

THE BOTTOM LINE

Information and insight to advance the financial performance of your practice.



ICD Codes Are Set to Multiply Like You Know What. Are You Ready?

If you're thinking coding is a challenge now, it's a piece of cake compared to the ICD-10 codes that go into effect October 1, 2013.

And if you think there's nothing to worry about because the implementation date is two years away, think again. With the number of diagnosis codes multiplying from around 13,600 to about 69,000, ICD-10 is predicted to radically change the way coding is currently done and will require tremendous effort on the part of coders, practice managers, physicians, and hospitals to effectively adjust and ensure appropriate reimbursement.

The Centers for Medicare and Medicaid Services (CMS) has several motivations for the change. The current ICD-9 platform is maxed out in terms of available codes for new procedures. In addition to expanding the coding system, ICD-10 will also allow for better analysis of disease patterns and outcomes that will support advances in evidence-based care.

Though the new system is largely based on a World Health Organization code set in use for more than a decade, the complexity and sheer volume of the new ICD-10 codes have spawned criticism. For example, instead of one code for suturing an artery, there will be 195. A badly healed fracture currently covered by a single code could possibly be addressed by 2,595 different codes.

MedOptima has established an internal ICD-10 Committee to plan for the billing changes and client education that will be necessary with ICD-10. Additional details on ICD-10 will be forthcoming to our billing and consulting clients.

Contact Melissa Doepke at MedOptima for things you should be doing now to prepare your practice personnel for ICD-10. mdoepke@medoptima.net or 260.969.1950 ext. 118

Conquering Today's Challenges Requires Choice and Change

Yes, the business of medicine is tough these days. Reimbursements are dwindling, operating costs are rising, and the government is throwing a whole slew of new mandates at physicians.

Is it time to pull the plug?

The answer, of course, is no. However, it is time to take a hard look at how your practice is handling revenue cycle management. Chances are, if you have an internal billing department that has not been continuously modernizing and improving, you will discover significant revenue leaks due to coding issues, ineffective collections, software limitations, or underperforming personnel.

To remain profitable in a challenging environment (see highlighted box), practices must concede the old ways of doing things aren't working and be open to change. Often, an outside perspective is the only way to identify how to plug revenue leaks and capture more income. Some changes are small, others more significant. MedOptima has discovered that the best revenue and efficiency results for its billing and consulting clients are generated by a laser focus on three key principles:

- The best software
- The best processes
- The best people

Software. Software is expensive, but the right systems can help practices secure more income from current patient volume. If you are not using data mining software to spot financial trends before they become serious, not using denials management software to process, analyze and prevent denials, or have not yet implemented state-of-the-art practice management software, you're leaving money on the table.

MedOptima can help you get more from your IT and save money. We can host software for you, eliminating the need to purchase the initial system and subsequent upgrades. If you

choose to purchase, we can oversee implementation, including training. Outsourcing your billing function to MedOptima eliminates the need to invest in certain healthcare IT.

Processes. One of the ways America's largest companies have remained profitable is by re-engineering their processes. Medical practices can do the same.

MedOptima can audit your practice and help you implement best practices based on "lean" manufacturing principles to replace inefficient, redundant processes with streamlined workflows that get better results. In one case, a MedOptima client was able to double the workload of its existing billing staff and create a higher level of job satisfaction among staff simply by implementing better processes. Other process improvements result in greater time-of-service collections.



People. We all have a tendency to do things the way it's always been done. Human nature is resistant to change. However, with the increasing reimbursement challenges from payers (often "non-payers"), the old ways are no longer good enough.

MedOptima can help staff adopt a culture of teamwork and continuous improvement. This *continued on page 2*



ASK THE EXPERT

Brose A. McVey
Vice President
Business Development
Senex Services Corp.

Brose A. McVey is the vice president of Business Development for Senex Services Corp. (www.senexco.com), an Indianapolis-based company that purchases self-pay bad debt from healthcare providers. Senex and MedOptima are establishing a new revenue cycle management model that will enable medical practices to accelerate bad debt collection.

Plagued by Self-Pay Bad Debt?

A New Model Will Allow Medical Practices to Turn Stubborn No-Pays into Cash

Q. Who is Senex Services?

A. Senex was founded in 1998. We are one of only a handful of companies focused entirely on purchasing healthcare self-pay bad debt receivables. Over the past 12 years, we have served more than 100 providers, purchased nearly \$1.8 billion in self-pay bad debt, and managed 3.67 million patient accounts.

Q. How is Senex different from a collections agency?

A. We actually own the bad debt, while collections agencies earn a portion of what they collect. We have a vested interest in collecting as much as we can.

Q. Why has Senex been successful?

A. Our growth is a sign of the times. According to a survey by the American Credit Association, healthcare is the fastest growing segment of bad debt. The poor economy, eroding payer mix, and the shifting of medical expenses from payers to patients have made it extremely difficult for providers to collect bad debt. This backlog of frozen cash has created tremendous financial pressure on providers. Having the option to sell self-pay bad debt to Senex is very attractive to providers as it accelerates cash flow, generates liquidity and captures "lost" income.

Q. Why is selling bad debt a good solution for medical practices and hospitals?

A. In the past, a certain level of slow or no pay was expected. Now that payers have cut reimbursements to the bone, capturing the patient's portion of the bill is critical. Collecting self-pay bad debt is a long, stubborn pathway. Very few medical practices or hospitals have the patience or resources to address the problem and make it pay. Selling bad debt to Senex provides an immediate solution.

Q. Does Senex work with medical practices?

A. Historically we have concentrated on hospitals with a minimum of \$1 million a month in bad debt. We are now developing a new co-service alliance with MedOptima that will enable independent and hospital-owned physician groups to take advantage of Senex's services.

Q. How are Senex and MedOptima working together?

A. We are creating a new model that is focused from start to finish on maximizing the efficiency, effectiveness, and timeliness of revenue cycle management. MedOptima is an expert in billing and coding. Senex is the expert in bad debt collections. Our co-service alliance will enable practices to capture as much revenue on the front and back-end as possible from payers and patients. The unique aspect is that Senex purchases self-pay bad debt on a monthly or quarterly basis, creating immediate, predictable cash flow and liquidity for practices.

Q. How do patients respond to Senex?

A. We respect the fact that this is a sensitive business. Our Indiana-based staff is very knowledgeable about healthcare law and finance, but also follow compassionate collection practices. We want to maintain the relationship between the provider and patient, and respect the fact that often it's not that people don't want to pay their bills, they may not have the money. We work with them to fulfill their obligations. Senex generates very few patient complaints.

Q. When will medical practices have the opportunity to work with Senex?

A. If our test with MedOptima goes as we expect, our plan is to allow all MedOptima medical practice clients to participate. This could take place as early as the end of the year.

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involves laying out performance expectations for claims filing, collections and other tasks, and establishing clear goals and metrics. Sharing this data will serve to engage and motivate staff.

Small things matter. There is no silver bullet to make practices more profitable; the world and the business of medicine are too complicated. To be profitable, practices must do everything, even the small things, better, whether it's coding, claims rework, collecting the self-pay portion of bills, or staff performance.

Change isn't easy and it often requires an expert like MedOptima to secure results.

MGMA's 2011 TOP FIVE CHALLENGES*

When the MGMA asked medical practice managers what kept them awake at night, here's how they responded:

- 1 Dealing with rising operating costs
- 2 Pending reimbursement models that place more financial risk on practices
- 3 Participating in the CMS electronic health records (EHR) meaningful use incentive program
- 4 Selecting and implementing a new EHR system
- 5 Implementing/Optimizing an accountable care organization

Other Top 10 Concerns

- Uncertainty in Medicare reimbursements
- Growing difficulty collecting from self-pay patients



* MGMA Connexion, July 2011

BILLING UPDATE:

Robust Denials Management Processes Have Reduced Client Denials by Up to 3%

Everyone is trying to hold on to their money, including insurance companies. With denied claims on the rise, MedOptima has taken aggressive steps to ensure we collect the most possible on clients' claims.

Why Payers Say No

Payers have become more stringent in their requirements, and constantly changing rules create opportunities for errors and denied claims. The most common reasons payers say no are:

- Patient insurance information incorrectly captured or is incomplete.
- The patient and the insured's ID number didn't match.
- Procedure was covered by another payer.
- Duplicate claim
- Medical necessity denial – the payer wants a more specific diagnosis or additional documentation to justify the service(s) provided.

Ramping Up the Offense

MedOptima has gone on the offensive to reduce denied claims. Since May 1, we have:

Implemented Allscripts Denials Management Software. This software automatically identifies denied claims so re-work begins immediately.

Added a Denials Management Specialist who is a certified coder with a strong background in accounts receivable management. She is focused entirely on denials, enabling MedOptima to address denied claims within 24 hours of receipt.

Selected as a Beta Site for Allscripts Practice Performance™ solution. Because of MedOptima's billing expertise and long-standing relationship with Allscripts, we were asked to beta test the new Practice Performance Software. This software is a powerful reporting and analytics tool that enables us to monitor and analyze denials and payer reimbursement shortfalls, and then respond quickly to obtain payment in full and identify opportunities to prevent denials.

In addition to global trends, we can drill down on individual denials to identify the exact cause of the problem:

- By payer
- By patient
- By physician
- By denial code

With these data dashboards, we can identify positive and negative trends as well as take proactive steps to avoid future denials. For example, we have approached individual payers to determine why certain denials are made.

Began Meeting with Clients to Educate Physicians and Staff on Common Denials and How to Avoid Them. Practice Performance enables us to provide important denials data to our clients so they can take corrective action. Some of the most common denials are associated with front office staff capturing incorrect payer information or missing payer-required data fields.

Thanks to Practice Performance, we are able to see exactly what is happening with denied claims at each of our client practices. We can then meet with physicians and their staff members to share our findings plus provide strategies to avoid recurrence of common problems. This effort has been extremely well received by clients.

Significant Results

In just three months of implementing Allscripts Denials Management and Practice Performance Softwares, MedOptima has achieved significant results. Our clients are experiencing a drop in denials of as much as three percent. MedOptima clients are achieving MGMA "better performer" results on denials, and also compare very favorably with state and national same specialty peer groups.

While MedOptima can't eliminate denied claims altogether, we are confident our clients will continue to see a decline in denied claims due to our ramped up offense.



Would you like to learn more?

Contact Amy Eavey, MedOptima's Vice President of Operations, aeavey@MedOptima.net or 260.969.1950 x102.



THE BACK PAGE



Nashville

MedOptima Shines at Allscripts Client Experience (ACE) Conference in Nashville in August



Eric Beier, MD, MBA



Amy Eavey

In August, 5,000 medical practice professionals descended on Nashville, TN for ACE 2011, Allscripts' annual conference showcasing the company's software solutions. MedOptima's President and Founder, Dr. Eric Beier, and Amy Eavey, Vice President for Operations, were front and center, giving four presentations over the course of the three-day gathering. Here's a recap:

Optimizing Physician Revenue Performance: Creating the Billing Engine

Eric Beier, MD, MBA
Steve Sandquist, CEO, ENT Associates, PC

Many medical practices are finding optimal financial performance increasingly difficult to achieve. Declining reimbursement, recalcitrant payers, the poor economy, under-insured patients, and rising operating costs challenge profitability on a daily basis.

Just ask Steve Sandquist, CEO of ENT Associates, a 15-physician practice with 17 locations and 170 employees. In 2010, ENT Associates, merged with another practice, resulting in opportunities and issues. Sandquist tapped MedOptima to assist in creating a high-performing "billing engine" from the merged billing departments.

At ACE 2011, Beier and Sandquist presented both sides of the practice's transformation story, addressing how ENT Associates optimized its IT/software assets, streamlined its processes, engaged its people in a new results-driven culture, and employed metrics to ensure performance goals were met. The process included implementing a new Allscripts PM system.

The results were worth the effort. ENT Associates doubled the workload of its billing staff without adding people, while reducing staff stress and improving morale. Charge entry lag time plummeted from four weeks to 24 hours. Cash flow also improved.

Physician Coops: A Model to Optimize Operational and PM/HER Results

Eric Beier, MD, MBA
Jonathan May, BSN, MBA, Integrated Healthcare Associates

With hospitals actively acquiring medical practices and payment systems that threaten the viability of one- and two-doctor practices, physicians are faced with the choice of maintaining independence or becoming hospital employees.

In this session, Dr. Eric Beier and Jonathan May outlined a new option for those physicians wanting to remain independent: the medical coop model. In this model, physicians own the coop while a management company provides IT hardware, software, training, support, and analytics; human resources; revenue cycle management; and business office services. Coop members enjoy a shared cost structure, low monthly fee, and an opt in/out of the various services.

The coop model can be adopted by same specialty practices, multiple specialty practices, and by hospitals that wish to offer a dynamic business model to medical practices without acquiring them. The advantages are the same: powerful technology; independent practices with flexibility and autonomy; and "buying bigger and better than what you could do on your own".

Allscripts Practice Performance Case Study

Eric Beier, MD, MBA
Amy Eavey
Terri Kennedy, Allscripts

In this session, Beier and Eavey provided the CEO and operations manager perspective on Allscripts Practice Performance™ (APP) solution. APP allows users to monitor and quickly

respond to changes in key performance areas such as denials. APP has three critical functions:

- Proactive messaging that assists in operational performance monitoring
- Interactive dashboards that summarize key performance indicators
- Comparative analysis for benchmarking against state and national peer groups

APP currently provides insight into unexpected claims denial percentages, including early identification of new denials by specialty, CPT code, providers, and payers. In the near future, APP will include accounts receivable and productivity performance monitoring and dashboarding capabilities.

APP has given MedOptima a means of identifying and proactively addressing reimbursement trends before they become a major threat to our clients' revenue streams.

Underutilized Features of Allscripts PM that Impact A/R

Amy Eavey

Allscripts practice management software is a robust tool for revenue cycle management—if the practice staff knows how to use it. In this session, Amy and a colleague from Delaware took attendees through underutilized yet highly valuable features that affect collection practices, reporting, analysis, and ultimately, cash flow.

One example is the ability to review, sort, and process self-pay and insurance credit balances separately, which helps practices work unpaid balances more effectively. Practices can also track when a case was turned over to a collections agency and auto adjust various charge entries.

If you would like details on any of these presentations, email Dr. Eric Beier at ebeier@medoptima.net or Amy Eavey at aeavey@medoptima.net. Or, call 260.969.1950.