. That visit must be within 90 days prior to, or within 30 days after initiation of home health care. Although a physician must provide the certification, a nurse practitioner in the same practice can see the patient and document the visit. Re-certifications may be done without a face-to-face visit.

There has been a renewed focus on what constitutes a physician's signature, both handwritten and

electronic. The Medicare rules for signature requirements will be enforced anytime a document is reviewed, whether for payment, or in review, after the fact. RAC's are looking at signatures when they perform their records reviews. Handwritten signatures have been defined as "a mark or sign by an individual on a document to signify knowledge, acceptance or obligation". If that signature is illegible, a signature log or attestation statement is needed. A log can also be used to identify persons who signed by initialing. All logs and attestations must be signed by the person who made the original entry. Electronic signatures must be passworded and must "freeze" the record, therefore preventing any further changes to the record, except by a separate addendum. Signatures should also include a date. Other rules relating to signatures include:

- No one may sign for anyone else
- Signature stamps are unacceptable
- Unsigned records and orders are unacceptable
- "Dictated but not read" is not acceptable

The use of EHR's has led to new problems related to templated documentation. The OIG calls these "cloned notes", when so much of the documentation is copied forward from visit to visit, that the record is no longer unique to the specific service provided, or in some cases, when all of the records created on a single date are so similar, the information is not specific to the patient seen. Both governmental and commercial payers have begun refusing payment for cloned documentation, when it is not unique to the services being billed for a particular date. Each patient and each encounter should have unique documentation. You must develop processes in your EHR usage that allow providers to make use of defaulted, templated information for easy documentation, but still create a unique note for each visit.

Last, but by no means least, is proving medical necessity in your documentation. CMS defines medical necessity as 'complex medical judgment' made after consideration of the severity of the signs and symptoms, medical probability of an adverse outcome for the patient and the need and availability of diagnostic studies. All governmental auditing contractors are advised by CMS not to challenge a physician's judgment, but to determine if that judgment is clearly documented in the record. Documentation must contain sufficient information to support the diagnosis, justify the treatment or procedures ordered and/or performed, document the course of care, identify diagnostic test results and treatment results and finally, promote continuity of care. As the required implementation date for ICD-10 draws closer and closer, this will become more important than ever.

Although these issues do not constitute the full scope of a compliance plan, as defined by CMS and the OIG, they are certainly an integral part of the processes your practice should be reviewing as you consider formulating your written plan to minimize, and even prevent instances of billing errors in your practice – errors that could possibly lead to allegations of fraud and abuse.

A well-constructed compliance plan will not guarantee that your practice never encounters any errors or violations, but it will certainly help to make it possible to detect any internal problems early on and allow you to fix them before they escalate into more serious issues.

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A Message from our ACMPE Forum Representative

Joy Yates, CMPE
Hattiesburg Clinic
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Service Line Development
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"Tis against some men's principle to pay interest and seems against others' interest to pay the principal."

How to Develop, Communicate and Implement an Effective Earned Time Off Program

Conference Guest Speaker

Reed Tinsley, CPA

Historically, employers have offered paid time off to employees for vacation, illness, personal time, holidays and other reasons. For employee recruitment, retention and satisfaction, time off has become an increasingly important aspect of an employer's benefit package. A growing trend has developed where employers are moving from granting paid time off based on categories and circumstances, to a blanket Earned Time Off (ETO) program. An ETO program combines the majority of the various types of paid time off into one main category of time available for the employees to use for vacation, personal use, illness and other time away from work.

A single bank of ETO allows the employee to have more ownership, responsibility and flexibility in managing his/her time off. Employees who use less time for illness and similar unplanned absences consequently have more time for planned time off such as vacations. For example, a parent may be more encouraged to make alternative arrangements for a sick child and preserve an ETO day for vacation rather than take an unplanned absence to stay home with the child. Unplanned absences are more disruptive and problematic for healthcare operations than when time is scheduled to be off. In some traditional plans, dishonesty can occur as employees take unused sick time in attempts to maximize their benefit time. But with ETO the employer does not have to excessively monitor the category for the use of the time off as with sick versus vacation time, thus simplifying program administration. ETO policies can be ideal for flexible and part-time positions, as it can be easily pro-rated for these employees. With appropriate development and implementation, an ETO program can be a winning strategy for both employees and employers.

ETO programs are adaptable to virtually every size of healthcare entity. In tailoring a program, several key elements must be addressed to make it effective. Among them are that consideration must be given to the current time off program, employee and family illnesses, holidays and length of employment.

Management should analyze the current time off program for its strengths and weaknesses. Evaluate the total number of days provided, employee perceptions of the current program, management concerns experienced by the employer. In addition, management should specify the goals for the revised program such as simplification, reduced absenteeism and more flexible benefits. As early as feasible, employees should be asked to participate in the analysis and provide feedback to foster additional ideas and employee buy-in. Another important element is that time should be earned or accrued throughout the benefit year instead of as a lump sum deposit of time at the year's beginning.

One of the first transitional details to address is the types of leave that will be covered in the ETO program. In its simplest form, ETO allotments will cover the time usually provided for vacation, sick and personal time. More comprehensive programs can include holidays and bereavement leave as well as the traditional vacation, sick and personal time.

After defining the types of leave to be addressed with the ETO, assigning a value or number of days is the next critical step. For example, a group practice typically offers ten days of vacation, six days of sick leave and one personal day for a total of 17 days of paid time off. This group may propose a total of 14 days of ETO. Employees gain control and flexibility to use the 14 days as needed, whereas the traditional program only allowed them to control the use of the vacation and personal time. Employers reduce the number of days paid per employee, discourage unplanned absences and empower the employees in the management of their time.

PLANNING FOR EXTENDED TIME OFF

Based on the size of the group, special consideration should be given to time off when employees encounter extended illnesses. When they are in place, short- term disability policies and the Family Medical Leave Act provide certain benefits to employees when they are faced with devastating illnesses. However, many small groups do not have these benefits and desire to support employees who have extended situations such as maternity leave, post-operative recovery or serious family illnesses. If the amount of ETO is generous, one option is to allow employees to "bank" unused earned time off to create a separate category for extended illness. If the amount of ETO days available to employees is more limited, a separate bank for extended illness can be set up. A separate "extended illness bank" generally accrues six days per year. With either method, it is important that the bank have definitive rules for use. For example, time from the "ex-

tended illness bank" can only be used after three or five days of the current ETO is used for the same illness. If the employee defers current ETO into the extended illness bank, the extended illness bank is generally paid, at a full or discounted rate, upon termination from employment. When the employer gives a separate extended illness bank, unused accruals are commonly forfeited at termination. Maximum amounts in the extended illness bank should be designated in conjunction with rules for use.

MANAGING HOLIDAYS

Another common inclusion into the ETO pool is the allotment for holidays. Groups who require staffing for traditional holidays should add the holiday time into the ETO to equalize the available time off for employees who work holidays and those who take holidays off. If the employer does not open for holidays, holidays can be designated and observed as a separate paid time off to simplify the administration of ETO and scheduling.

REWARDING CONTINUED SERVICE

Allocations of ETO should be designed to incrementally increase with length of employment. With a lower number of ETO days initially, the increase in ETO can occur more quickly with length of service. Using the earlier example above, 14 days ETO may be accrued during the first year of employment and then increased to 15 days for the second of service. The newer employees receive an incentive and the employer continues to realize an overall lower number of benefit days.

MORE DECISIONS IN DESIGN

There are other factors to consider in developing an ETO program. The decisions are dependent upon the group's experience, culture, leadership and goals. An important component is whether an employee can carryover accrued, but unused ETO beyond the employment anniversary date. If so, is there a maximum carryover amount? If not, do you pay an employee for the unused ETO? At what rate do you pay an employee for unused ETO? Another administration issue is whether employees can borrow against future accruals and have a negative ETO balance. If so, in what circumstances and how much can you borrow? Planning must also include determinations for how ETO is managed at an employee's termination. The employer may differentiate between payment, in the situation of a resignation, and a forfeiture when the termination is by the employer.

There are also several approaches a group can use for accrual of ETO. Although the accrual total may be fixed, it can be allocated on either a per payroll or per hour worked factor. Using the previous 14 day ETO example, a full-time employee would accrue 4.308 hours for each bi-weekly payroll. This is computed using 14 days at 8 hours per day divided by 26 pay periods.

PREPARING FOR THE TRANSITION

As the ETO program is developed, it is critical to test the new program against common situations that occur with the current paid time off program. How many employees are using the maximum number of days allowed? How many sick days did employees use? How many employees have unused time left at the end of the year? Determine how employees will be impacted by the ETO plan and anticipate their perception – gain or loss. Review unusual circumstances related to paid time off that have occurred to determine how they would be managed under the ETO plan, again assessing employee reaction.

Such a comparison against the existing plan can suggest modifications that may be needed, transition allowances that must be made, or obstacles to be overcome. For example, if there is unused vacation, sick or personal time at the ETO conversion date, it is not unreasonable for that time to become a beginning balance for the employee's ETO plan. Otherwise, the employee feels cheated out of time not used, affecting employee morale and threatening the transition's success.

Communication becomes key to successful implementation, as is the timing of the introduction of the new ETO program. Other important implementation considerations include:

- Plan for a logical start time, such as a new calendar year, and allow employees sufficient time – prior to implementation – to understand the new system.
- Begin with written policies and procedures for the new ETO program.Written guidelines should be specific and detailed.
- Hold staff meetings to educate employees with clear explanations of the goals and benefits of the new ETO system. Try to anticipate any aspects that might be perceived by the employees as negatives and address the concerns directly.
- Demonstrate areas where the employer has compromised to promote a smooth transition.
- Discuss with employees specific examples of how ETO is used.
- Provide employees with the written materials and handouts to clarify the plan and address their questions.
- If practicable, consider meeting with each employee individually to review the current time off plan, the transition to the new ETO program, and address the employee's personal circumstances.

Ongoing communication is important for ongoing success and administration. It is helpful to include an ETO report of the accrued, used and balance with each employee's payroll. If applicable, extended illness bank amounts should be included with the payroll reports. An annual evaluation of the employee's use of ETO can be instrumental to discuss time management and is necessary if the employee must make accrual elections to carryover or be paid for unused time. As issues develop or modifications are made to the policies and procedures of the ETO plan, communicate these changes with the employees.

ETO is a prevalent benefit program in healthcare settings due to its simplified administration, flexibility to accommodate healthcare positions and ability to motivate and empower employees' management of time. These ETO benefits are available for small and large practices alike, if addressed with detailed planning and communication.

Reed Tinsley, CPA is a Houston-based CPA, Certified Valuation Analyst, and Certified Healthcare Business Consultant. He works closely with physicians, medical groups, and other healthcare entities with managed care contracting issues, operational and financial management, strategic planning, and growth strategies. His entire practice is concentrated in the health care industry. Please visit www.rtacpa.com

Reed Tinsley will be a featured speaker at our Summer Conference this month. Visit www.mgmams.com for registration details!

MGMA of Mississippi Summer Conference Agenda

Wednesday, June 26

12:00 p.m.	Registration Desk Opens
6:00-8:00 p.m.	Wine Tasting Networking Reception in Exhibit Hall (Grand Point)

Thursday, June 27

7:00-8:00 a.m.	Breakfast in the Exhibit Hall (Grand Point)
7:00-8:00 a.m.	New Members, First Time Attendees & Past Presidents Breakfast (Grand View)
8:15 a.m.	Welcome, Pledge, Announcements (Salon ABC)
8:30-9:45 a.m.	General Session: *Job Function vs. Job Purpose – Jamie Verkamp* (Salon ABC)
9:45 -10:15 a.m.	Break in the Exhibit Hall (Grand Point)
10:30-11:30 a.m.	General Session: *Washington Update – Jeb Shepard* (Salon ABC)
11:30-12:00 p.m.	Business Meeting
12:00-1:15 p.m.	Networking Lunch (Grand Point)
1:30-2:45 p.m.	General Session: *How to Thrive Not Just Survive – Reed Tinsley* (Salon ABC)
2:45-3:15 p.m.	Break in the Exhibit Hall (Grand Point)
3:30-4:30 p.m.	Breakout Session #1: *New Marketing Initiatives to Improve Patient Referrals – Jamie Verkamp* (Sand Castle II)
3:30-4:30 p.m.	Breakout Session #2: *Compliance – Reed Tinsley* (Salon ABC)
5:30-8:30 p.m.	Beach Party! *Please pre-register your guests. Attendee admission is included in conference registration fee. (Adults-$15, Children-$5, Children 2 & under-free)*

Friday, June 28

7:00-8:00 a.m.	Breakfast in the Exhibit Hall (Grand Point)
8:15-9:30 a.m.	General Session: *Financial Analysis in Negotiating Your Payer Reimbursement – Penny Noyes* (Salon ABC)
9:30-10:00 a.m.	Break in Exhibit Hall, Exhibitor Drawings for Door Prizes (Grand Point)
10:15-11:15 a.m.	Breakout Session #1: *Deal Breakers in Contract Language – Penny Noyes* (Salon ABC)
10:15-11:15 a.m.	Breakout Session #2: *ACMPE Update – Joy Yates* (Sand Castle II)
11:30-12:00 p.m.	General Session: Closing remarks, adjourn (Salon ABC)

CE Credit

This program is eligible for:
8 ACMPE CEUs
8 AAPC CEUs
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CONFERENCE SPEAKERS

Jaime Verkamp

As Managing Partner and Chief Speaking Officare at (e)Merge, Jamie works shoulder to shoulder with medical professionals in both hospital and clinical settings to improve the patient experience and has seen measurable growth in her client customer service efforts, referral volumes and bottom lines. As a sought after speaker and trainer, Jamie shares her knowledge with audiences at more than 50 events each year speaking on topics related to new marketing initiatives, the patient experience and healthcare social media. Her expertise has also been featured in multiple industry publications including MGMA Connexion, Medical Practice Digest and the American Medical Association. Verkamp's 2010 article for the Medical Group Management Association (MGMA) Connexion, titled "The Real Value of Social Media in Healthcare" was awarded the Edward B. Stevens Article of the Year in 2011 by MGMA and the American College of Medical Practice Executives (ACMPE)

Job Function vs. Job Purpose
Why Satisfied Patients Cost You Money

We have all been there; we are in a customer service experience in which a company's representative goes above and beyond their call of duty to ensure we receive the best treatment possible and that our expectations are exceeded. Then, there are the experiences in which the representative, "did their job" by addressing our concerns or taking care of our needs, but we were left with a lackluster impression of the organization and walked away merely satisfied with little to say about the experience or the company. What makes these two experiences so different to us as the consumer? Why are we left with a great story (and the motivation) to share with our friends from the experience that exceeds expectations and little to say or remember about the other? During this interactive session, we explore the thought provoking concept of, "Job Function verses Job Purpose" and how this concept plays daily in our organization. Real examples will be shared to demonstrate the concept and how it applies to your staff, your administrators and even your physicians. You'll walk away challenged to implement simple tips to help train and refocus your organization on the "purpose" side of your roles and how you can best serve your customers and patients–to create a lasting impression. It's time to break free from the sea of sameness that plagues the medical office experience today and do something different to help you take your customer service to the next level and exceed expectations every day.

New Marketing Initiatives to Improve Patient Referrals

In the reality of our shifting economic climate, successful, business-minded medical practices are shifting the way they approach marketing. Successful practices are now putting the focus back on their patients and using innovative marketing strategies that bring greater return on their investment. You can expand your practice in this economy, and during this session you will learn what it takes to make that happen. You will learn key marketing initiatives you can implement right away in your practice to increase new-patient volume and successfully market to your current patients to increase patient retention and referrals, including:

- Attract new patients using online and offline strategies
- How to create "wow" patient experiences that will increase referrals
- Effectively market to your current patient base

Reed Tinsley, CPA

Houston-based CPA, Certified Valuation Analyst, and healthcare consultant. He works closely with physicians, medical groups, and other healthcare entities with managed care contracting issues, operational & financial management, strategic planning, and profit strategies. His entire practice is concentrated in the health care industry.

How to Thrive Not Just Survive in a Changing Healthcare Environment

Times are a changing and so should physician medical practices. Constant Medicare changes, healthcare reform, integration competition, ACOs, and continued attacks on reimbursement are just a few of the many issues now facing physicians. To survive in this ever changing healthcare environment, physicians need to adopt strategies to deal with it head on. This presentation will provide an overview of the changes now occurring in the healthcare marketplace and how any medical practice can create tactics to address them.

Compliance Strategies for Physician Practices

Healthcare fraud is the #2 priority of the Department of Justice, second only to terrorism and violent crime. In fact, the Department of Health & Human Services estimates that $17 will be returned for every $1 invested in fraud & abuse initiatives. This presentation will provide an overview of fraud and abuse, along with a discussion of actions and activities by physicians that run afoul of the law. The presentation will also discuss compliance initiatives every medical practice should undertake, no matter the size of your practice.

Jeb Shepard
Government Affairs Representative
Midwestern and Southern Sections

Jeb answers member questions about technical details of federal legislative and regulatory issues, coordinates grass roots efforts by MGMA members, and speaks before MGMA state and national meetings. Prior to joining MGMA, Jeb worked as a Legislative Associate at a leading state and local government affairs firm where he tracked and analyzed healthcare, immigration and labor legislation for corporate, trade association and non-profit clients in thirteen states. From 2007-2009, Jeb was a Legislative Assistant to a Representative in the Washington State House of Representatives, where he worked on a wide array of policy issues.

Washington Update

Penny Noyes

Penny Noyes brings over 36 years of healthcare related experience to the table. With 18 years on the payer/network side of the industry and 7 years on the practice management side, in 1999 she founded Health Business Navigators (HBN), a firm dedicated to assisting practices with payer contracting and credentialing. From 1995 through 1999, she served as Sr. Vice President of Business Development at U.S. HealthWorks responsible for acquisitions, marketing, managed care contracting, national account sales, pricing, outcomes research, revenue enhancement and reserve reduction…acquiring in 2 years nearly 80 practices in 7 states representing $100 million in annual revenue. Prior to USHW she spent over 11 years at Allmerica Financial, where she became chief operating officer of the managed care division, AMM, responsible nationwide for contracts with 180,000 providers, utilization management and product development. While at AMM she was among the founders of PHCS, selected by PHCS' 17 payer partners to represent the payers' interests at PHCS board and senior management meetings. And, before Allmerica, Ms. Noyes was with Blue Cross of Massachusetts for over 6 years. Penny is a regular speaker for MGMA at Financial Management and Payer Contracting conferences and well as MGMA's annual conferences, and for HBMA, DecisionHealth, medical societies and more.

Financial Analysis in Negotiating Your Payer Reimbursement

This session will walk you through the initial steps of gathering and inventorying all of your contracts and rates so a methodical process of evaluating and renegotiating your payer agreements can be achieved. With this information systematically gathered, the renegotiation strategy and time frames will become obvious. Next, this session walks you through how to evaluate the adequacy of your charge master, how to take your fee schedules and utilization date to create a compelling argument for a payer to improve your rates and how to model an offer, or test a counter-offer, utilizing numerous methods such as carve-outs, percentages of Medicare, percentages of proprietary schedules, banding, and escalators.

Deal Breakers in Contract Language

While rates are paramount when signing a new payer or network agreement, don't forget to look at the rest of the provisions. In this session you will learn how to protect the reimbursement that you just negotiated and identify other administrative provisions that can undermine your practice. 20+ contract provisions are outlined with a handful of examples of the most dangerous provisions, why they can cause havoc, alternate language to request and how to manage those that payers will not change. This session also provides you with information regarding who has access to these agreements, what laws they are subject to and how leased and owned networks differ. Among the issues covered are amendments, timely filing and payment, patient hold harmless, product participation including Exchanges, over/underpayment time periods and process and more.

Identify and understand the payer contract provisions that cause the most heartache Negotiate alternative language more favorable to your practice Articulate the provisions that you can and cannot change and how to manage them.

Joy Yates, CMPE

Joy is the Assistant Administrator of Service Line Development at Hattiesburg Clinic. She is also our MGMA of MS ACMPE Forum Representative.

ACMPE Update

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