

Americans use the Internet to manage their health. Why are MOST Dr's slow to use available Tech Tools?

While 51% of patients are willing to pay for e-health record services if reasonably priced, only 11% of the doctors surveyed say they use electronic patient records.

There's a gap between how American patients want to use the Internet for health care and how doctors are actually using it in their practices, according to findings of several new surveys.

Americans are using the Internet to manage their health care, and they also want their doctors to use online tools to improve care services. However, most physicians aren't using those IT tools, according to the surveys. One in three Americans say the Internet is changing the way they manage their health care, says a new survey of 4,105 adults that was commissioned by Cisco Systems and conducted recently by research company Illuminas.

The Cisco survey found that 62% Americans have used online health tools. The top five reasons cited for using the Internet for health-related reasons were to access information about symptoms and diagnoses, access general wellness and fitness information, attempt to self-diagnose, manage prescriptions, and self-assess health.

And while 45% of those surveyed say they'd like to directly e-mail their doctors, only 11% report their doctors are accessible electronically. Thirty-four percent of Americans say they'd like to access lab tests via a secure Web site, but only 7% say they have that option from their health care providers. And while 33% say they'd like to schedule health care appointments electronically, only 9% say online scheduling is available to them.

Still, while many consumers say they use online health tools, they also admit there are "hurdles" -- especially concerns about data [privacy](#) and security -- that prevent them from using personal technology more to manage their health, according to the Cisco study. Thirty-nine percent say they're concerned about their private health information being released unnecessarily, while 38% fear identity information will be stolen or abused. Nearly one in four fear that their private health information will be used to discriminate against them. The top e-health record benefits cited by consumers are the ability to ask their doctors more informed questions, the ability to confirm information provided by the doctor, easier access to medical information, and getting a better understanding of treatment options.

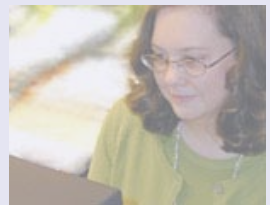
From the doctors' perspective, top benefits of e-health records are easier sharing and obtaining of information, access to more comprehensive patient information, fewer lost records, improved efficiency in patient billing, and reduced clinical errors. The initial investment and ongoing costs associated with health IT are the most common barriers that hospitals and doctor practices cite in deploying e-health records and other electronic clinical tools. For doctor offices especially, a lack of trained staff to support the systems is also a big challenge, as well as the time needed for busy practices to adapt to changes in processes and [workflow](#) that technology brings.

—Information Week



■ *“Americans are using the internet to manage their healthcare...”*

■ *“..45% of those surveyed say they'd like to directly e-mail their doctors...”*



Individual Highlights:

- P. 1** Internet: Its use in healthcare **P. 3** Improving Cash Flow **P. 4** We are...
P. 2 Medicare: Important initiative **P. 3** HIPAA compliance: at-a-glance

Medicare: Important initiative...



- ***“The awarding of the Coordination of Benefits contract provides many benefits for employers, providers suppliers...”***

“Questions concerning how to bill for payment should continue to be directed to your local carrier.”

The Centers for Medicare & Medicaid Services (CMS) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. To consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries, CMS awarded the Coordination of Benefits (COB) contract.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the COB Contractor. This is no longer the function of your local Medicare intermediary or carrier.

Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor provides customer service to all callers from any source, including but not necessarily limited to, beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB Contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses first before Medicare.

The table on the Medicare web site (listed below) describes a few of these methods and programs.

Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing is not a function of the COB Contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor.

Questions regarding Medicare claim or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

For additional information, please visit the web at;

<http://www.cms.hhs.gov/ProviderServices>

-US Department of Health & Human Svc.

Improving Cash Flow: start with denials & missing information...

It might seem impossible that a patient would undergo hip-replacement surgery without anesthesia, but it's been known to happen. Likewise, there have been cases of surgery to implant a pacemaker without the actual pacemaker. Or at least that's the impression you might have upon noticing such items glaringly missing on the bills sent by the healthcare provider!

The situation is almost humorous, if it were not so serious. Doctors across the country lose millions of dollars every year due to mismanagement of the billing process. The reasons range from inaccurate charging, such as undercharging for a service or procedure or missing a charge altogether, to sending out claims that are for various reasons deemed inaccurate by the insurance carrier and therefore denied.

These service and item omissions and claims denials generally stem from an unhealthy mixture of unwieldy process, improperly trained employees, and inadequate technology. Fixing the problem, therefore, means determining the underlying causes and then directing resources toward those areas.

Whether the solution involves instituting new procedures and technology, or outsourcing the billing altogether, the benefit should be obvious.

HIPAA check: at-a-glance...

Do you, or a third party billing company or clearing house, conduct any one of the following business transactions electronically?

- Claims or equivalent encounter information?
- Payment and remittance advise?
- Claim status inquiry / response?
- Eligibility inquiry / response?
- Referral authorization inquiry / response?

YES: If you answered yes, you are most likely covered by HIPAA.

NO: If you answered no, you are most likely NOT covered by HIPAA.

It is up to you, as the healthcare

Accurate charge capture and claims denial management processes mean not only improving cash flow, but also protects revenue that the provider is entitled to – and that adds up to a healthier bottom line.

No matter the size of the organization, billing inconsistencies affect all healthcare facilities to some degree – even those that are on top of the problem.

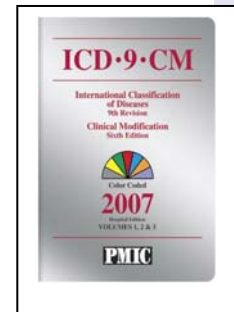
On average, providers lose 5 percent of gross revenues, and that can translate into millions of dollars for a single organization – yes, even the smaller practices over time.

With reams of regulatory rules, disparate software systems, and frequently high employee turnover, opportunities for mistakes to occur in the billing process are many.

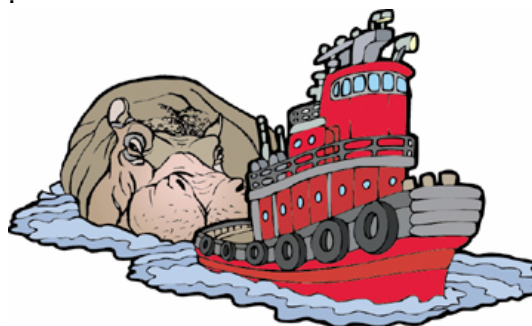
At the worst point in the health system's billing problems, the actual denied claims were measured in yards and feet and inches, depending on the size of the practice.

If you are hesitant in getting help from an outsourced solution on a full time basis, reach out for help on a project to project basis. A good Medical Billing Company should leap at the opportunity.

-HFMA, Mar. '07



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The **ONLY** medical billing company capable of:

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- ✓ **Implementing a strategy for continuous personal attention**

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- Nortel and Cisco Certified

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- Via partner company, Direct Health Access, LLC (I.C.E.)

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EMR (Electronic Medical Records)

Collection Services

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