

Medical Billing solutions to Physician's, Medical Groups and Billing offices are being done out of India since 1994/1995 and has successfully helped many entities in the healthcare sector to avail the benefits of increased cash flows and process efficiencies of outsourcing to India. The whole activity from being staff centric has been developed as a process to ensure uniformly error free performance. The main activities have been subdivided into functional units and they are as follows:

- **Claims data entry**
We have the data processed and input into the system within 24/48 hours of receipt for normal workflow. These data are audited for accuracy to ensure that the claims submitted are clean and in compliance with rules to ensure optimal and faster reimbursement.
- **Claims generation and submission (electronic and paper)**
Most of our claims are submitted electronic to avail the benefit of faster payment. We use clearinghouses like Medic Fast claims, Envoy and other direct submission modes. Paper claims with attachments (primary and Secondary) are printed and dispatched for postage in US on frequent basis. This takes about 3 business days to reach Clients office.
- **Payment posting**
The copies of check and Eob's are scanned and received by the Service provider in India for Payment posting. All payment posting is completed with 24/48 hours of receipt. End of day, balancing of posted to deposit is done and also included for month end balancing of receipts.
- **Underpaid / unpaid claims identification and appeal, follow up**
Denials/Under paid claims are identified at the time of payment posting and also by scrutiny of the regular mail. All identified items are researched for further resolution by calling up insurance companies or by taking appropriate action. All the denied claims are acted within 3-4 business days of receipt
- **Account receivables analysis and management**
We have experienced analysts who research the unpaid claims by insurance company to identify potential problems and takes appropriate action for resolution. Also payment patterns of the major insurance companies are identified and all unpaid claims over the benchmark days are set up as work order for our call center agents to call up Insurance companies and check on the claim status. It is a policy it to check the claim status on all claims that are unpaid and this process result in identification of the problems early and results in increase in the collections by 15-20 % and also reduces the reimbursement cycle.

- Financial reporting including customized reports as and when required
A dedicated MIS team will complete the financial and other practice reports on agreed timelines. Also the client's requirement of reports, which occurs during the month, is met on a timely basis.
The general month reporting would cover
 1. Daily recap summary
 2. Patient type/Financial class activity
 3. Doctor wise financial summary
 4. Service analysis by doctor, location, department etc.
 5. Aged receivables report by Financial class
 6. Any other report requested by the client as part of month end reporting

- Patient billing and follow-up
Prior to start of the project it is discussed with the client to evolve a policy on balance billing the patient. Patient billing is carried out as per the policy for frequency, value and number of bills before it is sent out for collections. We take reasonable steps to follow up with the patient for collection of the dues from them.

- Handling patient enquires
We have diligent and courteous staff to handle sensitive patient enquiries and explain to them any clarifications that they may require on the bills sent.

- Provider enrollment assistance
Staff from time to time checks the provider details with the insurance companies to ensure that the details of the provider are correctly reflected. We assist the practice in submission of application forms and track the processing on a weekly basis to ensure that the provider enrollment is done timely and accurately.

At every stage of the whole process, QA practices are adopted to ensure that clean and error free claims are sent out to the Insurance companies. This results in quicker processing and faster turnaround of the claims resulting in increase in cash flows to the clients by 10-20 %.

Our main focus areas are

- Ensuring that monthly collection targets are met
- Identify all problem claims and resolve quickly for payment
- Establish trends per carrier for delayed processing and focusing special attention for such claims
- Formulate Billing rules per plan/carrier to generate clean claims
- Advise physicians of denials and bundling issues
- Call on each outstanding account over the benchmark days and arrive at an action plan.
- Aggressive follow up until the issues are resolved.
- Conversion of data into claims within 24-48 hours.

TIF' Image of the Patient Demographics:

Imaging	
File Edit View Page Zoom Annotation Help	
PERSONAL DATA (please print)	
Name: <u>Louise Lack</u>	Birth Date: <u>11/5/54</u> Age: <u>47</u> Sex: <u>QM</u> <input checked="" type="checkbox"/>
Address: <u>7626 Southern Shook Bend #107</u>	Ht.: <u>5'1"</u> Wt.: <u>130</u> lbs
City: <u>Southern</u> State: <u>FL</u> Zip: <u>32117</u>	Social Security #: _____
Phone (Day): _____ (Evening): _____	Drivers License #: _____
Mailing Address: <u>7626 Southern Shook Bend 107</u>	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian
City: _____ State: <u>FL</u> Zip: _____	<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other
Emergency contact: <u>Lauren Lack</u> Relation: <u>Daughter</u> Phone: (Day) _____ L (Evening) _____	City: _____ State: _____ Zip: _____
Address: <u>Same</u>	
This visit is for <input type="checkbox"/> Work related Injury <input type="checkbox"/> Auto-accident <input checked="" type="checkbox"/> Illness <input type="checkbox"/> Other Injury	
How did you hear about us? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Previous patient <input type="checkbox"/> Friend/Family <input checked="" type="checkbox"/> Other physician <input type="checkbox"/> Other	
INSURANCE INFORMATION:	
<input type="checkbox"/> Workmen's Compensation <input type="checkbox"/> Auto-accident Case	<input checked="" type="checkbox"/> Private Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> PPC
Insurance Co.: _____	Insurance Co.: <u>United Health Care</u>
Claim Address: _____	Address: <u>PO Box 20555</u>
City: _____ State: _____ Zip: _____	City: <u>Spokane C.B.</u> State: <u>WA</u> Zip: _____
Date of Injury/Accident: <u>1/1</u>	Phone: _____ Fax: _____
<input type="checkbox"/> Employer at time of Injury	Policy Holder: <input checked="" type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Address: _____	Name: _____ Relationship: _____
City: _____ State: _____ Zip: _____	SS# or ID# of Policyholder: _____
Phone: _____ Fax: _____	Plan Name: <u>Willis</u>
Claim No.: _____	Policy # _____ Group # _____
Claim Adjuster: _____	Policy effective date: _____
Phone: _____ Fax: _____	Primary Care Physician: _____
Case Manager: _____	Phone: _____ Fax: _____
Phone: _____ Fax: _____	Referral Clerk: _____
Name of Attorney: _____	Referral obtained <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None Needed. If Yes:
Contact person: _____	Referral No: _____ No. of Visits: _____
Phone: _____ Fax: _____	Referral Expires on: <u>1/1</u>
Lawsuit Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No	Co-Pay: Office Visit: \$ _____ Hospital/Surgery: \$ _____
Auto-accident cases: Deductible: \$ _____ <input type="checkbox"/> Met <input type="checkbox"/> Not met	Deductible: \$ _____ <input type="checkbox"/> Met <input type="checkbox"/> Not Met
LIEN: <input type="checkbox"/> Yes <input type="checkbox"/> No LOP: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> MEDICAID: Signed up with HMO? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> MEDICARE: Signed up with HMO? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Medicaid #: _____
HMO Plan: _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Expires on: <u>1/1</u>
Medicare #: _____	Medipass Physician: _____ Phone: _____
EMPLOYMENT INFORMATION:	
Occupation: <u>Self Account Manager</u>	Address: _____
Employer: <u>Willis of Florida</u>	Phone: _____ Fax: _____
City: _____ State: <u>FL</u> Zip: _____	
AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:	
I authorize release of all medical information necessary to process this claim and is pertinent to my care. I assign all medical and/or surgical benefits including MEDICARE benefits to _____ This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges. I have read this information and understand it.	
Signature of Patient: <u>[Signature]</u>	

Insurance Card Copy and License of the patient:



Patient Demographics entered in SysMed:

Patient				Guarantor		Insurance	
PERSONAL DATA (please print)							
Name: <u>LOUISE LACK</u>		Birth Date: <u>11/5/54</u> Age: <u>47</u> Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Ht.: <u>5'1"</u> Wt.: <u>130 lbs</u>			
Address: <u>7626 Southern Brook Bend #103</u>		City: <u>Tampa</u> State: <u>FL</u> Zip: <u>33635</u>		Social Security #: <u>092-48-6935</u>		Drivers License #: <u>L200 533 549050</u>	
Phone (Day): <u>813-490-6825</u> (Evening): <u>813-854-9082</u>		Mailing Address: <u>7626 Southern Brook Bend 103</u>		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian		<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	
City: <u>Tampa</u> State: <u>FL</u> Zip: <u>33635</u>		Emergency contact: <u>Lauren Lack</u> Relation: <u>Daughter</u>		Phone: (Day) <u>813-20-3392</u> (Evening) <u>813-854-9082</u>		Address: <u>Same</u> City: _____ State: _____ Zip: _____	
This visit is for <input type="checkbox"/> Work related Injury <input type="checkbox"/> Auto-accident <input checked="" type="checkbox"/> Illness <input type="checkbox"/> Other Injury							
How did you hear about us? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Previous patient <input type="checkbox"/> Friend/Family <input checked="" type="checkbox"/> Other physician <input type="checkbox"/> Other _____							
INSURANCE INFORMATION:							
<input type="checkbox"/> Workmen's Compensation <input type="checkbox"/> Auto-accident Case		<input checked="" type="checkbox"/> Private Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> PPC		Insurance Co.: <u>United Health Care</u>			
Insurance Co.: _____		Address: <u>PO Box 20555</u>		City: <u>SALT LAKE CITY</u> State: <u>UT</u> Zip: <u>84130 0535</u>			
Claim Address: _____		Date of Injury/Accident: <u>1/1</u>		Phone: <u>801-842-2060</u> Fax: _____			
City: _____ State: _____ Zip: _____		City: <u>SALT LAKE CITY</u> State: <u>UT</u> Zip: <u>84130 0535</u>		Phone: _____ Fax: _____			
Date of Injury/Accident: <u>1/1</u>							
Patient Account #	<u>L20259</u>	Last Name	<u>LACK</u>	First Name	<u>LOUISE</u>	Middle Initial	<u>M</u>
Address 1	<u>UTHERN BROOK BEND</u>	Address 2	<u>APT#103</u>	City	<u>TAMPA</u>	State	<u>FL</u> Zip Code <u>33635</u>
SSN	<u>092486935</u>	Date of Birth	<u>11-05-1954</u>	Licence #	<u>0533549050</u>	Sex	<u>F</u> Marital Status <u>M</u>
Status	<u>EMPLOYED</u>	Phone #	<u>(813)4906825</u> <input type="checkbox"/> Selfpay	Accept Assignment	<u>Y</u>	Signature on File	<u>Y</u> Send Statement <u>Y</u>
Employer Details:							
Name	<u>WILLIS OF FLORIDA</u>	Address 1	<u>7650 COURTNEY CAMPBELL</u>	Address 2	_____		
City	<u>TAMPA</u>	State	<u>FL</u> Zip Code <u>33607</u>	Phone #	<u>(813)2812095</u>	2 of 29	

SuperBill sample:

Imaging

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LACK, LOUISE
 Date of Service: _____
 DNKA RN _____
 Dictated Written Billed

Office Evaluation and Management:

New Patient	Estab. Patient	Office Cons	Second Opin	Other Codes	Procedure Codes	Other Codes	Procedure Codes	Life Disab	Procedure
99201	99211	99201	99271	99080	IME New	99361	Team Conf. 30 min.	99450	Basic Life
99202	99212	99202	99272	96320	Auth. IME	99362	Team Conf. 60 min.	99455	Work Rel tret
99203	99213	99203	99273	99025	OV w/Proc	99371	Telephone Simple	99456	Work Rel non tret
99204	99214	99204	99274	99050	Alter Hr.	99372	Telephone Intemed	99490	Unlisted E&M
99205	99215	99205	99275	99052	Oper-Ram	99373	Telephone Complex	99600	Insurance Form
MODIFIERS OTHER					99054	99075	Medical Testimony	99658	Emergency
21	Profing	24	Unrelat	25	Separate	32	Mandated	52	Reduced

Office Procedures: Modifier: 50 Bilateral 51 Multiple

Injct	Procedure	New Blsk	Procedure	PT Supr	Procedure	PT Allen	Procedure
20550c	Trigger Point	64412	Spinal Accessory	97010	Hot/Cold packs	97140	Joint Mobilization
20600	Small Joint	64413	Cervical Flexes	97012	Traction	98941	Manipulation (3-4)
20605	Intermed Joint	64420	Intercostal	97014	Electrical Stim	98940	Manipulation (1-2)
20610	Major Joint	64421	Intercostal	97032	Elec. Stim	97124	Therapeutic Massage
64450	Peripheral Nerve	64425	Iliocingal	97024	Diathermy	97112	Neuromuscular Re-ed
64405	Occipital	64430	Pubental	97035	Ultrasound	97250	Myofascial Release
64418	Suprascapular	64445	Sciatic	97780	Acupuncture	97781	Elect. Acceptor.
OTHER				OTHER			

Office Procedures:

Code	Pump	Code	Stimulator	Code	Medication	Code	Supply
96530	Pump Refill	95970	Stim Anal	J1030	Depo Medrol (40mg)	99070	Supplies
62367	Pump Anal	95971	Stim Reprg, Simple	J0702	Celestone (Jmg)	99071	Edu Material
62368	Pump Reprg	95972	Stim Rep, Con, 1Hr	64530	TENS Unit	99070	Cervical Pillow
A4220	Refill R/L	95973	Stim Rep, Con, Ea30m	OTHER		99070	Lumbar Support Bel
J2275x	Morphine	63690	Stim Anal (1998)			90070	Lumbar Support Pillow
J1170	Dilaudid	63691	Stim Reprg (1998)				

Diagnosis:

Spine	Leg/Th	Thora	Cerv	Pain	Code	Neuro	Code	Disease	Code
Pain	724.20	724.1	723.1	Extremity	729.5	PHN	053.13	Rheumatoid Arthrit	714.0
Strain	847.2	847.1	847.0	Abdomen	789.0	RSD, UE	337.21	Polymyalgia Rheum	725.0
Radicalo	724.3	724.4	723.4	Pelvic (F)	625.9	RSD, LE	337.22	SLE	710.0
DD w/v/m	722.10	722.11	722.00	Chest	786.59	Multiple Scl	340	Gouty Arthritis	274.0
Spondylitis	721.3	721.2	721.0	Headache	784.0	Migrain Clasic	346.01	Torticollis	333.83
DDD	722.52	722.51	722.4	Face/Atyp	350.2	Migrain Com	346.11	Chronic Pancreatit	577.1
PLS	722.83	722.82	722.81	Joint	719.40	Trig Neuralgia	350.1	Pancreatic Carcino	157.9
Stenosis	724.02	724.01	723.0	Myofas/FM	729.1	Phantom Limb	353.6	Sickle Cell Crisis	282.62
Sacroilitis	720.2	FJA	721.90	Muscle Spas	728.85	CTS	354.0	Organic writr cramp	313.84
Extremity	Hp/Sh	Kn/Eb	Ak/Wr	Coccydynia	724.70	Marsalgia Para	355.1	Sleep Disturbance	780.5
BursitisUE	726.10	726.30	726.4	Hard	719.44	Diabetic PN	357.2	Depress React Brief	309.0
BursitisLE	726.5	726.60	726.70	Foot	719.47	Anchlooiditis	357.2	Depress React Prole	309.1
Pain UE	719.41	719.42	719.43	Multi Joint	719.49	Meningeal Adh	349.2	Psychosual Dysfn	303.7
Pain LE	719.45	719.46	719.47	Rib	786.50	Tension Head	307.81	Drug Dependence	304.9
Spain UE	840.9	841.9	842.00	TMJ	524.62	Thor Out Synd	353.0	Drug Abuse	305.9
Spain LE	843.9	844.9	845.00	Corp Frac	733.13	PDPH	349.0	Teitz's Disease	733.6
OTHER				Pari Neurop	356.9	Crnia Pain	789.0		

Diagnosis on File: 1. _____ 2. _____ 3. _____ 4. _____
 Today's Diagnosis: Same Add New

Patient: _____ DOB: _____ SS#: _____ DOI: _____
 Insurance: Prim: **UHC POS** Sec: _____
 Ref Phy: **H. J. O'D** Auth #: _____
 Message: **#20, 00** Payment: Full Copy Pt Reso Deduct LOP

Charge Entry Screen with the charges entered:

+ SysMed - [Charge Entry]
_ □ ×

+ Practice Master Transaction FileTransfer Electronic Claim Activities Medical Software Reports Utilities Schedule Help
_ □ ×

LACK, LOUISE
Date/Of Service: _
 DNKA R/S
 Dictated Written Billed

Office Evaluation and Management:

New Patient	Estab. Patient	Office Cons	Second Opin	Other Codes	Procedure	Other Codes	Procedure	Life Disab	Procedure
99201	99211	99241	99271	99080	IME New	99361	Team Conf. 30 min.	99450	Basic Life
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99205	99215	99245	99275	99052	Uptn-8am	99373	Telephone Complex	99080	Insurance Form
MODIFIERS		OTHER		99054	Sun&Holiday	99075	Medical Testimony	99058	Emergency
21	Prolong	24	Unrelat	25	Seperate	32	Mandated	52	Reduced

Office Procedures: Modifier: 50 Bilateral 51 Multiple

Inject	Procedure	Nrv Blok	Procedure	PT Supr	Procedure	PT Atten	Procedure
20550x	Trigger Point	64412	Spinal Agency	97010	Her/Colt	97010	

Charge Entry

Patient Account #

Name

Admission Date Discharge Date

Practice Name

Authorization # Number of Visits

Issue Date Expiry Date

Procedure Entry

Place of Service OFFICE

Type of Service OFFICE

Location ABC SCAN CENTRE

Referring Physician RAFFEL

Provider RAFFEL

Condition Related to

CoPay CHECK#4211 No Charge

Procedure Entry with ICD Codes and Date of Service:

SysMed - [Charge Entry]

Practice Master Transaction FileTransfer Electronic Claim Activities Medical Software Reports Utilities Schedule Help

LACK, LOUISE
 Date/s Of Service: _____
 DNKA R/S
 Dictated Written Billed

Office Evaluation and Management:

New Patient	Estab. Patient	Office Cons	Second Opin	Other Codes	Procedure	Other Codes	Procedure	Life Disab	Procedure
99201	99211	99241	99271	99080	IME New	99361	Team Conf. 30 min.	99450	Basic Life
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99204	99214	99244	99274	99050	After Hr.	99372	Telephone Intermed	99499	Unlisted E&M
99205	99215	99245	99275	99052	Optm-Sam	99373	Telephone Complex	99080	Insurance Form
MODIFIERS		OTHER		99054	San&Holiday	99075	Medical Testimony	99058	Emergency
21	Prolong	24	Unrelat	25	Seperate	32	Mandeted	52	Reduced

Office Procedures: Modifier: 50 Bilateral 51 Multiple


Inject	Procedure	Nrv Blok	Procedure	PT Supr	Procedure	PT Atten	Procedure
70550	99204	99244	99274				

Charge Entry | **Procedure Entry**

S.No	Date of Service	Procedure Code	Modifier 1	Modifier 2	Units	Dx-1	Dx-2	Dx-3	Dx-4	Amount
1.	01-15-2003	99204			1	724.2	724.3	322.9		\$20.00
Total										\$20.00

Payment Entry or Cash Posting:

141MMMPIS10053102



U
2
M

Check No: 55887
 Check Amount: \$671.00 Entered Amount:
 Check Date: 05-10-2003
 Patient Account #: B05019
 Last Name: BURLINGAME
 First Name: MILDRED I
 Insurance: P UNITED HEALTHCARE

Reference No: 452 Allowed Amount: \$40.00
 DateOfService: 02/10/2003 Adjustment Amount:
 Procedure Code: 93000 Paid Amount: \$35.00
 Bill Amount: \$40.00 Balance Amount: \$5.00
 Copay: Denials Adjustments

Responsibility Party: BURLINGAME, MILDRED I
 Primary Insurance Tertiary Insurance
 Secondary Insurance Self

Payment Details :

REF #	DateOfService	Procedure Code	Bill Amount	Allowed Amount	Adjusted Amount	Paid Amount	Balance Amount	RP
359	09/05/99	99241	\$275.00	\$200.00	\$75.00	\$115.00	\$85.00	Balance due fro...
358	09/06/99	40650	\$650.00	\$350.00	\$300.00	\$325.00	\$25.00	Balance due fro...
357	09/07/99	93320	\$250.00	\$176.00	\$74.00	\$74.00	\$102.00	Balance due fro...
356	09/08/99	93325	\$150.00	\$61.00	\$89.00	\$50.00	\$11.00	Balance due fro...
355	09/09/99	93230	\$300.00	\$160.00	\$140.00	\$140.00	\$20.00	Balance due fro...
354	09/10/99	71020	\$75.00	\$38.00	\$37.00	\$30.00	\$8.00	Balance due fro...
353	09/11/99	54800	\$1200.00	\$600.00	\$400.00	\$600.00	\$200.00	Balance due fro...