Revenue Cycle Management

ELIGIBILITY AND VERIFICATION

Are you or your staff tired of waiting on the phone or jumping from website to website to verify patients' insurance eligibility? Being able to verify a patient's eligibility and benefits information in a timely manner is critical. To do this consistently, you need support that is easy, efficient and cost effective.

Medlite Healthcare RCM Services eligibility and benefits verification obtains all pertinent information required – not only coverage confirmation, but also specifies what kind of coverage the patient has (HMO, PPO, POS, etc..) what their deductible is, and how much has been applied, and helps generates complete payer information to bill the claims appropriately. Having all relevant E & V information takes each claim to the right step of getting it paid on time and reduce your administrative cost.

We would be glad to obtain any/all information from the list of questions which you may have as of today.

CHARGE & DEMO ENTRY

Charge & Demo entry is the most sensitive of all departments in medical billing. This department holds the key to a successful claim filing. Charges and codes for every medical procedure are updated often and we stay ahead of these changes among the fellow players. Our team has exemplary capacity in entering/keying the data under the following headers:

Charge Entry:

- Date of Service
- Billing Provider
- Rendering Provider
- Place of Service
- Admission Date
- Referring Physician
- Prior Authorization/Referral #
- Procedure Code (CPT) and the number of units performed
- Modifiers
- Diagnosis Code

Demo Entry:

Patient Details-

Patient ID#, Patient Name, Date of Birth, Gender, Marital Status, SSN#, Address (physical & mailing address), Telephone Number, as well as Work Mailing Address and Telephone Number

Guarantor/Account Details-

Guarantor Name, Date of Birth, Gender, Marital Status, SSN#, Address (physical & mailing address), Telephone Number, and Work Mailing Address and Telephone Number.

Insurance Details-

Insurance Name and Address, Insurance Identification Number, Group Name/Group Number, Policy Effective and Termination Date, Financial Class (FC), as well as the Name, Date of Birth, Gender, and Relationship of the Subscriber to the Patient/Guarantor

EDI SERVICES

Claim File Creation

Our team is well trained in the process of pushing the claims that were entered on a given day along with claims that were set to resubmit from the previous day, through the internal system scrubbing process and creating a clean claim file (s) as per your requirement.

Error out Claims from Scrubbing Process

There will be some amount of claims that error out during the internal edits process. These edits could be due to coding, file maintenance, eligibility issues, etc. Our EDI team is trained on addressing these issues that are within our limitations of resolution.

Uploading Clean Claim Files

Our EDI staff will upload the claim files to the respective clearing house. In addition, we also confirm the receipt of the file.

Clearing House & Payer Rejection

Our EDI staff is trained to address any clearing house or Payer rejections rising out of the claim files that were uploaded.

Value Additions

- Daily/Weekly/Monthly reconciliation (based on requirement) between claims billed from client system and clearing house website to ensure all claims were received.
- Provide clearing house and payer rejection trend weekly/monthly (based on requirement) for additional edits to be placed on client system to ensure future claims go out as clean claims.
- Acceptance ratio will be in line with industry standards.
- We have knowledge working on Gateway EDI, Emdeon, Navicure, RealMed, Zirmed, Claims Remedi, etc...

PAYMENT POSTING

Payment posting is one of the most crucial processes involved in the full service revenue cycle management business. We are experts in handling small, mid-sized, and large volumes of payments. We have handled posting payments of up to $40 million every month and maintained a turnaround time of 24 to 48 hours. In addition, we have closed all month ends on the last working day of the month. We have 100% success ratio in closing month ends for a period of more than 25 months continuously.

We are experts in the below operations and are willing to offer the same services:

- Bank Deposits – Retrieve lockbox files from the bank websites and upload them to the client system to start posting.
- Bank Statement Reconciliation – Our staff is well versed in doing reconciliation between bank statements versus the lockbox deposits, EFT, and Credit Card Payments to ensure that the following are complied with:
    - All money received is accounted for so that we and the client are reimbursed appropriately.
    - Avoid any unaccounted money in aging for which there would be unnecessary follow up activities that might take place.
    - Prevent hold ups of any secondary and tertiary claims, patient balances etc.
- Posting Payments – Appropriately post Lockbox Payments, EFT, Co-pays, and Credit Card Payments.
- EFT/ERA Downloads – Our staff is trained to download 835 files from clearing houses websites such as Gateway, Emdeon, RealMed, Navicure, Zirmed, Claims Remedi etc. and upload them to the client system/software and process it. Credit Card Payments – We are knowledgeable of processing insurance credit cards and patient credit cards received through mail, over-the-phone, and over-the-counter. We are also very much aware that any piece of paper with this information should not be attached to the system which results in non-compliance.
- Some of the key activities in posting payments which our staff is proficient in are:
    - Posting the payment to the apt encounter/account and corresponding CPT codes.
    - Attaching/Scanning the EOB/ERA to the encounter/account depending on the system capability.
    - Applying appropriate payments and patient responsibilities (Co-pay, Co-Ins, Deductible, Non-covered expenses, etc.)
    - Applying the correct insurance when posting payments.
    - Moving the balance to the appropriate status (forwarded to secondary, moved to secondary, moved to patient)
    - Adding the COB set wherever required to ensure secondary electronic claims are transmitted as clean claims.
    - Best practice is to capture the denials or adjust the balance by following the client specifics.

Value Added Services

- Converting Paper Checks to EFT – We are experts in providing you information on payers where paper checks are received however the end client has an option to transform paper checks to EFT for faster cash inflow.
- Converting Paper EOB's to ERAs – We are experts in providing you information on payers where paper EOB's are received however the end client has an option to receive ERA from payer through clearing house website which will reduce manual intervention.
- EFT's Weekly Reconciliation – We do this process to ensure all ERA's received as EFT's through clearing house website are posted in system by comparing with money posted in client software.

DENIAL MANAGEMENT

Denials can have an adverse impact on your monthly revenue. Denial management can result in lower or no reimbursement. Few reasons for denials can include:

- Incomplete or inaccurate insurance information
- Lack of pre-certification or prior authorization
- Coding related errors and omissions
- Past timely filing limits
- Medical necessity
- Incomplete provider enrollment/credential issues

Best practice is to track the denials by:

- Payer
- Financial Class
- Type of denial
- Provider

Medlite Healthcare understands that an effective denial management program must address both historical and future claims, recovering otherwise-lost revenue and preventing future denials by adding meaningful First-Pass level edits.

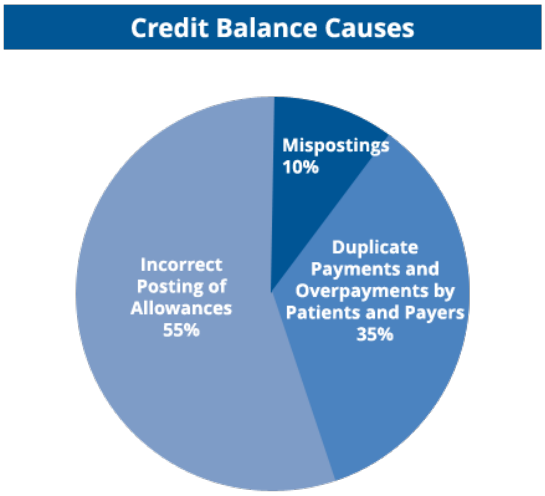
Medlite Healthcare denial management program includes:

- Analysis of the volume of denials, including a baseline analysis
- Distribution of statistics across payers, providers, CPT codes, and causal CPT/ICD-9 relationships
- Evaluation of age of denials in relation to claim expiration, refilling deadlines, etc.
- Understanding of the revenue impact on the organization

CREDIT BALANCE

What is a credit balance?

Credit balances occur when payments and adjustments exceed posted charges. They are not "extra cash" or a positive asset for a provider. Instead, they are a ticking time bomb that needs to be addressed through an effective accounts receivable (AR) solution initiative.



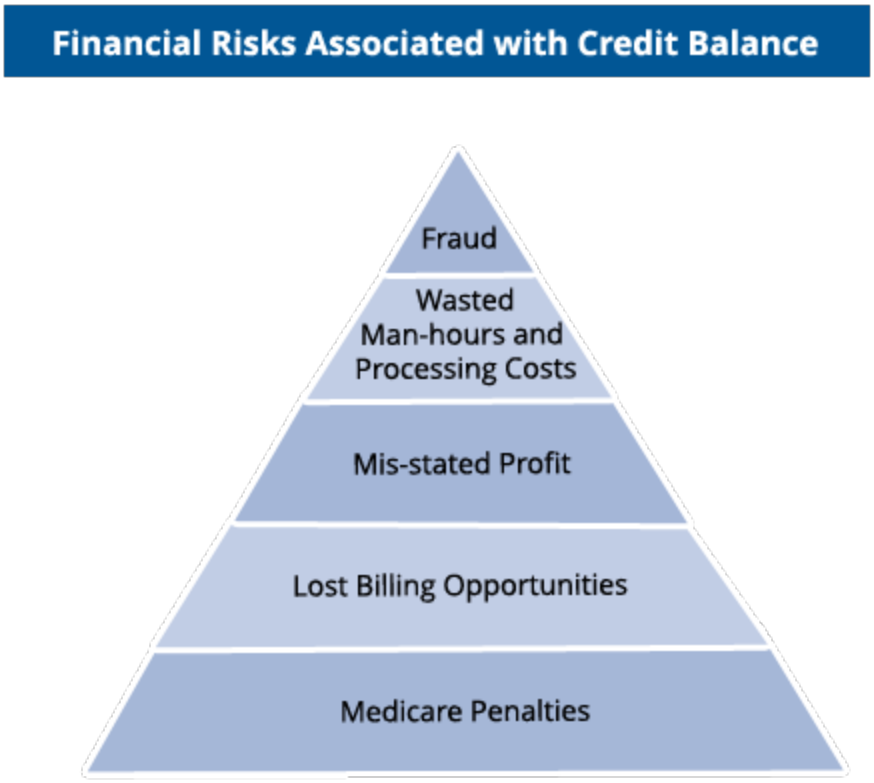
What are the Primary Causes of Credit Balances?

Most credit balances do not reflect actual monies owed to payers by providers. According to the Healthcare Financial Management Association (HFMA), the typical composition of credit balances looks something like this:

Understanding the risk of Credit Balances

Failure to address the issue of credit balances poses a number of risks for the provider, including the following:

- Lack of compliance with government payers. Failure to timely and accurately process all credit balances can result in significant fines, withholding of money, and even imprisonment.
- Misunderstanding the provider's financial situation due to an understatement of the accounts receivable and overstatement of liabilities.
- Reduction in staff productivity. Assuming a backlog of old credits as well as an incoming daily flow of new credits, existing staffing levels may not be able to handle the necessary CBO processing capacity.
- A false sense of security due to assumption that credit balances are a "profit center" or tangible asset.
- Lost revenue opportunities. Credit balances often camouflage billing opportunities due to mis-posting. This includes other payers and self-pay co-payments and deductibles.
- Lack of internal control in the management of credit balances can lead to potential internal fraud.
- Credit balances can also result in negative publicity and loss of goodwill for any healthcare organization.



How do we help you with this?

Patient Credit Balance

Our staff is well versed in reviewing the accounts and during the course of review; if determined credit balance is a result of patient overpayment, we process the refund accordingly or move the status to patient refund for a refund check to go out to the patient in a timely manner. Also, ensure account balance is zeroed out.

Government Payers Credit Balance

Our staff is aware that all government payers' refunds should be processed within 60 days from the time of refund request date. We prioritize the requests from government payers and process the requests.

Valid requests - After our review, if refund request is valid; it would be moved to insurance refund status or we post the refund depending on your requirement.

Disputes - After our review by refund analyst, if determined request is not valid; it would be moved to a senior analyst to review for a possible appeal if we dispute the decision.

Commercial Payers Credit Balance

Refund requests from commercial payers on majority of instance occur due to COB issues, incorrect allowed amount, eligibility issues etc. Our staffs are well aware of this and process the refund requests accordingly.

Valid requests - During our review, if determined request from insurance is valid; we either process the refund or move the status to insurance refund / follow up with the payer to see if they would be willing to offset the payment from future payments depending our your requirement.

Disputes - After our review by refund analyst, if determined request is not valid; it would be moved to a senior analyst to review for a possible appeal if we dispute the decision.

MEDLITE

Call (866) 914-1977

sales@Medliteinc.com