INDEPENDENT PRACTICE (Internal Medicine)

Introduction

Medicalbillersandcoders have been effective in streamlining the revenue cycle for an independent practice in Fort Myer's, Florida, US. Our efforts have resulted in resolving enrollment issues, filing issues and bringing payments back on track, subsequently reducing the total AR by 32%, thus increasing collections by 71%.

The Client – Background

Independent practice at Fort Myers, Florida which specializes in Internal Medicine

- **Infrastructure**- Own lab and clinic with an in-house technician and Nurse Practitioner working for the practice
- **Approximate Patient visits** - 2500 patients each month
- **Total bills on an average** amount to- ($411,000 per month)
- **Collections on an average** amount to – ($284,000 per month)

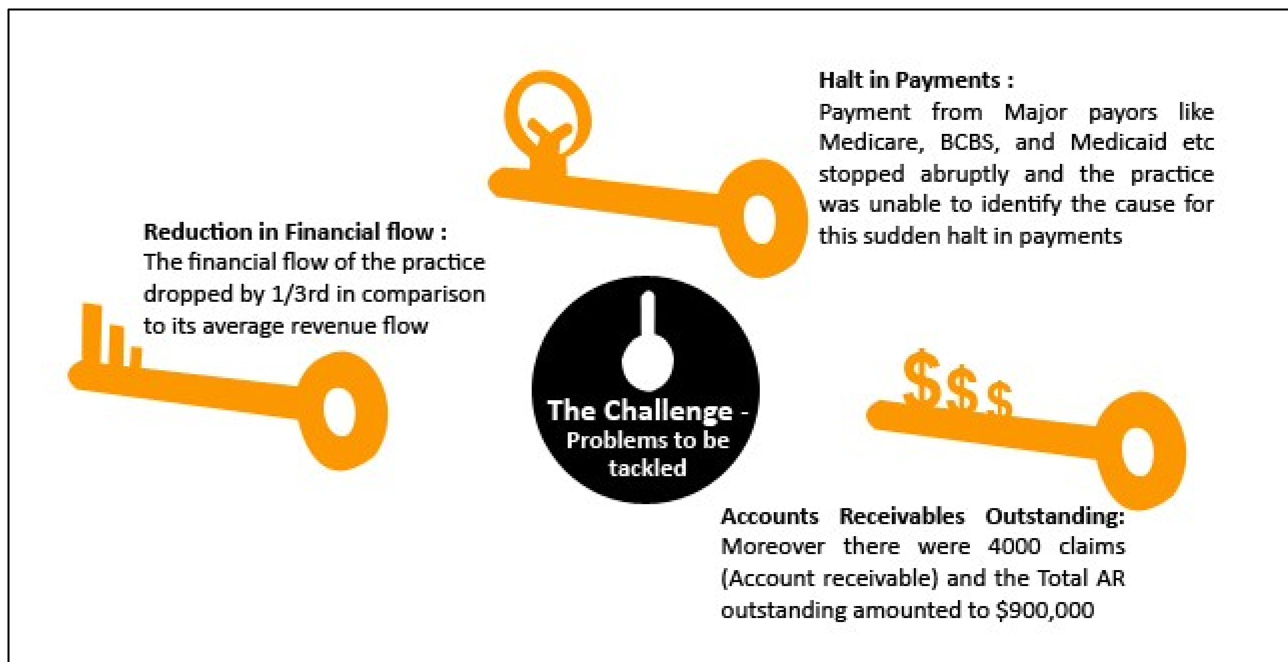

Fig:1 Major Issues with Revenue Cycle

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Challenges

Florida based Fort Mayer clinic suffered from various issues related to claims and other payments related issues following are the summary of the outstanding payments

1. Due to the medical records not submitted **UHC claims** were denied which amounted to a total outstanding balance of **$2,00,000**
2. **Medicare claims** were not being paid and the total outstanding for the claim amounted to **$2,75, 000**
3. **BCBS claims** were not getting paid and the total outstanding was almost **$2,00,000**
4. The major **payor Stay-well paid** their dues but they **were not cashed** and posted into the system.

Other related Issue

- Payors were billed as a Group with claims being billed incorrectly and not filed according the NPI cross walk.
- When the practice tried to change the Group to NPI we found that NPI Cross Walk was not followed.
- On changing the address there was no update with the major insurance payors and the payment checks were going to the old address hence not being cashed
- Not changing Medicare pre enrollment caused the claims to get rejected at the Clearinghouse.
- About $2 00,000 payments were un-posted for various reasons
- Average claims were billed with multiple errors

Our Approach

For resolving issues of Fort Mayer clinic, Medicalbillersandcoders had adopted the winning formulae strategy. The strategy is based on complete process flow followed by various steps till final resolutions.

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Fig:2 The Winning Formulae

Analysis

Initially we identified the major payors to be Medicare, Medicaid, BCBS, UHC, Humana & Cigna. Then each issue was resolved issue step by step which has been briefly explained-

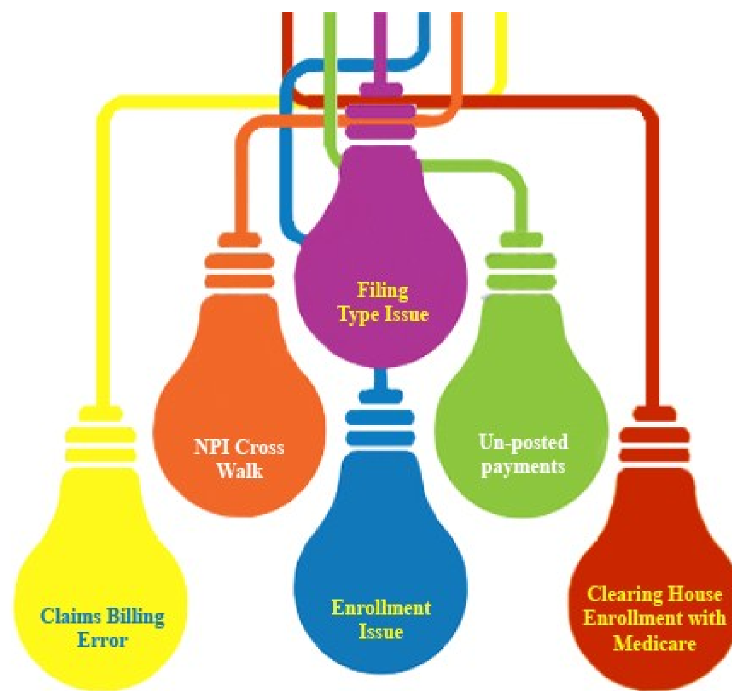

Fig:3 Steps For Resolving Claim Issues

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The winning formulae adopted by Medicalbillersandcoders had solved many issues such as:

Issue	Solution
Payors were billed as a Group with claims being billed incorrectly and not filed according the NPI cross walk.	In resolution to the issue we changed the filing type according to the insurance enrollment system
When the practice tried to change the Group to NPI we found that NPI Cross Walk was not followed.	The application setup was changed
On changing the address there was no update with the major insurance payors and the payment checks were going to the old address hence not being cashed	Medicalbillersandcoders.com contacted the Major payors for change of address
Not changing Medicare pre enrollment caused the claims to get rejected at the Clearinghouse.	Our team fixed the rejections report issue with the clearinghouse
About $2 00,000 payments were un-posted for various reasons	Each issue was carefully analyzed, & the ERA's which were not posted were identified through the AR process & the information was retrieved
Average claims were billed with multiple errors	MBC reviewed the problem with the coding team and provided the necessary changes

Result

MBC Roles Performed:

1. The MBC team worked daily on the rejection process, as there were rejections that had not been worked on for various months- currently all the older rejections have been cleared.
2. Complete denial management by an AR specialist including contacting payors in case of any information required, with a dedicated person working on resolving the denials
3. The AR process involved running the complete aging report every month and also prioritizing the work based on the major payors, major issues, etc. the POA is sent to the practice. Approximately 2000 claims are addressed each month with at least three dedicated AR specialist working on the account.

Our Performance Parameter:

We always measure our performance through the AR breaks down. Please find below a report depicting how we managed to approximately reduce the total AR by 32% (300,000) with the AR decrease in each bucket-

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Month	AGE 0-30	AGE 31-60	AGE 61-90	AGE 91-120	AGE 120+	Total
May, 2015	$295,483.74	$210,035.62	$93,219.73	$113,817.31	$255,294.45	$967,850.85
August, 2015	$200,274.24	$133,259.27	$41,357.49	$37,260.74	$250,037.85	$662,189.59
%	-32%	-37%	-56%	-67%	-2%	-32%

Table:1 Showing Monthly reduction in AR

With aggressive follow-up on each and every claim in AR, MBC managed to bring down the AR by 32%

The AR>120+ remained a challenge due to UHC's outstanding $160,000, a huge documentation fallacy landed into UHC outstanding. MBC has worked on customized appeal letters and proper documentation practices to improve the recovery with UHC.

Result till now..

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Conclusion

The practice is very satisfied with the results and following this MBC has been diligently working towards improving the filing system, reducing the error rates and streamlining all the medical billing functions for the practice.

With currently have an entire team dedicated to the practice including an ongoing research done in terms of any industry changes within Internal Medicine to guide the billing team- so they can work towards achieving maximum collections for the practice while the doctors can be solely looking into patient care.

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