Accelerate your revenue with Practice Insight and MicroMD

Presented by: Dave Henshaw
Introduction to Practice insight!!

- Full Service EDI Clearinghouse
- EHNAC and Core Certified
- 62,000 providers in all 50 states including Puerto Rico
- Connections to 5300+ Payers
- A proud Micro MD Partner
- Integrated on the Micro MD platform
- We process Claims for all specialties

“Behind the Scenes, Ahead of the Curve!”
The life of revenue cycle!
How to maximize your reimbursement with eligibility manager

• Real time Eligibility check
• Ability to collect all Co-pays, Deductible’s, and Co-insurance while the patient is in your office
• Ability to reduce collections percentage on the back end
• Detailed 271 response

“User interface with your Micro MD PM will allow you to access your eligibility reports right from your PM”.
HAS THE PAYER EVER DENIED RECEIVING CLAIMS? OF COURSE THEY HAVE! AND WE HAVE THE SOLUTION!

CLAIM MANAGER

- Process and edit claims in real time
- Track complete history of the claim
- Proof claim was sent and received by the payer
- Access the payer claim status flies
How can you accelerate with Clinical Claim Scrubbing!!

Reduces Denials with Clinical claim scrubbing, with over 28+ edits and real time response!!

- Correct Coding Initiative (CCI)
- CPT, ICD, and Modifiers
- Dates
- Evaluation and Management
- Medical Necessity (LCD/NCD, Commercial, Proprietary)
- Units allowed
- Time filing
- Ability to scrub Institutional and professional claims
How can I sell more Clinical Claim Scrubbing and the PQRS Registry Solution?

June 29, 2016
Why use the PI PQRS Registry Solution?

- Easy Correction Wizard
- Task Manager – manage corrections
- Benefits to customers
  - Protects your revenue
  - Secured web based portal
  - Fully Integrated with PI
  - Great user interface allows monitoring throughout the year!
What the future holds for PQRS coming 2017 and beyond!

• PQRS is the precursor to MACRA
  • Merit-Based Incentive Payment System (MIPS)
  • MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

-4% -5% -7% -9%
+4% +5% +7% +9%

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

Merit-Based Incentive Payment System (MIPS)
PI and Alpha II will always be a source of support for PQRS and MACRA

- PI and Alpha II will be there to help you
  - Kick off call
  - Status Calls
- Training on tools
  - Task Manager
  - Easy correction wizard
  - Registry User Interface
- Reseller is armed to assist
- Resources
  - Newsletters
  - Webinars
  - Help and Support
What is Clinical Claim Scrubber

- Web-based claim scrubber
- Analyzes claims for errors before submission to clearinghouse or payer
- Over 20 million payer rules
- Speed: 20 to 40 claims per second (conservative – usually faster)
- **Integrated with Practice Insight**
- Edits attached to each individual claim for immediate reference and action
### Clinical Claim Scrubbing
**With CPT and ICD Descriptions Showing All Line Items**
**Job Number 41632917**

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Trace ID</th>
<th>Patient Account</th>
<th>Patient Name</th>
<th>Procedure</th>
<th>Destination Code</th>
<th>_bill Amount</th>
<th>Facility</th>
</tr>
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<tbody>
<tr>
<td>000644</td>
<td>125736209C2001</td>
<td>3265526474</td>
<td>CORRIS, THOMAS</td>
<td>TORRES N, CALLIE</td>
<td>Medicare</td>
<td>261022</td>
<td>MEDICARE F I</td>
</tr>
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</table>

**CVS001** - (1/2) The diagnosis code selected is questionable in support of this CPT/HCPCS code. An LCD policy for this CPT/HCPCS code does exist, but the diagnosis is not listed on the LCD policy. **Line Item Rejected**

**CVS001** - (1/2) The diagnosis code selected is questionable in support of this CPT/HCPCS code. An LCD policy for this CPT/HCPCS code does exist, but the diagnosis is not listed on the LCD policy. **Line Item Rejected**

<table>
<thead>
<tr>
<th>Seq</th>
<th>DOS From</th>
<th>DOS To</th>
<th>POS</th>
<th>CPT Code</th>
<th>Modifiers</th>
<th>Units</th>
<th>Diagnoses</th>
<th>billed</th>
<th>Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>02/11/2014</td>
<td>02/11/2014</td>
<td>22</td>
<td>11046</td>
<td>1</td>
<td>458.01</td>
<td>707.10</td>
<td>707.10</td>
<td>$250.00</td>
</tr>
<tr>
<td>02</td>
<td>02/11/2014</td>
<td>02/11/2014</td>
<td>22</td>
<td>11046</td>
<td>1</td>
<td>458.01</td>
<td>707.10</td>
<td>707.10</td>
<td>$250.00</td>
</tr>
<tr>
<td>03</td>
<td>02/11/2014</td>
<td>02/11/2014</td>
<td>22</td>
<td>11046</td>
<td>1</td>
<td>458.01</td>
<td>707.10</td>
<td>707.10</td>
<td>$250.00</td>
</tr>
</tbody>
</table>

**11042** DEBRIDEMENT, SUBCUTANEOUS TISSUE (EXCLUDES EPIDERMIS AND DERMIS, IF PERFORMED): FIRST 20 SQ CM OR LESS
**11045** DEBRIDEMENT, SUBCUTANEOUS TISSUE (EXCLUDES EPIDERMIS AND DERMIS, IF PERFORMED): EACH ADDITIONAL 20 SQ CM. OR PART THEREOF, LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE.

459.31 VENOUS HYPERKERATOSIS WITH ULCER
707.15 ULCER 707.19 ULCER OF OTHER PART OF LOWER LIMB
Content driven rules – sampling of edits

**CPT/HCPCS**
- Code Validity
- Max Units Allowed
- Questionable Services
- Conditionally Bilateral
- Individually Bilateral Inherently Bilateral
- Add-on w/o Parent
- Blood Services
- Blood Products
- Statutory Exclusions
- DME
- Unclassified Drugs
- Nuclear Med
- Partial Hospitalization
- Psychotherapy
- Lab Services
- Device Codes
- Bundling
- Prof/Tech Component
- Multi Proc Adjustment
- Gender Designation
- Supervision

**ICD-9 & ICD-10 Diagnosis**
- Age specific
- Laterality Mismatch
- Gender specific
- Onset of Injury / Illness
- Inclusionary / Exclusionary
- Mental Health
- Etiology /Manifestation Sequence
- Cosmetic
- Qualifier Validation

**Professional**
- Physician Services
- Ambulatory Surgical Center
- Lab
- Anesthesia
- Ambulance

**Modifiers**
- Bilateral services
- E/M
- Technical / Professional
- Separately Identifiable
- Multi Surgery
- Therapy
- Anesthesia
- Surgical Team
- Global Fee Period
- Ambulance Transport
- Reduced Services
- Repeat Procedure
- Multiple Procedure

**PQRS**
- Individual Measures
- Group Measures
- Claim Reportable
- Registry Reportable
- Qualifying Event ID

**Too Many to List**
- Provider ID validation
- Units (MUE)
- NCCI (Unbundling)
- Revenue Codes
- 837 Format validation
- And more,
- And more....

**Institutional**
- Medicare Code Editor
- Integrated Outpatient Code Editor

**Medical Necessity**
- Proprietary Clinical Defensibility
- Nat’l Coverage Determination
- Local Coverage Determination
- Commercial Policies
- Medicaid Policies

**Provider ID validation**

**Revenue Codes**

**837 Format validation**

**And more...**

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Adding to the Practice Insight value proposition

- Reduce the number denied claims

Follow that Claim

Typically, you will spend between $14 and $25 for each claim that you audit and appeal. You can now perform successful low-cost audit and appeal processes by taking advantage of the various HIPAA Transactions available, such as obtaining electronic eligibility and benefits (270/271) prior to the patient’s visit and obtaining claim status (276/277), authorization (278) and remittance (835). Utilizing these simple electronic features will reduce the administrative burden and cost within your practice.
Adding to the Practice Insight value proposition

• Even the most successful practices can improve their denial rate

MGMA Performance and Practices of Successful Medical Groups: 2014 Report Based on 2013 Data

Key Findings Summary Report

Key Findings

Better-performing practices report having 4.05% of claims denied on first submission.
Adding to the Practice Insight value proposition

- Reduce days in A/R

MGMA Performance and Practices of Successful Medical Groups: 2014 Report Based on 2013 Data

**Key Findings Summary Report**

<table>
<thead>
<tr>
<th>Percentage of Total A/R 120 or More Days</th>
<th>5.01%</th>
<th>11.42%</th>
<th>17.25%</th>
<th>16.75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Single Specialties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Single Specialties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multispecialty, All Practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Better-Performing Practices

Other Practices

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According to the 2007 NHXS study sample, the average physician billed for 374 services per month, and the average monthly underpayment rate was a total of $889 per physician. Using the typical research and correspondence methods employed by most physician practices, the cost to dispute a single underpaid service is $22 for the physician practice and equally as much or more for the health insurer. The economics of dispute resolution overwhelmingly favor first-time payment accuracy by the health insurer.
Additional benefits to current Practice Insight clients

• Alpha II will help create edits for clients
  • Unlimited number of edits
    o User defined custom edits
    o Medical necessity inclusions/exclusions
  • No additional charge
Return on Investment to current Practice Insight clients

- Return on investment (ROI) calculator

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>ALPHA II</strong></td>
<td><strong>ROI Calculator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients/Provider/Month</td>
<td>200</td>
<td></td>
<td>Average of 30 patients per day, 20 working days/month</td>
<td></td>
</tr>
<tr>
<td>Number of Providers</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Rejection Rate</td>
<td>4.05%</td>
<td>4.05%</td>
<td>4.05% Average Denial Rate; we assume a fraction of that is due to inaccurate demographics Source: MGMA, Performance and</td>
<td></td>
</tr>
<tr>
<td>Cost/Claim Resubmission</td>
<td>$ 14.00</td>
<td></td>
<td>According to the AMA, the average is between $14 and $25 per claim</td>
<td></td>
</tr>
<tr>
<td>Monthly loss</td>
<td>$ 100.00</td>
<td></td>
<td>Average provider monthly loss due to inaccurate coding. *According to the AMA, the average is $889 per provider per month (2007)</td>
<td></td>
</tr>
<tr>
<td>TOTAL ANNUAL SAVINGS</td>
<td>$ 2,560.80</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other resources available

• Prominent on the Practice Insight website
• Promotion piece on Clinical Claim Scrubbing available on the vendor portal
  • Can be private labeled to fit your needs
  • Custom promotions available upon request
• Webinars, demos, presentations at user group meetings
• Training as well as sales webinars available on vendor portal
Reduce your denial rate with ERA & Denial Manager

• Detailed ERA Files, with group reasons and remark codes
• Ability to sort data with various filters
• Eliminating lost EOBs
• Prioritize and assign denials and underpayments to team members
• Task Manager integration for work flow set up
Have unpaid claims that gone unnoticed?
Is time filing approaching?
Practice Insight has the solution!

Task manager has the ability to integrate with Eligibility, Claim manager and ERA &Denial Manager.

- Ability to create and track work flows
- Assign task to various employees
- Assign and sort in alphabetical order and/or dates
2017 Coming Attractions
New and Improved

Presented By:
Dave Henshaw—Director of National Accounts
AGENDA

- **Highlights of 2016 Releases**
  - PQRS- CMS Reductions Report
  - PQRS – One-Click reporting

- **2017 Coming Attractions**
  - ERA Manager Teaser Report (Vendor sales)
    - Stand-alone option also
  - NEW! Benefits Manager
    - Patient Cost Estimation
    - 278 Prior Auths
    - Eligibility

- **Question and Answer**
PQRS – CMS Reductions Report

- PQRS Reductions
- Meaningful Use Reductions
- EHR Reductions

HIGHLIGHTS OF 2016 RELEASES

### Demonstration Vendor
2016 Medicare PQRS Reductions
Analyzing Claims Issued 03/01/2016 to 03/31/2016

<table>
<thead>
<tr>
<th>Customer</th>
<th>March 2016</th>
<th>Full Year Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI</td>
<td>Total Paid</td>
<td>PQRS Reduction</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>CUSTOMER EIGHTEEN (21068)</td>
<td>$49,090.94</td>
<td>$2,307.12</td>
</tr>
<tr>
<td>54516092784</td>
<td>$37,608.99</td>
<td>$1,755.75</td>
</tr>
<tr>
<td>17808382380</td>
<td>$10,481.95</td>
<td>$511.37</td>
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<tr>
<td>CUSTOMER ELEVEN (10084)</td>
<td>$18,639.63</td>
<td>$1,314.72</td>
</tr>
<tr>
<td>14171711361</td>
<td>$18,639.63</td>
<td>$1,314.72</td>
</tr>
<tr>
<td>CUSTOMER TWO (6074)</td>
<td>$25,298.04</td>
<td>$704.09</td>
</tr>
<tr>
<td>31158910157</td>
<td>$14,245.00</td>
<td>$594.33</td>
</tr>
<tr>
<td>6922415686</td>
<td>$16,349.84</td>
<td>$103.21</td>
</tr>
<tr>
<td>9042689212</td>
<td>$583.05</td>
<td>$66.65</td>
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<tr>
<td>5144984285</td>
<td>$701.12</td>
<td>$12.82</td>
</tr>
<tr>
<td>CUSTOMER ONE (8005)</td>
<td>$17,295.40</td>
<td>$479.34</td>
</tr>
<tr>
<td>11048532342</td>
<td>$17,295.40</td>
<td>$479.34</td>
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<tr>
<td>CUSTOMER EIGHT (465)</td>
<td>$11,413.68</td>
<td>$222.56</td>
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<td>1457484991</td>
<td>$11,413.68</td>
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<tr>
<td>CUSTOMER SEVENTEEN (12506)</td>
<td>$8,081.57</td>
<td>$252.14</td>
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<tr>
<td>7008134569</td>
<td>$4,051.57</td>
<td>$252.14</td>
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<tr>
<td>CUSTOMER TWENTY TWO (526)</td>
<td>$9,255.66</td>
<td>$226.96</td>
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<tr>
<td>1093085897</td>
<td>$9,255.66</td>
<td>$226.96</td>
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<tr>
<td>CUSTOMER FOUR (5594)</td>
<td>$6,802.83</td>
<td>$231.22</td>
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<tr>
<td>1370589904</td>
<td>$6,802.83</td>
<td>$231.22</td>
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<tr>
<td>CUSTOMER THIRTEEN (333)</td>
<td>$950.01</td>
<td>$12.42</td>
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<tr>
<td>1124181005</td>
<td>$950.01</td>
<td>$12.42</td>
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<tr>
<td>CUSTOMER TWELVE (9893)</td>
<td>$6,320.65</td>
<td>$73.20</td>
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<td>1487999913</td>
<td>$6,320.65</td>
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<tr>
<td>CUSTOMER TWENTY ONE (6350)</td>
<td>$15,516.78</td>
<td>$1,330.58</td>
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<tr>
<td>1145453999</td>
<td>$15,516.78</td>
<td>$1,330.58</td>
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</table>

*EHR Reduction values shown are sums of all CARC 237 amounts with RARC of N790.

all CARC 237 amounts with RARC of N790 on 2016 reporting.
PQRS – One-Click Reporting
ERA Manager Teaser

- Runs for a selected customer for a month’s worth of data
- Shows them their revenue status
- Can only access via ERA Manager
- Can run any report (including header) as a stand alone in ERA Manager

2017 COMING ATTRACTIONS
Benefits Manager

- Includes Patient Cost Estimation,
- 278 Prior Authorization, and
- Eligibility (enhanced view!)

2017 COMING ATTRACTIONS
Brainstorming

How can we help you sell more?

• Clinical Claim Scrubbing?

• PQRS Registry Solution?
  • Claim Reduction Report

• ERA and Denial Manager?
  • ERA Teaser Report
Resources

• Promotional Pieces
• Webinars
• Vendor Portal
• Educational Sessions during User Group Meetings
• Demos
• Other needs
THANK YOU FOR YOUR TIME PLEASE VISIT US AT BOOTH #6 OR THE COMPUTER LEARNING LAB