

Letter from the President

Spring is upon us and change is the air, and I don't just mean the changing season. The early months of 2010 have brought about many changes in the healthcare industry with many more to come before the year's end.

This edition of Practice Management Partner will provide you with valuable information that will help you prepare for some of the biggest changes that our industry has seen so far, including ANSI-5010, ICD-10, and the finalization of the Meaningful Use requirements required to receive ARRA funding.

As always, we are here to help you every step of the way. Please don't hesitate to contact us.

Steve Ruhle

Keeping Up with Healthcare's Rapid Changes

Healthcare technology change has been dramatic over the last twenty years. The rate of change has accelerated in the last five years due to both advances in technology as well as regulatory changes in both the clinical and financial aspects of healthcare practices. Keeping up with those changes can be challenging; however, many providers are finding that it's an even greater challenge to catch up after allowing software and technology to slide until regulatory changes force an upgrade.



There will be more change in the next two to three years than we have seen in our industry since the introduction of HIPAA. We will provide you with valuable information that will help you plan for the changes in workflow, staffing and technology and to avoid the last minute rush to meet government-mandated requirements for submitting claims and clinical reporting measures.

The three major areas that will require your attention are the implementation of ANSI-5010, ICD-10 CM, and the Meaningful Use Requirements associated with the ARRA legislation. We have provided basic information on each of these areas in the following sections. Use these as starting points for your internal plan of attack. We can assist you each step of the way and would be happy to provide you with information on how Medisoft will meet these requirements.

Where Do I Begin?

Within the last six months there has been a tremendous focus on electronic medical records technology and the ARRA legislation which provides financial incentives to qualified healthcare providers who implementing an electronic medical record that meets the meaningful use criteria yet to be finalized by the Office of the National Coordinator (ONC). Although this is a great opportunity for providers to improve patient care and

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Medisoft Tips & Tricks

Using Medisoft Reports to Find Missing Charges

It is important to make sure that you are collecting every dollar possible for your practice. The Appointments with No Charge report in Medisoft Reports is a powerful tool that can help you find dollars that could be lost due to missing superbills. The Appointments with No Charge report is accessed from the Medisoft Reports window in the Focus on Collections folder.

Appointments with No Charge					
Happy Valley Medical Clinic					
Mallard, J.D. (JM)					
Chart Number	Name	App Date	Time	Status*	Reason Code
AGADW001	Agan, Dwight	12/12/02	8:30 am	0	CHECKUP
AGADW001	Agan, Dwight	12/22/09	10:15 am	0	
AUSAN000	Austin, Andrew	02/07/03	2:00 pm	6	
CLIWA000	Clinger, Wallace	02/05/03	1:15 pm	6	NEW
DOEJA000	Doe, Jane	02/06/03	2:00 pm	6	
HARTO000	Hartman, Tonya	02/04/03	1:15 pm	6	NEW
KARJE000	Karvel, Jessica	02/03/03	9:00 am	6	MEDICARE
NIELI000	Nielsen, Lindsey	03/08/07	3:45 pm	0	
WAGJE000	Wagnew, Jeremy	02/07/03	9:15 am	6	

If your office has a policy of charging a "no-show" fee for missed appointments you may also want to run the Missed Appointments with No Charge report.

Missed Appointments with No Charge					
Happy Valley Medical Clinic					
Morris, Melvin (MM)					
Chart Number	Name	App Date	Time	Reason Code	
HARTO000	Hartman, Tonya	02/04/03	8:15 am	EXISTING	
SIMTA000	Simpson, Taurus	02/04/03	10:00 am	CHECKUP	
Lee, Robert (REL)					
Chart Number	Name	App Date	Time	Reason Code	
AGADW001	Agan, Dwight	02/04/03	8:00 am	FOLLOWUP	
ZIMAN000	Zimmerman, Anthony	02/06/03	9:00 am	NEW	

In order for each of these reports to provide maximum benefit you must use the appointment status function in Office Hours Professional to mark patients as Checked-in, Missed, Cancelled, etc...

Medisoft Version 16 has been released with a fresh new look!



Call us today for great deals!

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Great Features and a Fresh New Look in Medisoft V16!

Call us today for great deals on Medisoft Version 16 and Medisoft Clinical.

## Healthcare Changes

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efficiency while covering much of the cost, the regulatory changes requiring the use of ANSI-5010 and ICD-10 may have a far greater financial impact. Yet few practices have spent much time educating their staff or preparing their software. We have put together a few facts to bring you up to speed. Let's start with ICD-10.

### ICD-10 CM

The primary goals for implementing the ICD-10 code sets are to allow better analysis of disease patterns and treatment outcomes. They will also make it easier for payers to understand the need for the services provided by providing more detail in the initial claim submission.

The ICD-10 CM diagnostic coding system was implemented by the World Health Organization (WHO) in 1993 to replace ICD-9 CM, which was developed in the 1970s. ICD-10 is in almost every country in the world, except the United States. It is scheduled to replace the current ICD-9-CM on October 1, 2013. Although there are similarities, the differences between the two systems will affect information technology and software at your practice. A notable difference is the sheer volume of codes in the ICD-10 CM code set – 69,000 versus 13,600 in ICD-9 CM. The code structure is also very different. ICD-9 codes are mostly numeric, and are between three and five characters. ICD-10 codes all contain both alpha and numeric characters and are between three and seven digits. Most practice management software, including Medisoft, currently accommodates five digit diagnosis codes. So your software must be upgraded for the longer codes.

Software upgrades are not the only thing that you will need to prepare for ICD-10. In fact, software changes will be one of the easier pieces of the transition. Physicians and staff will need to be trained on the new coding structure. This process will not be easy and should begin well in advance of the implementation deadline of October 1, 2013. It is also important to communicate with colleagues, particularly if you are in a specialty that receives referrals from other providers. It is critical that your referral sources be familiar with the new codes and be able to provide this information when issuing referrals. Encourage them to prepare for the changes well in advance.

### ANSI-5010

The current standards for transmitting information electronically do not allow for the expanded ICD-10 code set. ANSI-5010 accommodates the new codes; however that is not the only change implemented in ANSI-5010. The changes apply not only to claims transactions, but also to eligibility and remittance advice. Additional data elements will be added to provide more information to providers from the insurance companies when eligibility requests are made or remittance advice is received.

The deadline for converting to the ANSI-5010 transaction set is January 1, 2012. Most clearinghouses and software vendors are planning to begin testing for these transactions by the end of 2010.

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The change to ICD-10 CM and ANSI-5010 is manageable but it is not easy. Remember the challenges of implementing NPI? The implementation of ICD-10 is exponentially more complicated so it is critical that you begin preparing now to avoid claim rejections and interruptions to cash flow. McKesson has committed that there will be Medisoft upgrades that will accommodate the ANSI-5010 and ICD-10 requirements well in advance of the deadlines to allow adequate time for implementation and training. We will provide you with updated information as it becomes available.

### Meaningful Use Criteria for Electronic Medical Records

The Office of the National Coordinator (ONC) and the Center for Medicaid and Medicare Services (CMS) have not yet finalized the Meaningful Use rules for implementation of an EMR, but the proposed rule was made available early this year for a comment period. The final rule is expected to closely reflect the Stage 1 Meaningful Use criteria in the proposed rule. The major goals of the Stage 1 criteria are: electronically capture health information in a coded format; utilize that information to track key clinical conditions; communicate that information for care coordination purposes; and initiate the reporting of clinical quality measures and public health information. Contact us for a summary of the proposed criteria.

The ONC plans to further define and publish the objectives and measures for Stage 2 meaningful use requirements by the end of 2011 and for Stage 3 by the end of 2013.

We are committed to providing EMR solutions that will meet the Meaningful Use requirements necessary to receive the financial incentives in the ARRA legislation. McKesson will update MediSoft Clinical EMR as the rules are finalized and well before the reporting deadlines. We encourage you to continue moving forward with your EMR implementation plans because demand for EMR implementations will increase rapidly and we want to accommodate all of our clients. By implementing early you will avoid the last minute pressure and will have the benefit of the functionality of a proven EMR to streamline workflow in your practice, eliminate lost charts, and improve patient care and communication.

### Getting the Most from Your Revenue Cycle Management

For many practices, the billing process is a great challenge and a source of cost and frustration. It is particularly daunting for smaller practices where billing staff fill multiple roles within the office. To further complicate matters, the portion of the typical patient visit for which the patient is financially responsible is increasing as employers turn to higher deductibles and copayments to save premium dollars. It is more critical than ever to stay on top of the billing and collection process. If your practice is lucky enough to have a qualified full time medical biller on staff, be thankful. Many that don't have qualified billing staff have outsourced their billing to a medical billing



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## Revenue Management

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service so that they can focus time and effort on patient care instead of chasing down insurance companies and collecting delinquent patient accounts. We encounter practices every week that discover that their billing processes, whether in house or outsourced, are not adequately managed. Money is being lost every month due to rejections that are not followed up, missed timely filing deadlines, and lack of follow up on patient balances. Too many providers do not stay involved in the revenue cycle management process and fail to review aging and analysis reports that provide valuable information on the financial health of their practice.

Whether your billing is handled in house or you utilize a billing service, we have a few recommendations for ensuring that your revenue cycle management processes are effective.

1. Verify eligibility for EVERY new patient prior to the first visit and for existing patients upon change of insurance or every 3-6 months, even if there are no known changes. Many employer insurance contracts have renewal dates at various points through the calendar year and changes in contracts may affect benefits without patients being aware of them.
2. Ensure that all charges are entered on a daily basis. Charges should be entered no more than 48 hours from the time of service and ideally, within 24 hours. If you are using Office Hours for scheduling, you can use the Appointments with No Charges report to identify any missing charges for each date of service. (See page 5 for information on this report.)
3. Submit claims on a daily basis and resolve any clearinghouse rejections within 24 hours of notification. This will ensure that claims don't slip through timely filing deadlines, as claims that are rejected on the front end never make it to the insurance company's adjudication system and therefore do not meet the timely filing requirement.
4. Review both Insurance Aging and Patient Remainder Aging reports on a monthly basis to identify problem accounts and follow up immediately.
5. Review Analysis Reports to monitor trends in revenue, correct payment from insurance companies based on contracted amounts, and profitability of the practice based on the payer mix.

We can help you determine if your revenue cycle management process is adequately meeting the needs of your practice. And if it's not, our medical billing services can fix it for you, or we can provide personalized on-site training to help resolve any problems.