



# Using MBA's eAccess with EMR Systems

by Pete Meyer, BSCpE, MSCpE, President  
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WHITE PAPER

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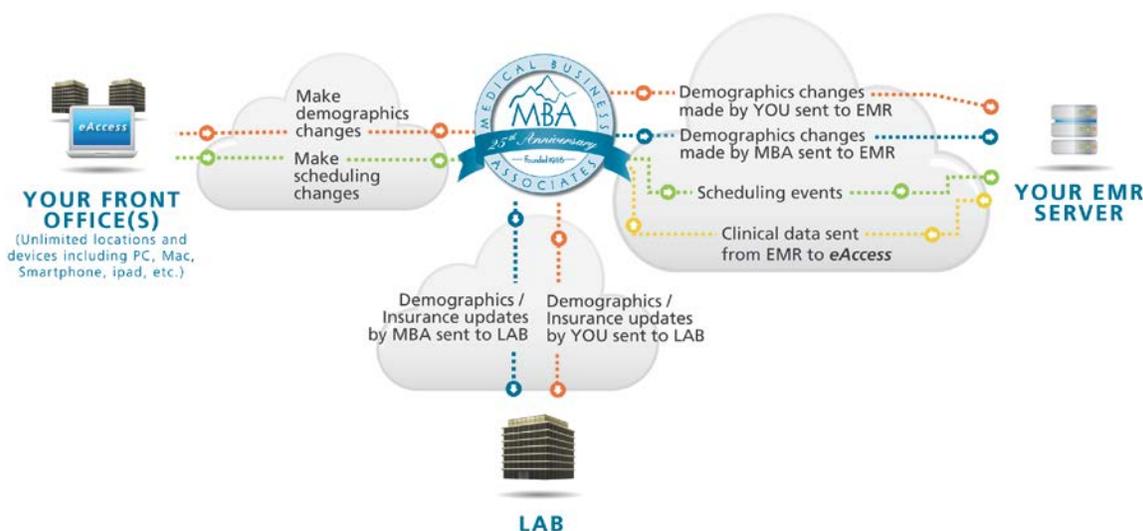
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## Executive Summary

When your front office staff uses MBA's eAccess system to perform everyday functions like scheduling, patient entry, scanning insurance cards and posting co-pays; and your back-office staff uses your EMR for clinical data, it will result in the highest revenue potential for your practice. MBA's eAccess system supplies your EMR with demographic data and your EMR supplies eAccess with clinical data needed to bill the encounter. Both MBA and your staff can access insurance cards, update demographic information, and have accurate financial records.

## Introduction



Electronic Medical Record (EMR) systems are becoming more the “norm” as opposed to the “exception.” With the passing of the bill in Congress allowing for incentive payments for “Meaningful Use” of the EMR and to eventually penalizing physicians for not using an EMR, the landscape for medical practices is changing.

If you are not currently using an EMR, you are probably overwhelmed at the process of buying one and have no doubt heard conflicting feedback. You may have heard horror stories from a neighboring practice about the vendor they chose, but heard rave reviews from another practice about the same vendor. The truth is, large computer systems and software are complex...very complex. Unless you are

technically adept, this complexity can be crippling since making the wrong decision can seriously affect your bottom line if not downright drown you financially.

In this white paper, I hope to show you how we see the market at this time and how we've positioned ourselves in this ever changing scene. I emphasize that this is how I see this world...you are free to agree or disagree...that's the beauty of America!

## **What should an EMR do, exactly?**

As EMR systems have become more and more popular, companies have sprung to life across the country competing for a piece of this government-induced buying frenzy. Some estimates show there are over 400 vendors competing for your business in the EMR segment alone. Most of these vendors are highly leveraged with venture capital money and/or debt from banks. You can bet this will cause some changes in their software down the road as these loans come due! Having "grown-up" in this business, it is very similar to the explosion of Practice Management systems that came up in the early 90's. Companies were springing to life left and right trying to get in on the "computer wave." The beauty of the free market and capitalism eliminated a lot of those, and a few of the strong businesses survived.

We are now in the EMR era and most of the "strong" practice management (PM) systems were pretty good at writing software to manage a practice, scheduling and posting payments, but medical records and the wide variability they take on is a different animal entirely. Conversely, companies that started out writing EMR systems 10-15 years ago found that writing a good PM system was totally foreign. So, what to do? Acquisition! Most of the larger PM software vendors started acquiring EMR software systems and tried to "glue" the two software systems together "under the covers" so it appeared to be a complete system. Of course, some EMR companies also bought up some PM systems and did the same thing. They got their marketing department together and did a wonderful job of selling these "all-in-one" systems to the medical community. Most providers found these systems to be buggy and inconsistent since they were really different products marketed under the same name. Word started spreading that "interfaces" just don't work and are buggy and, and, and....

So, what's the solution? The bottom line is that software designed to effectively handle billing and practice management type functions is a different world entirely than software that excels at medical record documentation (EMR). As a software developer myself, I can attest to this first hand. So, generally speaking, companies that make outstanding EMR software usually don't do well with the PM function. Likewise, companies that produce pretty good PM systems generally don't make great EMR software. The two are just different worlds that must come together in your practice. If you think about it, the PM functions are usually handled by the front office and business managers, whereas the clinical software is primarily used by the medical provider...do you think doctors think differently than business managers? You bet they do! So what works great for the business person will likely be frustrating for the physician and vice versa.

That's why we believe you should choose the "Best of Breed" model. By choosing MBA for your billing needs, you've already made a huge step in the right direction for "Best of Breed". We are really, really good at what we do. There are a handful of EMR software vendors out there that focus solely and completely on EMR (and they are really, really good at what they do, too). They recognize the different mindset of the medical provider and the business office and have chosen to focus on the medical provider. The EMR system should do just that...assist the provider with a semi-structured platform for them to document the encounter and manage medications, vitals, etc. It should perform this task flawlessly and be able to adapt to your preferred method of practicing medicine. There are external interfaces that need to be hooked up such as lab interfaces or medical equipment interfaces. In and of itself, it is a very complex piece of software. That is what an EMR should do... store patient's Electronic Medical Records, and manage everything related to the patient from a clinical perspective.

## What an EMR shouldn't do

An EMR doesn't need to handle all the complexities of insurance policies or any financial matters. I once heard an EMR vendor say, "There isn't a dollar sign anywhere in our software!" I couldn't agree more...there shouldn't be! As I said above, the EMR should be handling the clinical end of the visit with the patient. It doesn't need to deal with insurance cards, guarantors, and current balances.

To realize the full revenue potential for your practice, you must start with accurate demographic information from the patient. This includes correct name spellings, dates of birth, *valid* address, phone numbers, and Social Security numbers, etc. This forms the foundation of a correctly billed encounter.

Next in importance are insurance cards...capturing the actual image of the card. Important details are tucked away in very, very small print on the backs of these cards. Some insurance carriers go out of their way to make the card difficult to read and to try to trick the unknowing user into entering incorrect data. Entering the insurance information may seem very simplistic, but you would be amazed at how difficult it can be and how the slightest mistake can make the difference between getting paid and getting denied. Having a printout from an EMR after someone else has keyed in the data is highly prone to error because we are now relying on that individual's interpretation of the card. The EMR system may not have fields to capture every piece of data, so the person entering that data may occasionally make a mistake or unknowingly omit important information. The more "hands" the data has to go through before being entered in our system, the greater the chances are that a mistake will be made. In order for a claim to get paid, it must get to the payer correctly. Most assuredly, the way we at MBA map out the path for each payer is going to be different than how your EMR vendor did it. Inevitably, occasional mistakes will be made when entering this information, as that is human. When that happens, we need to be able to look back at the source document to see where the error has occurred. That is why it is *crucial* for our mutual success in billing to have quick access to the latest images of the insurance cards.

Finally, collection of the patient's financial obligation for the current visit and any prior balance is needed for any practice to achieve its revenue potential. Patient responsibility makes up approximately 15-20% of what you are due, so if you are not diligent about collecting this, you are missing out on a significant portion of your revenue. If the staff member checking the patient in or out at the front does not know how much the patient owes from past visits, and strong accounting controls are not in place, I guarantee you will not reach your potential in revenue. Patients are savvy; they will learn which medical practices they visit "are on top of things," and which ones don't have a clue what's going on. Believe me, they will gravitate to the ones that don't have a clue (and will tell all their friends, too)! To be successful, you must enforce collection of the patient portion and ensure that when it is collected it is properly credited to the patient's account and deposited into the practice's bank account. Accounting controls are not a luxury item. Every practice I come in contact with that has had the misfortune of being embezzled has always said they "...trusted so-in-so was doing their job and never thought they could do such a thing."

To accurately bill your encounter with the patient to their insurance company, and in turn correctly bill the patient, all of the above pieces must be present and be perfect in the billing system, i.e. MBA's

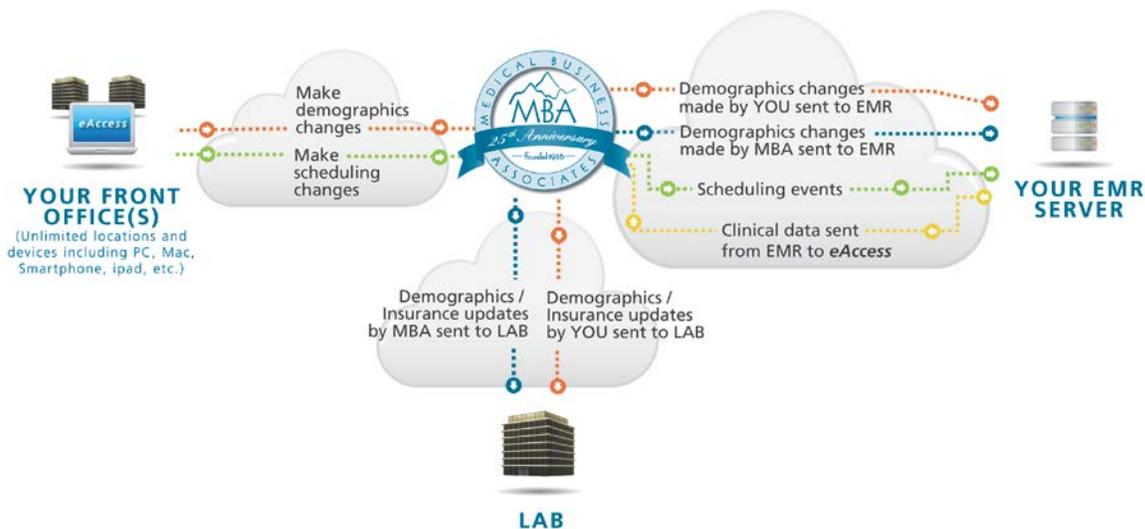
system. You can have the most beautiful and elegant EMR with everything scanned in nice and neat, but it won't help you get paid the first dollar if it doesn't match what we have in our system. Checking the patient's insurance card against the scanned copy in your EMR to verify you have the latest copy doesn't matter in the least if what MBA has in our system is different. The address, guarantor, DOB, SSN, insurance, co-pays, prior balance, etc... are all pieces of information that are critical to ensuring that you get paid for the work you do. To make that happen, we need to have correct information in our billing system.

Scheduling is another area that blurs the line between EMR and PM. What side of the fence should it be on? The EMR side or the PM side? For the sake of pure scheduling, i.e. knowing when a patient is coming and who the patient is scheduled to see, it really doesn't matter. Appointments are appointments....or are they? Equally important to seeing and treating your patient is making sure you are paid for the work you did. How do you get paid for the visit? Well, while it may seem simplistic, we need to get it into our billing system. I can assure you we will pursue that claim to the end if it is in our system, but if it never gets there, there is no way for us to know we didn't get something. That is why we developed our scheduling product...with the goal of having an automatic electronic cross-checking process to ensure that if the patient checked in, the encounter was billed. Each month, we capture thousands of dollars of encounters that would have never made it to us for one reason or another simply by having the schedule of patients and electronic cross-checking. In addition to cross-checking, by knowing ahead of time a patient is coming in, we can put alerts in that your staff sees when checking in a patient to bring something to their attention. We will soon be offering automatic eligibility to alert your staff if the insurance we have on file is no longer valid. This can save your staff hours of time by not having to verifying insurance benefits.

## So how does it work again?

For everything to work together, you need a good EMR system that you like, works like you think it should and assists you in documenting the medical record and storing it for later use, i.e. clinical data. The EMR needs a very small subset of data to do this...the patient's name, DOB, sex and possibly insurance information if the provider uses this for making decisions on testing. That's about it for what the EMR needs to do its job. The rest of the data should be entered directly into the MBA eAccess system...scheduling, patient name, guarantor, guarantor SSN, guarantor DOB, address, phone numbers, email addresses, scanned insurance cards, and co-pays received. Having this information entered directly into our eAccess system allows you and your staff to securely access this information at any time, from anywhere in the world, while also allowing our staff to take full advantage of available data to validate rejected claims.

MBA has developed the ability to send notifications to your EMR when patient information is updated/added or scheduling events occur such as appointment check-in/check-out. This allows your business/clerical staff to use the eAccess system exclusively and still keep the EMR system up to date with demographics. Graphically, here's what happens:



# Questions and Answers

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## *I don't have an EMR...do I really have to buy one if I don't want one?*

No, you don't. At least not as of this writing. I do not think EMR systems will benefit every doctor in every situation. As new doctors enter the market, they are more likely to want an EMR starting out since that's what they trained on in residency. They are usually fairly proficient with computers and will probably do well with an EMR. Physicians who have been in practice in the "paper" world may not even have a computer in their office and are totally and completely computer illiterate. It would be a huge mistake for that type of physician to buy an EMR because he/she felt they "had" to do this. Remember, this is a computer that you are placing your entire medical documentation in. Everything! If your EMR crashes and takes the data with it, you are highly exposed from a risk standpoint with audits and malpractice because you can't produce any documentation about the patient encounters. Paper charts don't crash, but they're not without problems either. EMR systems don't lose charts due to a filing error. You will lose out on any possibility of government incentives for using an EMR which could add up to about \$40k, and you will start being penalized in the coming years for not using an EMR. **For some physicians, the loss in productivity from using an EMR is far greater than the penalty imposed by the government for NOT using one.** Only you can make that decision.

## *I don't have an EMR or I don't code in my EMR, can I still use the eAccess system?*

Absolutely! We built the eAccess system to be flexible in terms of how we get the data. Your staff can use the scheduler, check patients in/out, update their demographics, insurance info, scan insurance cards, etc. When the encounter is over, they can enter the diagnosis and CPT codes, co-pays and schedule a return visit. The data needed to bill the encounter is now complete and there is nothing you need to send to MBA.

## *I don't have an EMR, but I'm considering buying one. Where do I start?*

By choosing Medical Business Associates (MBA) for your billing needs, you've already eliminated about 2/3 of the decision-making headaches when it comes to EMR systems. This is because you don't need to worry about the practice management and scheduling components of the system and can focus solely on what you should be focused on, which is the medical charting component. This is your area of expertise. You need to be aware of the fact that, despite what the politicians say on camera, there is no standard for exchanging data between EMR systems. Every vendor stores the data the way they want to, and no two vendors do it the same way. So, whatever EMR system you pick, you're going to be stuck with that one for a while (or start over). Just ask the prospective EMR vendor how you would get your existing EMR charts into their system. The answer is always the same..."Print them out of your old system and scan them into our system." Well, yes, you will have the "chart" in your computer, but that's really no better than scanning in a paper chart. Why do they do it this way? Because there are no standards for that data to be exchanged in a structured format. Also keep in mind that, if you are chasing government incentive dollars, you're going to need to report data to the government in a

structured format that your EMR will most likely do. All EMR vendors assume that, once you buy their system, you will of course fall in love with it and use it until you retire. In other words, they assume that data will always be put into their system and you will use that system for all the years the government incentive programs are in effect. But what if you don't? What if you grow to hate your decision and jump ship a couple years from now to another EMR software package? When it comes time to "check in with big brother", the new EMR software can't export data it doesn't have, so you won't be able to push a button on your new EMR system and produce all the legacy data...you'll have to run this from multiple EMR systems and manually aggregate it. This can be a complicated and time-consuming process. In addition, all those nice charts that the EMR vendor demonstrated, such as how you can graph Glucose levels and BP levels over the course of multiple visits...once you change EMR vendors, you lose that ability and effectively "start over" with graphically displayed data. So, your decision on which EMR vendor to partner with is not one to take lightly!

### *Okay, but really, where do I start?*

Baby Steps! Think of your decision about buying an EMR just as you might think about your son or daughter buying his or her first car at the grand-ole wise, mature age of 16. They may think they know everything there is to know about driving, but you know differently, don't you? How do you know? You've been driving a while...you know what you like and dislike. You know what brands of cars are "you" and which ones are not. You know what questions to ask the salesman at the dealership about the next car you're buying. You probably notice that your friends like something different than you do. So, do you start by visiting the BMW dealer and looking at the latest X5 with a big turbo charged V8? If that's what you do, that's fine, but you and I are very different. I would start out with an inexpensive, reliable used car...one that would get my child safely from point A to point B. They need to start small, learn the ropes, and then move up to bigger and better. So it goes with EMR systems. If this is your first EMR, I do not advise you to go out and buy the biggest, fanciest, most expensive EMR available because you don't know what questions to ask yet. You're not "EMR mature" yet. You're the 16 year old buying your first car. You don't know if the software engineers that wrote the EMR think and practice medicine they way you do. Your friend down the street may absolutely love his/her EMR and thinks you should buy it, too. That's like saying that your friend loves their car, so you must love it to. You may hate the kind of car they drive...likewise, you may hate the EMR your friend has. Start small and inexpensively. Learn. Ask questions. After a while, you'll begin to see what works and doesn't work for you. At that point, it may be time to upgrade.

### *Do you know of any financing companies to help with my EMR expense? Once I get the government incentive money, I can easily pay it back.*

When I hear this question asked of me, I literally get chills running down my spine. My first rule of EMR systems is to only buy what you can pay cash for today (actually if you get to know me, that is my rule for every purchase, big or small). If you're willing to bet your practice on a government promise, well, you're more of a gambler than me! Debt=Risk. Period. It's a very simple equation, yet many practices go under because they do not understand this. You probably think it would be silly to take out a second mortgage on your home because I have a hot stock tip and to use your house equity to buy into this

because I think the payout is going to be huge. Sure, there is a chance you will come out ahead, but there is also a chance you'll lose the roof over your head. You assume risk when you go into debt. My advice, don't go into debt, especially on software, especially on EMR software. If you can't afford to buy an EMR system and really want the incentive dollars, there are "free" ad based EMR systems that will qualify you for the incentives.

### *Should I choose in-house server, hosted server, internet based or web-based solution?*

First, some of you may not understand the question. If you do, great, skip this paragraph. There are many technical variations of the four options above, but to avoid this whitepaper from becoming a novel, I have narrowed it down to these four categories. A *server based* solution means you purchase a server and put it in your building, and run it on your local network. You are then responsible for the integrity of that machine, its data and its security. If it goes down, you are responsible. A *hosted server* solution moves that server off site to a company that specializes in keeping servers up and running. These are staffed by experts in the technology field. These facilities usually have redundant power, climate control systems and many levels of security. They handle the daily backups and if your server goes down, they can usually have another one online with a matter of hours. *Internet based* solutions install the client software on your workstations, but access the data across the internet. The developers are not limited to web-based user interfaces which can be cumbersome. The program is running on your PC/Mac, so the developers are not constrained to web-based development, which is not efficient for mass data entry. A *web based* solution is just like you would use with your on-line banking. It runs completely from the web browser where the user interface and data both come across the internet. The user interfaces are usually "difficult" due to the limitations of web development, and you will usually find that these applications are not as fast as the previous three options above.

Now that you understand the question, with all of the options above, you are also going to be buying workstations and maintaining those computers, also known as "client workstations." If they fail (and they will), you will still need to get them running again, but since data is not stored on them, they are not "business critical." In other words, workstations are needed regardless of what method you choose.

So which method should you choose? The answer to the question depends on the size of your practice and the type of technical staff you have. If you are a large practice that has dedicated technical staff, then I would say without a doubt go with server based. The machine is on your local network and you are not dependent on the internet being up or external issues. Your workstations have fast access to the server and generally perform better than hosted solutions. Also, hosted solutions generally become the more expensive option when you have a large number of users as they are usually priced on a per user basis.

If you are like most practices and don't have the resources to have a dedicated technical staff, then I would recommend one of the other options. Hosting your server by a hosting company that isn't familiar with your EMR software is still going to put you in the middle when things go south. You need a hosting company that is intimately familiar with your EMR software. Many EMR software companies offer this for their clients as an option. Hosting fees are not cheap, but neither is the risk of losing all

your medical records. Think of it just like buying an insurance policy. It's part of the cost of doing business.

Internet based solutions are probably the "sweet spot" in my mind, with web based being next, as you do not have to own/operate the server. The EMR database is hosted by the EMR company. They know their product and all the intricacies that go with it. They are responsible for servers, backups, etc. You do not have to worry about the technical side of running the EMR. You will need a good, solid internet connection, so make sure you test your site first before going down this path.

### *How much is this going to cost me?*

Like anything that is complex...more than you think. As I said above, you are going to need a workstation for each "station" in your office. Good workstations run about \$1,200-\$1,500. You'll need at least a Windows 7 Pro level operation system. Do not try to get by with a home version, as you will run into problems at some point. Depending on the option you choose above will determine if you are buying a server or paying a monthly fee to access the EMR vendor's servers. If you opt to buy a good server, you're probably going to be spending \$5k-\$6k. Software prices range from totally free, ad-based EMR systems that are web-based to systems costing upwards of \$25k for solo practices (and that's JUST the software). Your initial purchase usually includes the first year of maintenance, but after that, be prepared for fees that run about 15-25% of your initial investment (again, just for software).

### *I love my EMR. It has everything...a scheduler and the ability to scan cards into my EMR. Can't I just export my data to you instead of using your eAccess software?*

Of course you can! We do not require you to use our software. However, if you choose to keep doing things the way you are, **I can guarantee you will not achieve your full revenue potential.** Think about it this way...data should be entered into the system for which it was designed. In other words, enter your clinical data into your EMR, enter the patient and insurance data into MBA's eAccess system. Software vendors generally assume that data will be coming in via their designed user interfaces which enforce certain rules and prevent certain types of data from being entered. If that data is being imported from another system, that level of error prevention cannot be done since the data is already in the database. At MBA, we have spent years and years developing and honing our system to prevent errors. We cannot prevent the error if it has already been made in another system. Let me give you a couple of simple illustrations. Go into your EMR, select any patient with insurance and go to their policy data. Somewhere on that screen, you will see a 'Relationship to Insured'. If it is currently "Self," change it to "Spouse" and save it. I can almost guarantee you that it saved just fine...but you just created a major billing error! If you attempted the same thing on our system, you would receive a warning about the subscriber name and patient name not matching your relationship selection. Sounds simple, but it is the difference between getting paid and getting a denial (or worse yet, paying on the wrong patient). Be sure to change this patient back to the way it was!

Continuing with this same line of changes, find a Medicare patient and go to the subscriber number. Put an 'A' as the first character and save it. Surprise! It probably saved just fine, but again, that's an automatic denial (a Medicare number that starts with an A is a Railroad Medicare number, which means

you are filing to the wrong Medicare). If you opened that same patient in our system and tried that, you would not be permitted to make that change because we have built-in logic that that does not allow invalid subscriber number formats for all major insurance carriers. If that really was the number, then you'd select the correct Railroad Medicare and viola! It would now take the 'A' at the beginning and not at the end. Does your EMR system prevent your staff from making that same mistake? Now, given that your EMR didn't give you an error and you exported that data to us...we would be stuck with bad information and an automatic rejection. So what to do...if we had the insurance card scanned, we could go back and look at that and make any corrections...oh, wait, that won't work...you wanted the cards stored in your EMR which we're not in! So, now change the number back to what it was and transpose one of the numbers and save it. Again, it probably saved just fine. It would do the same on our system, too! Humans still have to get the numbers right!

*I have an EMR with a scheduler and all my patient demographics entered and cards scanned into it. Can't you just pull what you need and enter it into your system?*

As a general rule, we do not want access to your EMR. We have several reasons for this:

1. We do not want the liability of possibly/accidentally changing, adding or deleting your data.
2. Our contracts specify that you must provide, or cause others to provide (hospitals, nursing homes, etc) us with the necessary information to create a bill for insurance.
3. Because of the above reason, we have built our pricing models around that assumption. If we were to have to pull data, it is extremely time consuming due to the fact that we must pull up every patient and review their demographics and/or insurance cards to see if there is a change. If there were no changes and we had to pull up and review 20 accounts, you can see this is a big waste of time.
4. If we extended this out to all clients, then we could potentially be in a situation where our entire clinical team would need to be trained on hundreds of EMR systems, each with their own userID's, passwords, etc. Imagine how much time and effort you spent just learning the one system you use...imagine having to learn 50 or even a 100 different ones just to do a day's work?!?
5. Given that no one can effectively learn multiple EMR systems, realistically there would be one MBA staff member that would be familiar with and know how to get into your system to get the data we need. If that person was out of the office for any reason, your claims would not get filed. We always cross train our clinical and accounting team members, so if one of our staff is out for any reason, your claims would still be processed.
6. EMR software goes through upgrades just like any other software. Sometimes, they are minor, and other times they are major. If we have learned where certain pieces of data are in your system, then an upgrade results in your staff entering that data somewhere else, there is a distinct possibility that we could be missing important data.

### *What interfaces do you have built already?*

We have interfaces built for Amazing Charts, Praxis, Modernizing Medicine, Practice Partners and any other system that uses HL7 interfaces or CSV flat file exports. We also have lab interfaces built for LabCorp, Solstas and Quest Diagnostics and are continually adding more.

### *My EMR isn't on your list, will you build an interface?*

This is a business case and each one is different. It depends on your EMR vendor to a large extent. They generally charge around \$2,500 to build an interface. While you may have heard that there are "standards" like HL7 interfaces, you should know that those are "loose" standards and are used between two vendors that agree on certain things that are left vague in the specifications. One example would be where to put the patient identifier...it can be in any of 3 or 4 different places in the "specification" so we have to know where they are putting it so we know where to look for it. This size of your practice and the EMR vendor itself are also details that we must take into consideration. For example, are you a small, solo practice and the only client we have using your particular brand of EMR? We probably would not develop this free of charge. Are you a large practice with multiple providers and a well-known EMR vendor? Then yes, we would gladly work with any willing EMR vendor to develop an interface for little to no charge. Developing and maintaining an interface is costly and complex, so it must make business sense to pursue it.

### *My lab isn't on your list, will you interface with them?*

Yes, we will be glad to. If it is a major lab that many clients are likely to use, then we would most likely be able to do it at little or no charge.

### *How much do you charge to use the eAccess system?*

We provide the eAccess system to you at no charge, with unlimited users and providers, as part of our service assuming you are using the full eAccess system (scheduling, demographic input, insurance card scanning and patient co-pay postings). If you choose not to use the system in this capacity, then there are charges for setup and monthly support on a per user basis to help offset the expenses we incur in making the software available.

### *I've read this and I hear what you're saying, but I just want to keep using what I have. Is that okay?*

Sure, that is fine. We have built a system that addresses the problems we have encountered in our industry over the past 25 years of doing business. Our systems and processes are intentional and very deliberate in addressing problems. We have spent years developing and honing our systems to prevent every problem we can possibly prevent. You can choose not to use these to their fullest capacity, but do recognize that you will not see the full potential of revenue that your practice can produce.