
CureMD™
Practice without boundaries

Optimizing Revenue Cycle

CureMD User Conference 2014

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It is much easier to improve collections on current patient revenue base than attempt to open new markets or drive new patients into your practice.

Current trends indicate that provider practices are losing up to 20% of their net revenue from inadequate revenue cycle management process and procedures.

Front Desk Procedure

The largest amount of revenue losses are a direct result of poor data capture at the front end of the revenue cycle and operational inefficiencies throughout.

- Bad debt continues to rise as patients take on higher deductible plans or cost sharing plans to reduce their overall out of pocket costs.

Providers are challenged by the rising cost and financial repercussion of performing revenue cycle activities such as:

- Handling insurance payment rejections, and denials
- Identifying lost charges
- Delayed payments
- Hidden cost of reworking denied claims

Providers are also plagued by:

- Complex and rapidly changing payer requirements
- Medical necessity and documentation requirements
- Timely filing limits
- Appeal time lines and changing policies

Single technology solutions are no longer an option, easy to use systems with fluid communication across all facets of the revenue cycle are needed.

Six Steps to Optimizing the Revenue Cycle

- Patient Eligibility and Benefits
- Proper Patient Registration
- Patient Financial Counseling
- Documentation and Medical Necessity Templates

Patient Eligibility and Benefits

Insurance Eligibility

- Completed upon initial entry of patient into schedule prior to patient appointment
- Re-verified 24 hours prior to patient appointment
- Used as a tool to determine patient financial liability
  - Deductible
  - Copayment
  - Cost-Sharing carve outs
  - Coinsurance
  - Out of Pocket Maximum

Insurance Eligibility

CureMD.com provides instant eligibility for most carriers and basic benefits including:

- Insurance status
- Co-Pay
- Deductible
- Co-Insurance
- Limitations
- Out of pocket
- Plan Information
- Basic Benefit information

Benefit Verifications

- Medical necessity checks during scheduling and registration can help reduce denials, increase revenue and decrease audits.

- Completed prior to initial visit and for all procedures performed in office that may have a specified coverage policy.

Medical

PATIENTS BENEFITS AND ELIGIBILITY COMMERCIAL INSURANCE CARRIERS

TODAY'S DATE: ____/____/____

PXS NAME: _____ EFFECTIVE DATE OF POLICY: ____/____/____

INSURANCE: _____ DATE OF BIRTH: _____/_____/_____

ID #: _____ Name of REP:

Plan Sponsor: _____ Plan Fiduciary:_____

How is the plan funded: fully-funded self-funded FEP State Health Other:_____

	Benefits
Does this patient have out of network benefits?	
Is there a DEDUCTIBLE? How much deductible has been met?	
Will patient receive check?	YES NO
Does the patient have a HRA or HAS fund? If so, how much money remains or has been used?	
Is there a CO-INSURANCE and a MAX OUT OF POCKET?	
Does this patient have Osteopathic Manipulative Treatment benefits? (98925-98929) Is there a limit on the number of visits? Is it combined with any other benefit? How many visits have been used? Is precert required? (phone and fax)	
Does this patient have benefits for trigger point injections (20551-20553)? Is precertification required? (phone and fax)	
Does this patient have orthotic benefits if given by a medical doctor? (L3020) Is precertification required? (phone and fax)	
Is Diagnostic Testing such as an MRI (72148) need precert? Name and number of precertification department.	
CLAIMS ADDRESS	
Does the member have benefits for DURABLE MEDICAL EQUIPMENT (TENS UNIT E0730)? Precertification?	
Does this patient have benefits for joint injections (20600, 20605, 20610)? Is precertification required? (phone and fax)	
Does this patient have benefits for Cognitive Testing (96120, 96103, 96116)? Are these procedures covered under an Internist? Is precert required? (phone and fax)	
Does the patient have benefits for Orthovisc J7324? Is precert required? (phone and fax)	

Podiatry

PATIENTS BENEFITS AND ELIGIBILITY COMMERCIAL INSURANCE CARRIERS

TODAY'S DATE: ____/____/____

PXS NAME: _____ EFFECTIVE DATE OF POLICY: ____/____/____

INSURANCE: _____ DATE OF BIRTH: ____/____/____

ID #: _____ Name of REP: _____

Plan Sponsor:_____ Plan Fiduciary:_____

How is the plan funded: FULL-FUNDED SELF-FUNDED FEP STATE HEALTH Other:_
Is Dr. In Network or Out of Network ? Is Dr. : In Network or Out of Network

	In-Network Benefits	**Out-of-Network Benefits**
Is there an in-network copayment/coinsurance/deductible? If there is an in-network deductible, how much has been met?		
Is there a referral required for podiatric care from the primary care physician?		
What is the out-of-network coinsurance, deductible, and max out of pocket? How much of the deductible has been met?		
Can x-rays be performed in a podiatrist's office? Is a referral or precert required?		
Does this patient have benefits for trigger point injections (20551-20553)? Is precertification required? (phone and fax)		
Does this patient have coverage for nail debridement (11719, 11720, 11721,). What type of limitations? (visits per month, etc)		
Does this patient have coverage for corns/callouses debridement (11055, 11056, 11057) What type of limitations? (visits per month, etc.)		
Does Diagnostic Testing such as an MRI (72148) need precert? Name and number of precertification department.		
Does the patient have coverage for joint injections (20600, 20605)? Is precertification required? (phone and fax)		
Does the member have benefits for DURABLE MEDICAL EQUIPMENT Is precertification required under 500.00/over 500.00? (phone and fax) Can a podiatrist give out Durable Medical Equipment?		
Does the member have benefits for Foot Orthotics (L3020)? Precertification? Can this office provider orthotics? How many pairs are allowed per year?		
Does the patient have coverage for Home Care Visits? (99341-99349)		
Claims Address:		

Diagnostic Testing

INSURANCE VERIFICATION

Patient Name: _____ DOB: _____
Insurance: _____
Insurance ID: _____ Spoke to: _____
Date: _____ Ref: _____ Time: _____
Effective Date of policy: _____ Plan Fiduciary: _____
Plan Sponsor: _____
How is the plan funded: fully-funded self-funded FEP State Health Other: _____
Are we in or out of network? IN-NETWORK OUT-OF-NETWORK
What co-payments, deductibles, coinsurances, and max out of pockets apply:
Co-pay _____ Deductible _____ Coinsurance _____ Max out of pocket _____

3D Analysis System testing covered?

93922 LIM BI-LAT UPPER/LOWER	YES	NO	95923 SUDOMOTOR, INCL (QSART)	YES	NO
93923 COMP BI-LAT UPPER/LOWER	YES	NO	95924 PARASYM & SYM FUNC W/ TILT	YES	NO
95921 CARDIOVAG INNERV	YES	NO	95943 PARASYM & SYM REST, HEAD UP	YES	NO

Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO
Does the service need to be provided by an E&M service provider? YES NO
Is pre-certification/authorization needed? YES NO If yes, who is precert needed by? _____
Phone for precertification division or company: _____ Fax for precert division or company: _____

CV Profilor/Max Pulse testing covered?

93922 LIM BI-LAT UPPER/LOWER YES NO
Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO

DEXA testing covered?

77080 AXIAL 1 OR MORE SITES YES NO
77081 APPENDICCULAR (PERIPHERAL) YES NO
Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO
How many DEXA tests are covered per year? _____

EECP testing covered?

G0166 EXTERNAL COUNTERPULSATION YES NO
Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO
Is pre-certification/authorization needed? YES NO If yes, who is precert needed by? _____
Phone for precertification division or company: _____ Fax for precert division or company: _____

Evoke testing covered?

92585 AUDIOMET TEST CNS	YES	NO	95930 VEP TEST CNS CHECKBRD/FLASH	YES	NO
93040 ECG 1-3 LEADS; INTERP & REPORT	YES	NO	96102 NEUROPSYCHOLOGICAL TESTING	YES	NO
95816 EEG RECORD AWAKE & DROWSY	YES	NO			

Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO
Is pre-certification/authorization needed? YES NO If yes, who is precert needed by? _____
Phone for precertification division or company: _____ Fax for precert division or company: _____

Gait Scanning covered?

96004 MOT. ANALYSIS REV. & INTERP	YES	NO	97535 HOME CARE TRAINING	YES	NO
97112 NMR SIT/STAND ACTIVITIES	YES	NO	97750 PHYS PERF TEST W/ REPORT	YES	NO
97116 GAIT TRAINING	YES	NO	97760 ORTHOTIC MANAGEMENT	YES	NO
97530 DIRECT THERAPUTIC ACTIVITY	YES	NO	97762 ORTHOTIC CHECKOUT	YES	NO

Are these services covered when performed by a cardiologist? YES NO
Are these services covered when performed by an internist? YES NO
Is pre-certification/authorization needed? YES NO If yes, who is precert needed by? _____
Phone for precertification division or company: _____ Fax for precert division or company: _____

Mailing address for claims: _____

Durable Medical Equipment

DME INSURANCE VERIFICATION

Patient Name: _____ DOB:____/_____/_____

Insurance: _____

Insurance ID: _____

Date: _____/_____/_____ Spoke to: _____

Ref:_____ Time_____

Effective Date of policy: _____

Plan Sponsor: _____ Plan Fiduciary:_____

How is the plan funded: fully-funded self-funded FEP State Health Other:_____

Are we in or out of network? IN-NETWORK OUT-OF-NETWORK

What co-payments, deductibles, coinsurances, and max out of pockets apply:

Co-pay_____

Deductible_____

Coinsurance_____

Max out of pocket_____

Is durable medical equipment (DME) covered?	**YES**	**NO**
E0730 -TENS UNIT	YES	NO
L0631-LUMBAR BELT	YES	NO
E0855 -Cervical DDS	YES	NO
64699 -EMS	YES	NO

Is pre-certification/authorization needed? YES NO

If yes, who is precert needed by?_____

Phone for precertification division or company:_____

Fax for precert division or company:_____

Mailing address for claims: _____

Ultrasound

ULTRASOUND AND ABI INSURANCE VERIFICATION

Patient Name: _____ DOB:____/_____/_____

Insurance: _____

Insurance ID: _____ Spoke to: _____

Date: _____/_____/_____ Ref:_____ Time_____

Effective Date of policy: _____

Plan Sponsor: _____ Plan Fiduciary:_____

How is the plan funded: fully-funded self-funded FEP State Health Other:_____
Are we in or out of network? IN-NETWORK OUT-OF-NETWORK
What co-payments, deductibles, coinsurances, and max out of pockets apply:

Co-pay_____

Deductible_____

Coinsurance_____

Max out of pocket_____

Is Ultrasound testing covered? YES NO

76536- Thyroid	YES	NO	93922- Single Level Bilateral	YES	NO
76604- Chest	YES	NO	93923- Mutli Level Bilateral	YES	NO
76700- Abdominal	YES	NO	93925- Lower Art Doppler	YES	NO
76770- Renal	YES	NO	93930- Upper Art Doppler	YES	NO
76856- Pelvis	YES	NO	93965- Lower Vein Doppler	YES	NO
76881- Extremity	YES	NO	93970- Upper Vein Doppler	YES	NO
93880- Cartotids	YES	NO	93975- Arterial/Venous flow Abd	YES	NO
93978- Aorta, IVC, iliac, grft	YES	NO			

Is pre-certification/authorization needed? YES NO

If yes, who is precert needed by?_____

Phone for precertification division or company:_____

Fax for precert division or company:_____

Mailing address for claims: _____

Chiropractic/ Physical Therapy/ Acupuncture

PATIENTS BENEFITS AND ELIGIBILITY COMMERCIAL INSURANCE CARRIERS

TODAY'S DATE:

PXS NAME: EFFECTIVE DATE:

INSURANCE: DATE OF BIRTH:

ID #: Name of Rep:

Tel #: Ref#:

Plan Sponsor: Plan Fiduciary:

How is the plan funded: Full-Funded Self-Funded FEP State Health Other:

NOTE: Per rep this is primary insurance.

	CHIRO		**PT**	**Acupuncture**
Are we IN or OUT of network? Please circle if in or out but verify both in and out benefits for chiropractic?	**In network**	**Out network**	**Out of network**	**Out of network**
Is there a limit on the NUMBER OF VISITS? HOW MANY MODALITIES CAN BE DONE PER VISITS (97110, 97140, 97112, 97535, 97014, 97010)? IS THERE A MAX DOLLAR PAID PER DAY?				
Can xrays be done in office by a chiropractor?	Yes	Yes	**Not applicable**	**Not applicable**
Is PRE-CERTIFICATION required?				
Is there a REFERRAL required?				
Is there a CO-PAY?				
Does the px have any OUT OF NETWORK BENEFITS?				
Is there a DEDUCTIBLE? How much deductible has been met?				
Will patient receive check?				
Is there a CO-INSURANCE and a MAX OUT OF POCKET?				
Is Diagnostic Testing such as an MRI (72148) need pre-cert? Name & number of pre-certification department			**Not applicable**	Can an acupuncturist perform Acupuncture?
CLAIMS ADDRESS				
Does the member have benefits for DURABLE MEDICAL EQUIPMENT (TENS UNIT E0730)? Pre-cert?			**Not applicable**	
Are ORTHOTICS covered? (L3020)			**Not applicable**	**Not applicable**
Are NCVs covered for a chiropractor? (95903, 95904, 95934)			**Not applicable**	**Not applicable**
Does px have a Flex Spending Account?				

Cardiology

CARDIOLOGY INSURANCE VERIFICATION

Patient Name: _____ DOB:___/____/_____
Insurance: _____
Insurance ID: _____ Spoke to: _____
Date: ____/____/_____ Ref:_____ Time_____
Effective Date of policy: _____
Plan Sponsor: _____ Plan Fiduciary:_____
How is the plan funded: fully-funded self-funded FEP State Health Other:_____
Are we in or out of network? IN-NETWORK OUT-OF-NETWORK
What co-payments, deductibles, coinsurances, and max out of pockets apply:
Co-pay_____ Deductible_____ Coinsurance_____ Max out of pocket_____

Is Ultrasound testing covered?	**YES**	**NO**			
93880- Cartoid	YES	NO	93978- Aortic Screen	YES	NO
93882- Cartoid LIM	YES	NO	93979- Aortic Screen LIM	YES	NO
93925- Arterial Doppler	YES	NO	76536- Thyroid	YES	NO
93965- Extremity Veins	YES	NO	76700- Adominal	YES	NO
93970- Venous Doppler	YES	NO	76770- Renal	YES	NO
93971- Ext Veins Limited	YES	NO	76856- Pelvic	YES	NO
93975- ART/VEN/ABD/PELVIS	YES	NO	76857- Bladder	YES	NO
93976- ART/VEN/ABD/Pelvis-LIM	YES	NO	76881- Extremity	YES	NO

Is pre-certification/authorization needed? YES NO If yes, who is precert needed by?_____
Phone for precertification division or company:_____
Fax for precert division or company:_____

Is Echocardiogram testing covered?	**YES**	**NO**	**Is ABI testing covered?**	**YES**	**NO**
93306- Echo	YES	NO	93923- Mutli Level Bilateral	YES	NO
93308- Echo (Limited)	YES	NO	93922- Single Level Bilateral	YES	NO
93351- Echo (Stress)	YES	NO			

Is pre-certification/authorization needed? YES NO If yes, who is precert needed by?_____
Phone for precertification division or company:_____
Fax for precert division or company:_____

Is Nuclear Stress testing covered?	**YES**	**NO**			
78451- MPI, Spect Single	YES	NO	J0152- Adenosine	YES	NO
78452- MPI, Spect Multiple	YES	NO	J1245- Persantine	YES	NO
93015- Treadmill Stress W/ EKG	YES	NO	J1250- Dobutrez	YES	NO
A9500- Cariolite/ MIBI per Study	YES	NO	J2785- Lexiscan	YES	NO
A9502- Myoview per Study	YES	NO	J0280- Aminophyline	YES	NO
A9505- Thalim Per Millicurie	YES	NO	J7050- Saline	YES	NO

Is pre-certification/authorization needed? YES NO If yes, who is precert needed by?_____
Phone for precertification division or company:_____
Fax for precert division or company:_____

Are Holter/Event Monitors covered?	**YES**	**NO**
93224- Holter Monitor	YES	NO
93227- Holter Int & Rpt	YES	NO
93268- Event Monitor	YES	NO
93272- Event INT & RPT	YES	NO

Is pre-certification/authorization needed? YES NO If yes, who is precert needed by?_____
Phone for precertification division or company:_____
Fax for precert division or company:_____

Mailing address for claims: _____

OB/GYN

URODYNAMICS INSURANCE VERIFICATION

Patient Name: _____ DOB:____/_____/_____
Insurance: _____
Insurance ID: _____ Spoke to: _____
Date: _____/_____/_____ Ref:_____ Time_____

Effective Date of policy: _____

Plan Sponsor: _____ Plan Fiduciary:_____

How is the plan funded: fully-fundedself-funded FEP State Health Other:_____

Are we in or out of network? IN-NETWORK OUT-OF-NETWORK

What co-payments, deductibles, coinsurances, and max out of pockets apply:

Co-pay_____ Deductible_____ Coinsurance_____ Max out of pocket_____

Is URODYNAMIC testing covered? YES NO

51729	Complex Cystometrogram, Uretheral Pressure Profile/Urethral Closure Pressure, Voiding Pressure	YES	NO
51797	Intra-Abdominal Voiding Pressure	YES	NO
51784	Electromyogram (patch)	YES	NO
51741	Complex Uroflowmetry	YES	NO
51792	Stimulus Evoked Response (bulbocavernosus reflex)	YES	NO

Are these procedures covered when billed with a 26 modifier (professional component) and the TC modifier (technical component)?
YES NO _____

Is pre-certification/authorization needed for any of the codes? YES NO

If yes, which codes need precertification?_____

If yes, how do you obtain precertification?_____

Phone for precertification division or company:_____

Fax for precert division or company:_____

Mailing address for claims: _____

Benefit Verifications

- Verifications should be reviewed prior to performing/ordering service to ensure proper coverage and patient responsibility.

- If authorization is needed, patient should be scheduled for another day and staff should complete authorization prior to the next visit.

Proper Patient Registration and Required Paperwork

Proper Patient Registration and Required Paperwork

(Commercial/Medicare)

Retrieving **accurate**, **complete** and **legible** information **prior** to any visit will prevent most billing delays, errors and denials.

- **Patient Registration Form**
- **Clear Copy of Insurance Cards and Patient Identification**
- **HIPAA Agreement**
- **Advance Beneficiary Notice**
- **Financial Consent (Assignment of Benefits)**
- **Authorization of Designated Appeal Rep (self-funded vs fully funded)**

Proper Patient Registration and Required Paperwork

(No Fault/PIP/Work Comp)

Retrieving **accurate**, **complete** and **legible** information **prior** to any visit will prevent most billing delays, errors and denials.

- **Patient Registration Form**
- **Clear Copy of Auto Insurance cards or Worker's Compensation paperwork, Claim number, and Date of Accident. Copy of declaration page.**
- **Copy of Driver's License and Secondary Insurance Information**
- **Name and Contact information for Insurance Adjustor and Attorney**
- **Assignment of Benefits/ NF3**
- **Authorization of Designated Appeal Rep**
- **HIPAA Agreement**

Proper Patient Registration and Required Paperwork

- Designation of Authorized Representative
- Assignment of Benefits
- NF3 forms signed by patient – NY No Fault
- 21 Day Notice

Proper Patient Registration and Required Paperwork

- Carrier-Specific Forms
  - Oxford Authorized Representative
  - State Farm Assignment of Benefits
  - Horizon BCBS State Health Benefits Authorized Representative Forms

- Authorization to Debit a Credit Card
  - Out of Network Must
  - Self-Pay Requirement

Authorization to Debit Credit Card

AUTHORIZATION TO DEBIT A CREDIT CARD

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. If there is any unpaid balance at _____days from my last visit, it will be charged to my credit card, (Office will safeguard a photocopy of the card.)

Authorization to Debit a Credit Card:

VISA/MC/DISCOVER _____ - _____ - _____ - _____ EXP. _____/_____

PRINT Name on Card _____ ZIP Code on card _____

I have read and understand the above.

Signature _____

AS a courtesy, if you would like to enjoy the added convenience of automatic billing to your card, please also check the appropriate box, below and sign again.

□ Please bill all my regular charges to my card, listed above, on the ____ day of each month beginning on ____/_____/_____. Since my payment amount varies each month, I will receive written notification of the amount and dates of services , prior to each scheduled transaction date.

I have read and understand the above.

Date_____ Signature_____

Patient Financial Counseling

Patient Financial Counseling

is critical to patient satisfaction and protects financial stability for the providers.

Patient out of pocket expenses should be collected upfront and should no longer be an option.

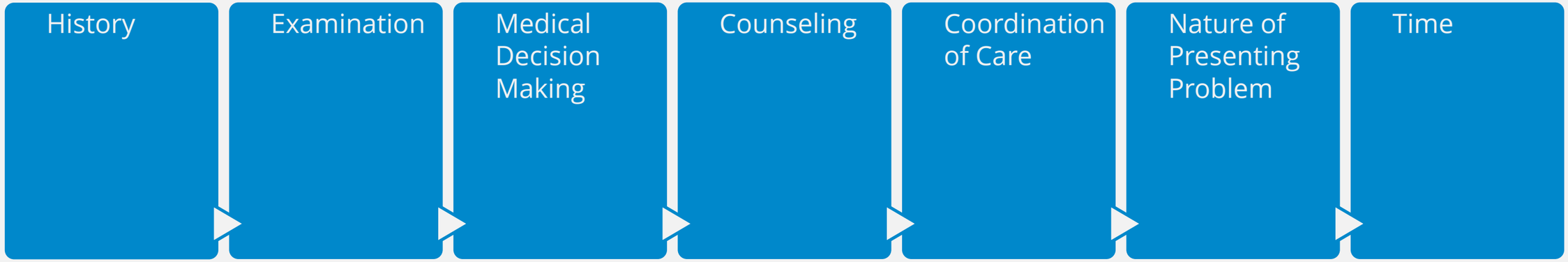
Allowing patients to access this information via portals or kiosks are the new industry “leading practices”.

- Healthcare Costs
- Schedule appointments
- Self-registration
- Receive online statements and make electronic payments

Documentation and Medical Necessity Templates

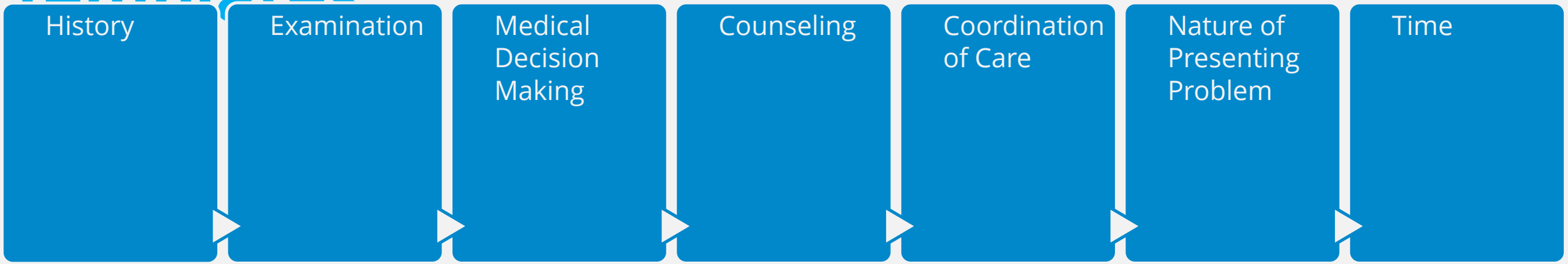
Documentation and Medical Necessity Templates

- Evaluation and Management Services
  - Office Visits
    - New vs Established
    - Level of service defined by six components



The first three components (**History**, **Examination** and **Medical Decision Making**) are considered the key components in selecting the level.

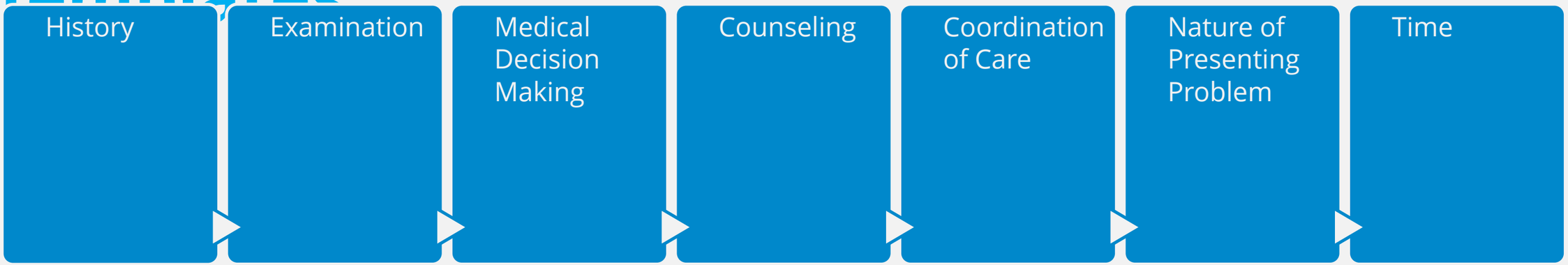
Documentation and Medical Necessity Templates



Counseling, **Coordination of Care** and the **Nature of the Presenting Problem** are contributory factors in the majority of encounters.

- Counseling and Coordination of Care are not required at every encounter.
- Coordination of Care with other physicians or healthcare professionals without patient encounters should be documented and billed separately.
  - Medical Team Conferences (99366-99368)

Documentation and Medical Necessity Templates



Time

- Intra-service time is defined as face-to-face time with provider
- Pre- and Post encounter time is not included in the time component for an E&M code

Documentation and Medical Necessity Templates

- Time component can override the level of the exam if counseling and/or coordination of care exceeds 50% of the total face-to-face encounter.
  - 99213 (15) vs. 99214 (35)
  - 99212 with 99354 (prolonged service, 30-74 minutes)
  - 99213 with 99401 (preventative medicine counseling, 15 minutes)
    - Family problems
    - Diet & exercise
    - Substance use
    - Sexual practices
    - Injury prevention
    - Dental health
    - Diagnostic & laboratory test

Documentation and Medical Necessity Templates

- 99213-25 with 99396 (or any preventative medicine visit)
  - “Split visit”
  - E&M should be billed with a preventative medicine visit if an abnormality or a pre-existing problem is addressed and require additional work to be done.

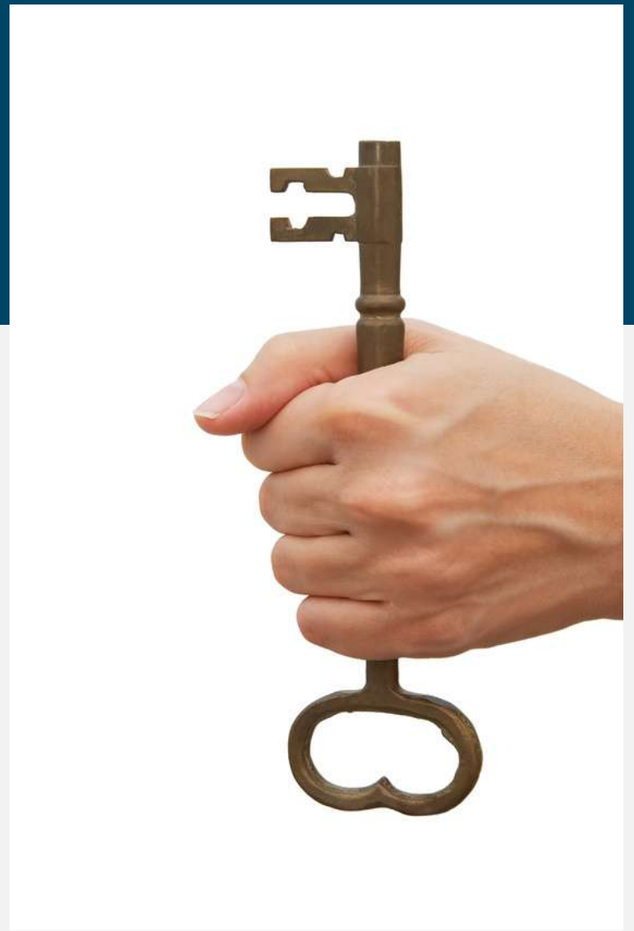
Payment for these types of coding examples is dependent on documentation and medical necessity templates.

Enhancing Insurance Collections

Key to Enhancing Insurance Collections

Coding to Maximize Revenue

- Evaluate practice coding for possible areas to increase revenue
- Learn how to maximize revenue per patient, per



Example

- Patient to receive an orthotic/brace of any type (knee brace)
  Orthotic on date received
  - Optimal billing & coding
    - 1st Visit
      97760 Orthotic management & training (15 minutes- assessment and fitting)
      2nd Visit
      L1843 Knee Orthosis
      97762 Checkout for orthotic/prosthetic (15 minutes)
      3rd Visit
      99213-25
      97762 Checkout for orthotic/prosthetic (15 minutes)

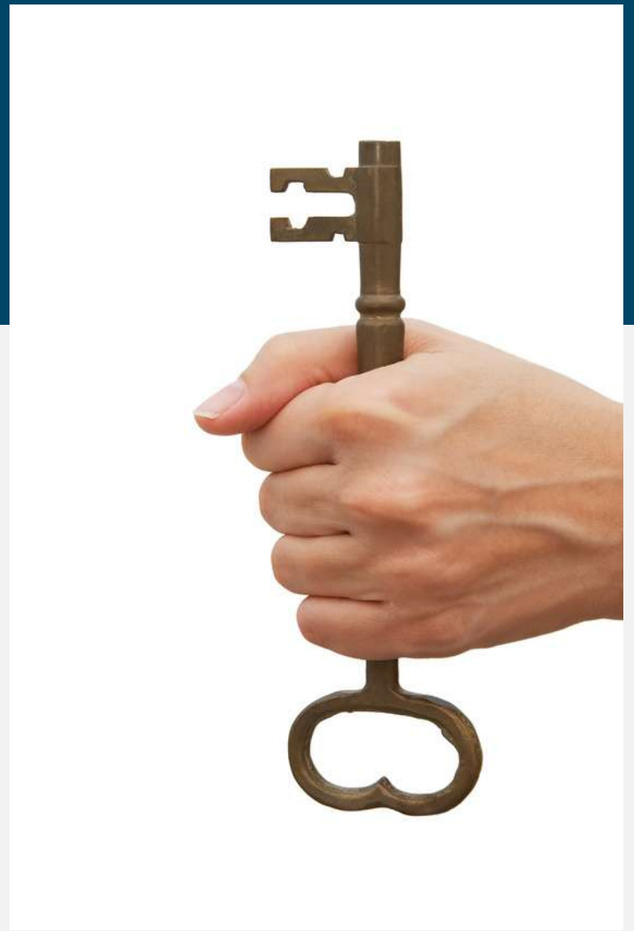
Key to Enhancing Insurance Collections

Coding to Maximize Revenue

- Template software to include hot lists of dx codes that are payable across the major carriers for procedures & testing

Example

- **Trigger point injections (20552-20553)**
  dx. 729.1 (myofacial pain)
- **Sacrioiliac joint injections (27096)**
  dx. 724.6 (disorders of sacrum)
- **VNG (92540)**
  dx. 386.1, 386.19, 780.4
- **0A Knee injections (20610 & J7323)**
  dx. 715.15, 715.16
- **Chiropractic manipulation (98940-98942)**
  Group D codes – 30 visits per calendar year



Key to Enhancing Insurance Collections

- Revenue cycle financial outcomes are tied directly to the patient intake and process flow
- Typical revenue cycle strategy has been to focus the bulk of resources at the back end
- Most revenue cycle challenges occur during patient entry, documentation, & coding
- Eliminating “rework” has to be the most important goal for revenue cycle optimization Minimizing “rework” will correlate to substantial labor cost savings
- 20% of a biller time is spent on following up & reworking claims that were processed wrong on front end

Key to Enhancing Insurance Collections

Managing Denials, Follow-up calls, & Financial Outcome

- Problem List
  - Includes comprehensive list of all denials whether from EOB or collection calls
  - Can be assigned to specific staff members

7/29/2014	Dr.	MEDICARE-NJ	990.38	Langschultz, Kelly	Pending	
Cpt code 76942 is denied due to missing referring provider information. So Please provide the require information to insurance		W, S 10/30/2014 04:02 PM			+Problem	+Comments
9/10/2014	Dr.	HORIZON NJ HEALTH	1083.72	Langschultz, Kelly	Pending	
Insurance denied the claim because insurance has no authorization on file. So please Suggest.		S, M 10/31/2014 11:14 AM			+Problem	+Comments
10/1/2014	Dr.	CIGNA	51.34	Langschultz, Kelly	Pending	
Working on CIGNA: Insurance denied the CPT 97762 under claim (9651429093483) as it should be billed to Orthonet. So, please submit the claim to Orthonet PO Box 5016, White Plains, NY 10605.		S, M 10/31/2014 12:24 PM			+Problem	+Comments
3/10/2014	Dr.	BCBS-NJ	184.00	Langschultz, Kelly	Pending	
Cpt code L4396 is denied due to invalid modifier. So please Resubmit the claim with correct modifier		W, S 10/31/2014 02:34 PM			+Problem	+Comments
7/25/2014	Dr.	BCBS-NJ	110.18	Langschultz, Kelly	Pending	
Authorization: Insurance denied the cpt code 20552 because they need the authorization. So please provide the authorization to reprocess the claim		W, S 10/31/2014 02:39 PM			+Problem	+Comments
9/16/2014	Dr.	CIGNA	10.41	Langschultz, Kelly	Pending	
Insurance denied the CPT 97110 under claim # 680922614403261 as it should be billed to orthonet, So please submit the claim to orthonet P.o Box 5016, White Plains,NY 10605.		S, N 10/31/2014 03:01 PM			+Problem	+Comments
7/16/2014	Dr.	(None)	60.00	Langschultz, Kelly	Pending	
CPT 64450 is billed with $0.00 under the claim #4260S06454 . So, please add the charge amount for this code and resubmit on paper on PO Box 29135. Hot Springs, AR 71903.		S, N 10/31/2014 03:11 PM			+Problem	+Comments
9/22/2014	Dr.	BCBS-NJ	640.00	Langschultz, Kelly	Pending	
Insurance denied the claim # 26142876052000 as this service is experimental or investigational based on our medical policy. So please suggest.		S, N 11/03/2014 06:40 AM			+Problem	+Comments

Financial Overview

- Date of service vs billed date
  - Tackle collections per carrier
  - Per aged bucket
- Target/Maximize follow-up potential with a greater return

Financial Overview

Report

Aging By: Billed Date

Patient/Plan	To Be Billed	Current	30 +	60 +	90 +	Total
Total	**5,444.50**	**18,931.22**	**16,659.30**	**1,453.82**	**5,407.19**	**47,896.03**
Patient	-1,700.33	0.00	15,610.89	0.00	1,387.91	15,298.47
AARP	0.08	1,013.30	208.38	0.00	71.32	1,293.08
AETNA US HEALTHCARE HMO	0.00	840.00	0.00	575.00	0.00	1,415.00
AMERIHEALTH HMO	0.00	0.00	0.00	0.00	200.60	200.60
BANKERS LIFE AND CASUALTY COMP	297.26	0.00	0.00	0.00	0.00	297.26
BCBS-NJ	2,530.00	251.86	0.00	0.00	592.44	3,374.30
CIGNA	-98.55	68.44	0.00	5.85	-38.03	-62.29
COMPUTER SCIENCES CORP	10.30	10.30	0.00	0.00	110.02	130.62
EMPIRE BCBS-NY	40.38	2,231.28	228.45	465.48	438.83	3,404.42
GHI INSURANCE	0.00	185.58	268.60	62.00	205.05	721.23
Humana	0.00	152.10	0.00	0.00	0.00	152.10
LUFTHANSA GERMAN AIRLINES	0.00	0.00	0.00	0.00	1,750.00	1,750.00
MAGNACARE	-2,100.00	0.00	0.00	0.00	0.00	-2,100.00
MEDICARE-NY-DOWNSTATE	3,257.68	8,550.57	342.98	277.05	508.38	12,936.66
MUTUAL OF OMAHA	0.00	0.00	0.00	0.00	40.38	40.38
TRANSAMERICA	68.44	0.00	0.00	0.00	0.00	68.44
UNITED HEALTH CARE	3,139.24	5,627.79	0.00	68.44	140.29	8,975.76

Financial Overview | BCBS-NJ - 91+

Claim | Statement | Report

All (3)

BCBS-NJ - 91+

Patient

Account	Patient	Date of Service	Provider	Procedure	Charge	Balance
57	GUSTERN, JOSEF	01/13/2014	RADWANER,BRADLEY	G8427, G8725, G8593, 99401, G8595, 99214	161.46	161.46
57	GUSTERN, JOSEF	05/12/2014	RADWANER,BRADLEY	93000, 99401, 99214, 36415	185.30	40.38
57	GUSTERN, JOSEF	05/20/2014	RADWANER,BRADLEY	99223, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233, 99233	1,952.99	390.60
				Total		**592.44**

Improving Payer Performance

Improving Payer Performance

- Coding specific to payer policy
- Reviewing coverage policies for applicable procedures & creating documentation & superbill templates to enhance reimbursement

  - Order CPT codes in RVU order
  - Review CCI edits & multiple modality reductions
  - Benefit verifications prior to procedures
  - Following proper authorization guidelines
  - Reviewing & documenting protocols for denial management

Improving Payer Performance

- Denial Management
  - Timely follow up on claims with no response (approximately 30 days)
  - Effective appeal process
    - Self funded vs fully funded
      - Self funded – ERISA (1st & 2nd level)
        - » Designation of Authorized Representative
        - » Summary Plan Description (SPD)
        - » Assignment of Benefits
        - » Coverage policies
      - Fully funded (1st & 2nd level)
        - » Assignment of Benefits
        - » Coverage policies
        - » Governed by Department of Banking & Insurance

Thank You

CureMD™
Practice without boundaries