MGMA MISSOURI

COMMUNIQUÉ

April 2024/May 2024

Reflections on the Gifts I was Given

The end of an era has come, and a new chapter has begun. I sadly had to say good-bye to the woman who was instrumental in building my career in healthcare management. My sweet mom passed away peacefully in her sleep on Palm Sunday March 24th. Her health and her memory were failing, and I did my best to take care of her in her final days, but she succumbed to heart failure.

Back in 2005, when I was just a young lad, I needed a summer job to make money for college, so my mom offered me a job at the clinic to file records and start the process of scanning paper charts into this new-fangled electronic health record system that the clinic decided to implement. I did odd jobs around the office and even some basic IT work because things were simpler back then. I worked summers, winters, and remotely from Kirksville until I graduated in 2008. When I graduated, the market was terrible, and I needed full-time work for health insurance because the ACA wasn't a thing yet so I couldn't piggy-back off my parents anymore. She and Dr. Budd offered me a full-time job being the "jack of all trades" learning many jobs in the office so I could cover for illness and vacations. Shortly after that, mom had one of her most serious strokes that took her out on medical leave for months. Dr. Budd asked if I would be the interim manager while she was out because I had knowledge of what she did and was a connection to her since we lived together too. Thus, my career as a manager began. I then went to school to get my MBA and began being mentored by mom to take over when she retired. I became a manager in 2013 and in 2020, when her health prevented her from working anymore, I took over as the head administrator. Even though she retired, she still asked me how things were going and would ask me to bring her in to visit sometimes. She moved in with me and my family in 2022 so that I could be her caretaker and she could see her grandkids every day.

Mom gave me the gifts of knowledge, work ethic, the love of practice management, and a successful practice that she put her heart and soul into building from the ground up. I have made some changes to her original design, but the roots and culture remain the same as what she worked hard to establish, and I cannot express how thankful I am for that. I get so many compliments on the atmosphere and the staff of my practice. I even have 5 people that have been working here since the practice started in 2001 and we all refer to each other as "the lifers". Even though she is gone, her influence on my life and on this practice will shine everyday as we continue to serve our patients and make them happy and healthy. That's all she wanted, was for everyone to be happy and healthy.

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Reflections on the Gifts I was Given

I will be glad to see everyone in Overland Park at our conference May 1-3. Please register if you have not done so and thank you if you have already registered. Help me remember my mom by sharing an afternoon cup of coffee (usually in the 2PM-3PM range) like she did every day. Hug your parents if you still have them; mine are together in heaven.

Love you momma mia and thank you for all you gave me.

Gregory Thompson, MBA
President, Missouri MGMA
greg@stlrheum.com

Poor documentation
during intake resulted in a

wrong-site surgery

causing permanent
damage to a good knee.

The Joint Commission data reveals that wrong-site incidents are the fourth most frequently reported sentinel event.

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* The Joint Commission, *Sentinel Event data released for 2022.* **Visit: bit.ly/43TXUGi.**

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Hi everyone! Spring is in the air! One of my favorite times of the year.

We are excited to remind you that our highly anticipated MO MGMA yearly statewide conference is just a mere four weeks away! On behalf of the board, we would like to extend our warmest invitation to you to join us for this prestigious event. The date again is May 1-3, 2024, at the Sheraton Overland Park Hotel. The conference promises to be a gathering of the brightest minds in the healthcare industry, offering a platform for sharing innovative ideas, networking with industry leaders, while interacting with some of the top vendors in the industry that will enhance your practice.

As a participant your presence is crucial in making this event a resounding success. Your contribution, expertise, and enthusiasm will undoubtedly enrich the overall experience for all attendees.

We encourage you to finalize your registration and make necessary travel arrangements to ensure your participation in this transformative event. Kindly visit our website https://mgma-mo.org for more information on the agenda, speakers, and registration details.

We look forward to welcoming you at the MO MGMA conference and embarking on a journey of knowledge sharing and professional growth together.

LET'S FIRE IT UP!

Laurie Atwood, President-Elect & Conference Chair
lauriejoatwood@gmail.com

MISSOURI MGMA ANNUAL CONFERENCE

May 1 - 3, 2024 ● Sheraton Overland Park

Wednesday, May 1st

11:00-5:00pm **Registration Open for Attendees and Business Partners**

1:00-4:00pm **Workshops**
LEAN Concepts: How They Affect Staffing – Stefanie Hohensee, MHA, FACMPE
Am I an 8? Using Enneagrams to Improve Communications – Cameron Cox, III, MHA, FACMPE
ACMPE Prep Course and Mock Exam – Tracy Bird, FACMPE, CPC & Beth Castens, MHA, FACMPE

4:15-5:30pm **Opening General Session: Finding the Masterpiece in the Mess** – Sam Glenn

5:30-6:30pm **Networking Reception**

Thursday, May 2nd

7:30-8:30am **Breakfast with Business Partners**
8:30-9:30am **General Session: What's Your Culture Club -** Cameron Cox, III, MHA, FACMPE
9:45-10:45am **Breakout Sessions**

Are you a LEADER or are you IN CHARGE – Cameron Cox, III, MHA, FACMPE
What's My Job, Really? Setting Clear Expectations for Your Docs – Stu Schaff
Firing Up Healthcare Excellence: Unleashing the Power of Benchmarking
Tracy Bird, FACMPE, CPC, CPMA, CEMC, CPC-I
10:45-11:30am **Networking Break with Business Partners**

11:30-12:30pm **Breakout Sessions**
Mobile Integrated Health – Doris Boeckman
Patient Experience Journey Mapping – Lisa Doran
Shark Negotiating for the Conflict Averse – Jason Levinson

12:30-1:30pm **Lunch with Business Partners**

1:45-2:45pm **Breakout Sessions**
Healthcare in the Age of AI—Thomas Douglas
Physician/APP Collaboration and Supervision – Debra Funk
Finding and Keeping Great Talent – Elizabeth Perlak, JD

2:45-3:30pm **Dessert Break with Business Partners**
3:30-4:30pm **General Session: The Healthcare Outlook**
Panel Discussion: David Argueta, Mercy; Max Buetow, CoxHealth; Brett Kolman, HCA Centerpoint; Jani Johnson, St. Luke's Hospital of Kansas City; Charlie Shields, University Health; Moderator: Kyle Adkins, Golden Valley Memorial Healthcare
5:00-8:00pm **BBQ Throwdown & Line Dancing**

Friday, May 3rd

7:45-8:30am **Breakfast with Business Partners**
8:30-9:30am **General Session: Your Secret Power – The Bean** – Lisa Duran
9:45-10:15am **Networking Break with Business Partners**
10:15-11:30am **Closing General Session:** Stay Alive All Your Life – Success Principles for Extraordinary Leadership & Living – Michael Ivanov

Missouri MGMA gratefully acknowledges the following companies for their sponsorship of our Annual Conference

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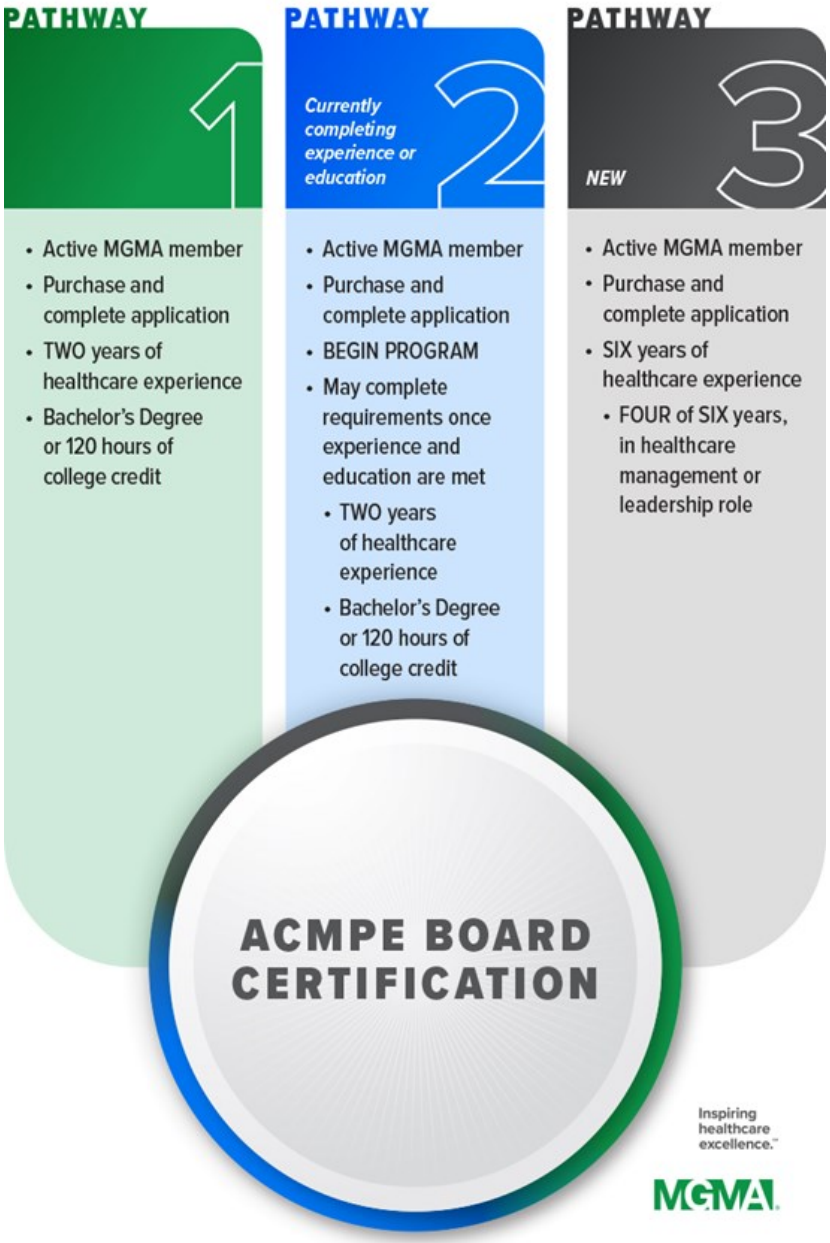
ACMPE Corner

Plan to attend the ACMPE Workshop at our 2024 Annual Conference, Wednesday, May 1st from 1-4pm. Tracy Bird, FACMPE will join Beth to present how you can succeed in your ACMPE pathway goals. The workshop will review CMPE/FACMPE eligibility criteria, timelines, fees, and preparation/best practice study tips for the CMPE exam.



2024 MO MGMA TREASURER'S REPORT

Bank Balances ending 03/031/2024

Checking	**$122,500.21**
Money Market	**$ 33,138.37**
Scholarship	**$ 2,753.90**
CD's	**$ 91,595.71**
TOTAL	**$249,988.19**

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MONTHLY MEMBER WEBINARS

APRIL WEBINAR

2024 TAX & TRANSACTIONAL TRENDS FOR HEALTHCARE LEADERS

Presented by:

TONY DAVIS, DIRECTOR, EISNERAMPER (MODERATOR)
ERICK CUTLER, PARTNER, EISNERAMPER
DAVID BRAUER, PARTNER, EISNERAMPER

17 APRIL 2024

1:00 PM EASTERN
12:00 PM CENTRAL
11:00 AM MOUNTAIN
10:00 AM PACIFIC

Eligible for 1.0 CE credit

April/May Legislative News

LEGISLATIVE UPDATES

I don't know about the rest of you, but I feel like this year is flying by. Spring has certainly sprung! I feel a sense of renewal and increased energy as the grass, trees, and flowers have begun to come alive. And for all you allergy sufferers, you are not alone. My allergies are also in full bloom .

National Policy Updates and News

Here are MGMA's most recent advocacy efforts:

- Mitigation impacts to the ransomware attack on Change Healthcare, particularly around revenue cycle disruptions and various electronic transmissions/submissions
  - ◊ Click here to visit UHG's dedicated response site with loads of valuable information related to pharmacy, claims, and payment impacts
  - ◊ Click here to review the fact sheet from CMS
- Continued support for telehealth reform, citing the CONNECT for Health Act (H.R. 4189) and the Medicare Telehealth Privacy Act (H.R. 6364) as two pieces of legislation that should be passed to expand access, protect providers, and improve coverage
- Concerns about the proposed rule, 88 FR 68006, allowing the FDA to regulate LDTs (laboratory developed tests) such as in vitro diagnostic products (IVDs)
  - Understand the desire to promote safety and effectiveness, but the legislation could also result in potential delays and volatility in tests making it difficult for practices to remain up to date with continued advances and clinical guidelines
  - Possible duplications of CLIA

Moving on to the CMS newsroom:

- CMS issued its final part one guidance on the Medicare Prescription Payment Plan (from Inflation Reduction Act)
- Temporarily extended SEP (special enrollment period) to assist people with coverage needs during Medicaid and CHIP renewals, helping them more easily transition to Marketplace
- Released the final rule fact sheet for Medicaid, CHIP, and BHP coverage
- Innovation Center is investing in person-centered primary care, providing a one-time payment advancement and a monthly payment to those enrolled in the ACO PC Flex Model
- CMS started a new value-based care strategy blog with intentions of publishing additional articles throughout 2024 – objectives include alignment, growth, and equity
- FY 25 Proposed Rules
  - ◊ Skilled Nursing Facility Payments
  - ◊ Hospice Payment Rates
  - ◊ Inpatient Psychiatric Facility Payments and IPF Quality Reporting
  - ◊ Inpatient Rehab Facility Payments

April/May Legislative News

LEGISLATIVE UPDATES

FY 24 budget increases appear to be underway for many healthcare related sectors. HHS looks to be getting a budget increase of about $955 million to $117.4 billion, the CDC with an increase of $4.5 million to $9.2 billion, and significate allocations for cancer, diabetes, mental health, and Alzheimer's disease research.

In related US news, The Real-Time Benefit Tool Implementation Act (HR 7512) passed which will help people with Medicare Part D coverage understand their potential out-of-pocket costs, as well as the Protecting America's Seniors' Access to Care Act (HR 2513) which prohibits the government from enforcing minimum staffing ratios in long-term care putting facilities at risk of closure.
MFH recently shared that the US House also passed five reauthorization bills for maternal mortality, pediatric research and cancer, oral care, primary care, and mental health coverage programs.

State Policy Updates and News

The Missouri Foundation for Health provides comprehensive news and does a great job of synthesizing state information too. It is where most of my information comes from… big thanks to MFH! If interested, subscribe to MFH's email updates using this form. You can also track and monitor specific bills here. Budget discussions continue and will likely pick up this month. The deadline for bill submission was on March 1st and about 2,600 bills were filed.

There are several bills of interest for this edition:

- House is still working on HB 2619 – a bill that impacts DEI initiatives and funding
- SB 748, a bill to reauthorize federal reimbursement allowance, is pending Senate floor action
- HB 2634 also awaits Senate floor action – affects Medicaid funding to Planned Parenthood
- Senate passed SJR 76 – enacts work mandates for people on Medicaid (of able-bodied)
- Two bills undergoing Senate hearings for prescription drug payments – SB 843 and SB 1105
- Senate bills looking to exempt sales tax on food include SB 1062 and SB 1252
- House bills also related to the topic of food include HB 2438 and HB 2730 – involve tax credits in food desert areas
- HB 2626 petitioning to expand Medicaid coverage to incorporate hearing devices
- SB 1212 – hospital price transparency law provisions
  SB 1260 – expansion of prenatal testing
- Two state bills regarding telehealth audio-only are HB 1421 and SB 931

Reach out with any questions or thoughts on future topics!

Ashley Sipes
MO MGMA Legislative Liaison
Ashley.sipes@ssmhealth.com

Welcome New Members

Active Members

Julie	Davis	Southern Missouri ENT & Allergy
Brandy	Miller	Sound Health Services
Mindy	Schneider	Spira Care
Tammy	Lett	St. Luke's Medical Group
Jim	Curran Jr	Gallagher
Alicia	Boyd	Verisma
Paul	Dow	Aledade, Inc.
Tammy	Elliott	KFMC Health Improvement Partners
Michael	Graham	DocCafe
Kala	Hutchinson	Anthem Blue Cross Blue Shield
Rhonda	Jackson	Reality Check Screening
Catelyn	Kimball	Nuance, a Microsoft Company
Ethan	Lund	Code Quick

Source: July 2024 MGMA Connection Magazine

Building denial prevention strategies to boost your practice's revenue cycle

By Felix Okhiria, MA, CMPE

Denial prevention involves proactive work to facilitate payment on first claim submission — a conscious effort to prevent denials and thereby avoid inefficiencies and rework.
The concept of denial prevention is different from denial management; the latter proposes that all efforts should be deployed to ensure payment at first submission, while the former proposes that denied claims be investigated, corrected and resubmitted to payers.

Revenue cycle processes

Revenue cycle management (RCM) is comprised of a combination of front-end and back-end processes to efficiently maximize reimbursements for services rendered. The rationale for assigning some front-end responsibilities — for accurately collecting relevant demographics and insurance information — is to facilitate efficient back-end processes of billing and collection.

Front-end processes

Front-end processes are the activities necessary to enable clinical encounters (e.g., appointment scheduling, insurance verification, prior authorization, appointment confirmation). The effectiveness of this operation has a direct correlation to the success or lack thereof of the subsequent billing and collection.

The verification process requires that providers validate insurance information presented by patients. Such information includes (but is not limited to): insurance coverage, effective date, expiration date, policy number, copayments, benefit periods etc. The validation of this information is necessary to avoid coverage denials.

Prior authorization determines the medical necessity of a proposed medical intervention. This function requires providers to obtain authorizations for specific medical services for specified period. Failure to secure the authorizations for such services will result in claim denials and loss of revenue. Most managed care payers require authorizations for a host of medical intervention, and it may not be too long before all payers, including governmental payers, require some proof of medical necessity for prescribed medical services.

Front-end revenue cycle functions may include appointment scheduling, appointment confirmation, check-in, insurance verification and prior authorization. It is dependent on staffing and task assignment.

Back-end processes

Back-end processes are the functions required to submit "clean" claims and receive payments in the shortest possible time. Medicare claims should be paid in about 14 days, Medicaid claims should be paid in about 21 days, and managed care claims should be paid in about 30 days. The back-end processes include but are not limited to ensuring that claims have the necessary information to ensure prompt payments. Information required for clean claims include demographic information, clinical information, insurance information, and authorizations when required. It is imperative that RCM staff adhere to payer guidelines and contracts to prevent denials. However, even when all the information required is provided, it is estimated that about 40% of claims are erroneously denied due to human errors and/or systemic failures. Since the RCM operation is responsible for billing and collection, we must evolve different solutions to mitigate against these denials.

Denial prevention strategies

The goal of denial prevention strategies is to make sure claims are promptly paid to eliminate the need to rework them. The following strategies help to prevent denials:

- Claims validation process
- Collaboration with payers to do the following:
  - ◊ **System test**: Sample claims testing for new/renegotiated contracts
  - ◊ Timely transfer of auth information into claims adjudicating system
- Positive and interactive relationships with payers.

Claim validation process

The claim validation process is the back-end equivalent to insurance verification. The process requires the revalidation of demographics and insurance information before claim submission. This process can and should be automated to "run" prior to claims submission. The addition of this automated functionality should eliminate all demographics and/or coverage denials, thereby strengthening the financial position of the organization.

Collaboration with payer

Collaboration between providers and payers to mitigate the inefficiencies of erroneous denials will result in timely and accurate reimbursements. There is the additional benefit of economy of scale by assigning staff to focus on other issues as opposed to reworking claims that were denied, which can also improve employee morale.

The following areas of potential collaboration with payers will go a long way in eliminating the incidence of preventable denials:

System integrity tests for new or renegotiated contracts

The implementation of new/renegotiated contracts may result in the following denials:

- Out-of-network denials
- Non-covered service denials
- Inconsistent billing code denials
- Underpayment

These denials are most likely due to a time lag from contract execution to system configuration of a new or renegotiated contract; the denials could also be due to human error. However, if the system is tested with a few sample claims to ascertain the accuracy of claims processing, potential erroneous denials can be identified and corrected thereby assuring a hitch-free payment for services. The denials that could be prevented by claims testing include:

- **Out-of-network denials**: Claims submitted after the execution of a contract but prior to payer system configuration. Such claims may be denied as out of network.
- **Non-covered service denials**: This may be due to a delay in loading the new contract into the claims adjudicating system.
- **Inconsistent billing code denials**: These denials may be due to a coder adding an erroneous code, not checking Correct Coding Initiative (CCI) edit, not updating claim scrubbers, or not loading payer billing codes upon completed negotiation..
- **Underpayment**: This usually occurs when there is a delay in loading enhanced rates into the system. Claims submitted prior to loading of the new rates will be paid at the existing rate thereby resulting in underpayment.

The denials enumerated above can be prevented with system integrity tests, thereby preventing unnecessary denials and potential loss of revenue.

Timely transfer of authorization codes into the claims system

One of the most common and frustrating erroneous denial is the “no authorization” denial. These denials can be grouped as follows:

- No auth denial when the service is authorized
- No auth denial when the contract does not require authorization
- No auth denial for the scope of service when the service is in scope
- Auth date range denial when additional services has been authorized.

A collaborative relationship between the provider and the payer can eliminate these erroneous denials, thereby eliminating the need for rework.

Positive and interactive relationships with payers

Developing and maintaining a healthy relationship with payers is priceless. It can be the difference between unmanageable A/R and a consistent cashflow. As has been discussed in the preceding section, claims denial — either legitimate or erroneous — is an unmistakable fact of provider and payer relationship. It is thus incumbent on RCM staff to mitigate the occurrence of erroneous denials by leveraging all available avenues to get the job done. One such avenue is the relationship that can and should be fostered by both entities. Sometimes, the development and maintenance of such relationship is the function of the contracting team, but fostering a collegial and respectful interpersonal relationship is the job of everyone. In an atmosphere of a good working relationship, some of the denials discussed above can be resolved with one phone call.

It is the expectation of this author that the strategies described above can create an enabling environment for a thriving revenue cycle operations with a motivated staff and a consistent cashflow.