SysMD

Excellence Delivered

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Medical Billing Solutions

- Micro Hospitals
- Urgent Care
- Freestanding ER
- Surgical Center
- Pediatrics
- Other Specialties

Introduction

SysMD is an organization that focuses on delivering full solutions tailored to our clients various Revenue Cycle operations. We have an experienced crew who has worked in countries such as texas, Louisiana, Arkansas, Oklahoma, Alabama, and New Jersey. We have utilized 23 differents of tware systems to perform services for our clients. This includes four different EMR tools, five clearing house portals, various payment portals, lock box tools, credentialing tools, etc. Our recent clients perform a variety of services from Urgent Care, Primary Care, Dermatology, Physical Medicine, Interventional Pain Management, Imaging, Age Management, as well as Telemedicine.

Our staff has performed operations with 100+ well qualified team members with around 15+ remote coders. We are building a core management team that consists of some of the most experienced and knowledgeable individuals in the revenue cycle management industry.

Our laser-focused strategy on operational efficiency and client relationship management is what makes SysMD. different from other revenue cycle partners. Our goal is to expand our services to clients worldwide. We have defined our target client as a client having a minimum of 3 locations in operations.

No company is more focused on the ins-and-outs of the physician revenue cycle than us. We believe that our enduring legacy will ensure the long-term financial stability and profitability of physician practices and health care organizations.

Services

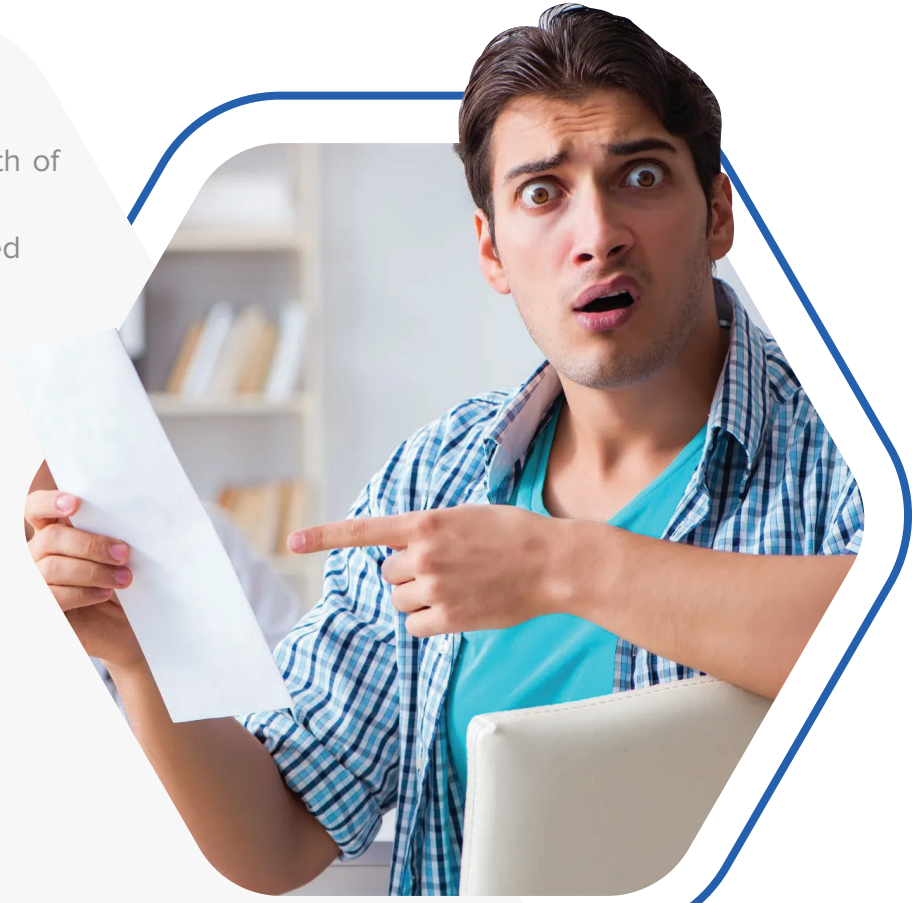
- HIPAA compliant healthcare revenue cycle management company
- Accelerators to overcome process and resource limitations within your RCM
- Our services encompass the whole 360 degree starting from credentialing, Advance eligibility and Prior Authorization to patientstatements
- Specializes in Pain Management, Ophthalmology, Cardiology, Gastroenterology, Pulmonology, Pediatrics, Internal Medical & Lab services etc.

Values

- Provide our customers with exceptional services by focusing on the health of their account recievable.
- Create an awesome place to work where everyone is committed to succeed

Vision

- Help our customers reach their highest level of success
- Treat our customers like family
- Treat their money as our money
- Be the leading experts at what we do
- Pursue excellence in everything we do



Benefits, Services & Strategy

- Superlative Quality and Personalized Service
- Faster Reimbursements and lowest aging
- Strong Denial Management
- Guaranteed Revenue Enhancement
- Result Oriented and Process Driven Company
- ICD-10 and HIPAA Compliant
- Cost Effective -Guaranteed
- 15 Years of industry experience
- Lowest %age of AR
- Ability to Handle Multi-specialty Practices

Advantage Of Outsource

In House Billing

- **Higher Cost**
  It's generally accepted that the expenses of paying billers salaries, covering employee benefits, and purchasing technology systems.

- **Liabilities**
  Medical billing departments can be hotbeds for embezzlement, and general employees can ignore encountered forms, discarded super bills, and un-appealed claim denials.

- **Support Issues**
  Your operations and cash flow can be majorly stalled with even one employee getting sick, going on vacation, taking a leave of absence etc.

Outsourcing Offshore

- **Less Expensive**
  By outsourcing you can reduce your administrative costs considerably and focus on your practice.

- **Transparency**
  A medical billing company should be able to supply you with comprehensive performance reports automatically or upon request.

- **Enhanced Consistency**
  Your outsourcer will be contractually obliged to perform certain services, such as Denying appeals for you with a certain level of success

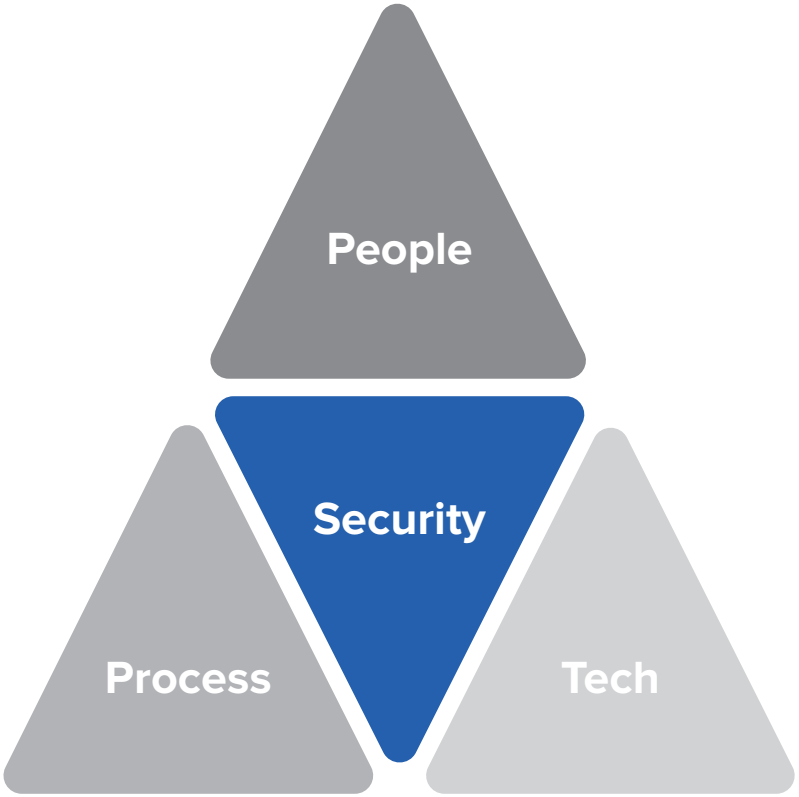
Days in Accounts Receivable

The days in accounts receivable (A/R) measurement represents the average length of time it takes for a claim to be paid based on average daily charge volume. As suggested by Medical Group Management Association (MGMA) , days in A/R should be fewer than 40 days and preferably in the 30- to 35- dayrange.

COMMON FACTORS THAT CONTRIBUTE TO LONGER DAYS IN A/R INCLUDE:

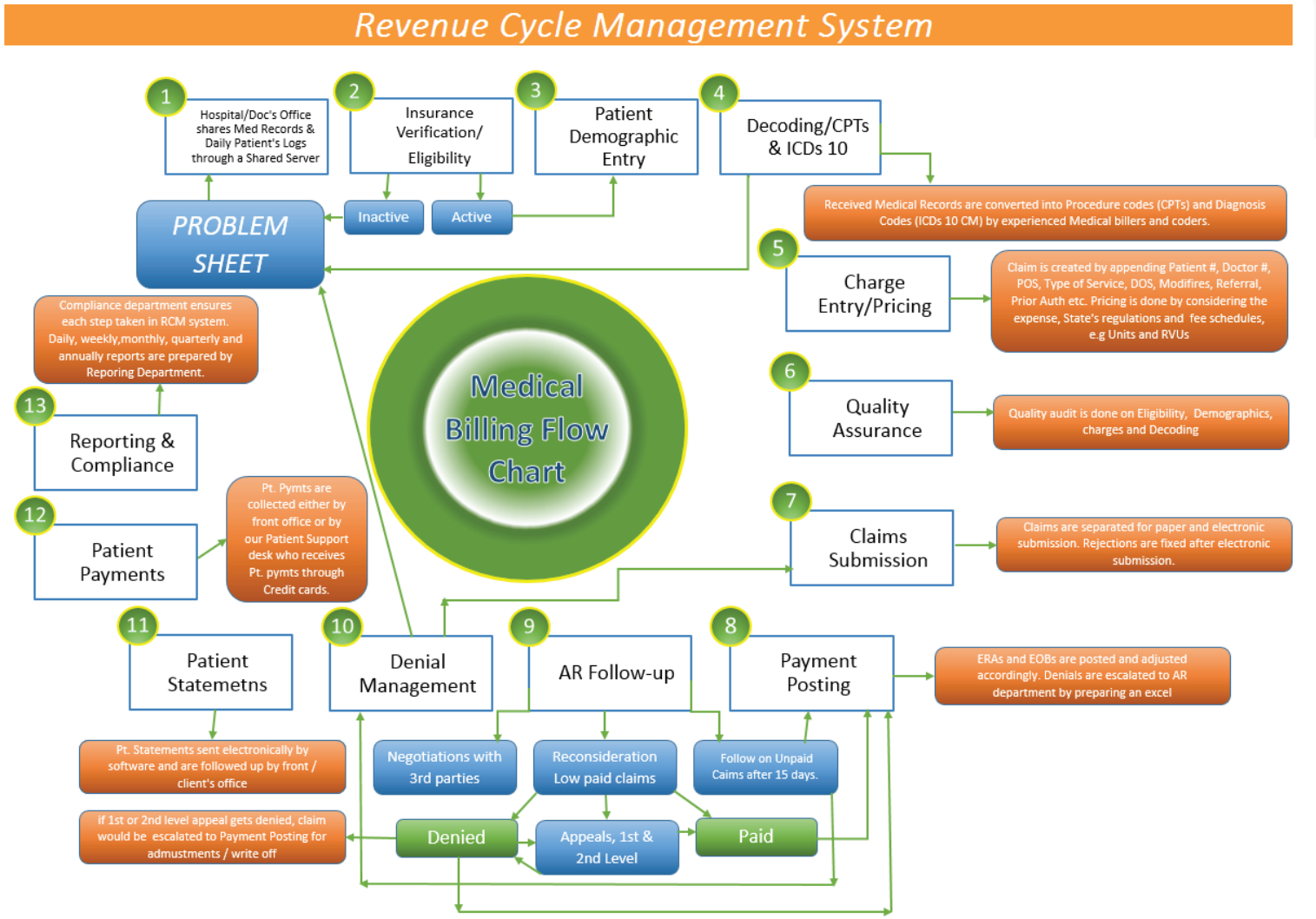
- Increased rejections and/or denials
- Incorrect coding
- Credentialing issues
- Incorrect posting process
- Incorrect appeals process

Our Ultimate Strategy



Process Guide

Process Flow Chart



Process Guide

Process Contents

- Demographic Information
- Eligibility & Benefits Verification
- Pre-Certification/Pre-Authorization Process
- Coding
- Charge Entry
- Denial Management & Accounts Receivable
- OLD Accounts Receivable
- Patient Accounts Receivable
- Payments Posting
- Reporting Weekly, Monthly & Yearly

Eligibility Verification

Importance of Eligibility

- Every patient screened before seen by doctor
- Verified by calling the insurance company
- Office gets report 72 hours prior seeing the patient

WHAT Should you Expect in Report

- Coverage Detail (Active or Inactive)
- Benefits Coverage
- Copay Amount
- Patient previous balances
- Deductible Information (Individual & Family)
- Precertification/Preauthorization
- Referral
- Internal Medicine Practice: 2,000 patients seen on an average in a month
- -3% of claims denied because of eligibility = 60

Average Reimbursement = $95.00

- 2000 x 3% = 60 patients
- 60 x 95 = $5,700.00/Per Month
- 5,700x 12 = $68,400 Annual Loss

Pre-Certification/Pre-Authorization Process

Required information & Documentation

- Approval from the practice
- Insurance information including the policy number, group number and the name of the insurance company
- Detailed diagnosis detailed clinical indications, past medical history (Complete Medical Notes), and the reason for the requested procedure
- ICD-10 and CPT For Authorization
- Frequency of the service
- The Date Range & DOS

Authorization Obtaining Process

- By calling in Insurance Authorization Department or Utilization Management Department
- By Using Web Portal Navinet, Availity or other insurance's own web portal etc.

Medicare Advantages

- Guarantee Reimbursement
- E.H.R Incentive up to $25,000.00
- Increase in monthly revenue
- Increase in Patient traffic
- PQRS enrollment can save 2% penalty on each claim

Credentialing Services For Government & Commercial Insurances

- Medicare & Medicaid
- HMOs & CMOs
- Tricare & Humana
- BCBS Of TX
- AETNA, CIGNA, UHC
- Other Commercials

Coding

- CPT & ICD codes are valid?
- Right ICDs are being linked to CPT according to NCCI edits and LCD/NCD coverage data base
- Incorrect Codes causes denied claims & lower reimbursements
- Procedure Code analysis
- Audit of charts
- Follow LMRP to avoid denials
- Training based on denials or discrepancies found

Charge Posting

- Map daily schedule with the billing received
- Charges posted with 100% accuracy or Received electronically in EHR
- Billing team checks the compatibility of CPT & ICD codes
- Attach appropriate modifiers and change diagnosis order
- Claim scrubbing
- Quality Department validates all claims through software
- Claims submitted electronically & Paper within 24-48 hours
- Proof of submission is maintained for both mediums
- After submission work on clearing house rejections

Reporting

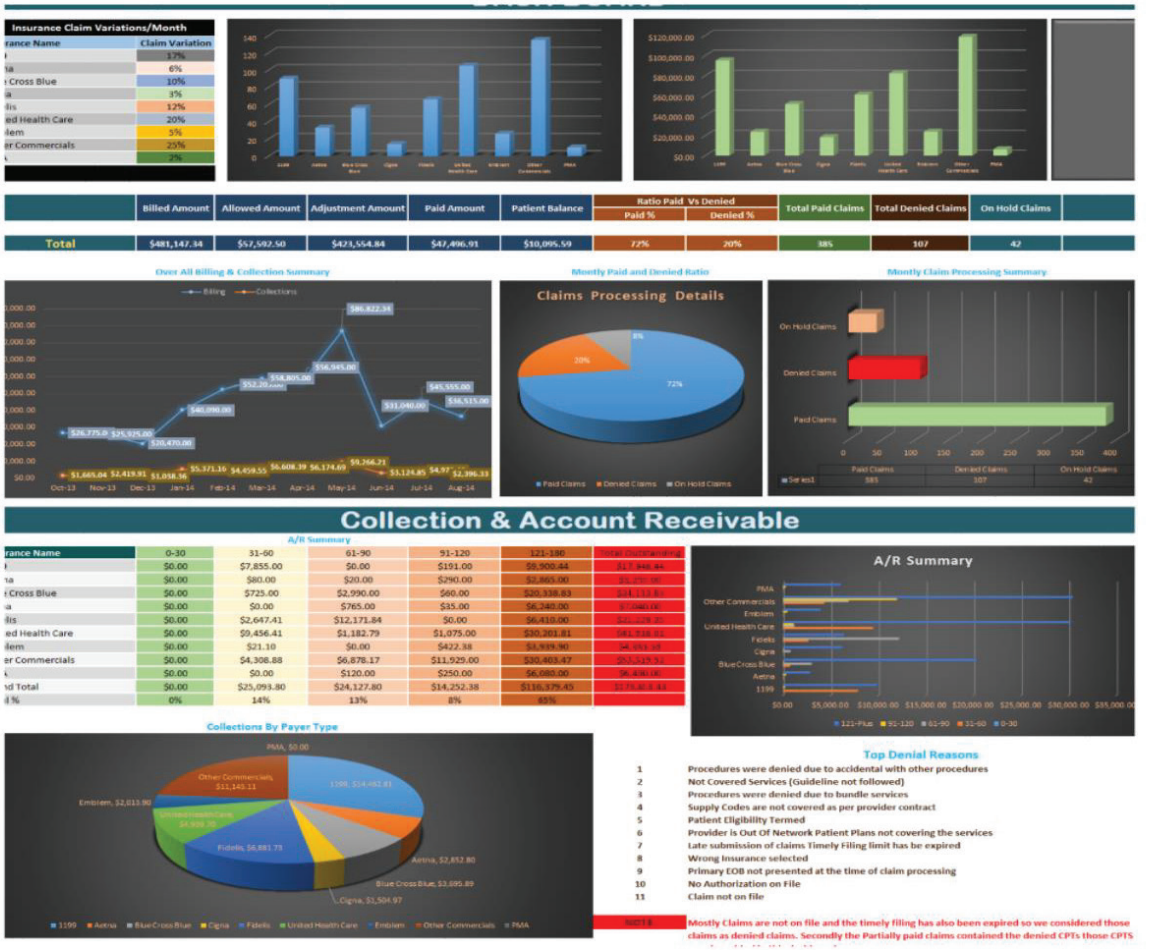
- Daily/Weekly/Monthly report sent to the practice (by patient names)
- Weekly/Monthly/Quarterly/Yearly Billed amount analyses
- Visibility enables you to take financial decisions
- Report by each location and for each provider
- Top CPT code report for each month and number of units billed

*All of the aforementioned reports can be retrieved by practice anytime through system directly

Practice Dashboard

Dashboard Contained following Information

- Insurance wise Claims Count
- Insurance wise Claims Charge Amount
- Total Billed Amount
- Total Allowed Amount
- Total Adjustments
- Total Paid Amount
- Total Patient Balances
- Over All Billing & Collection Summary
- Monthly Paid and Denied Ratio
- Monthly Claim Process Summary
- A/R Summary
- Collection by Payer
- Top Denial Reasons



Account Receivable

- On 14th day of submission – Call on ALL claims
- Acquire claim status to extract the exact denial reason
- Take Corrective actions as per each denied scenario
- Resubmission of denied claims before receiving the EOB/ERA
- Reverse engineer the denials to fix system issues and improve billing process
- Continuous follow up on claims until paid
- Follow CCI edits and LMRP to fix denials
- Call patients to resolve denial issues
- Train practice staff and providers on coding, based on denial reasons
- Continuous monitoring and ensure process is being followed by all parties

Reports

- **Detailed insurance follow up report**
  - Amount Billed
  - Amount Paid
  - Amount Denied/In-Process
  - Patient AR
- **Top 5 denial reasons Report**
- **AR write off report**
- **Aging Report**
  - 0-30
  - 30-60
  - 60-90
  - 90-120
  - 120-180+
- **Insurance Mix Report**
  - Balances outstanding by each insurance
  - How old the balances are?
  - Largest to Smallest payers

Old Account Receivable

- Separate team will be dedicated to the old AR up to 6 months
- Insurance wise segregation
- Analyze Timely Filing Limits
- Segregation of claims by dollar value
- Review Insurance policies and appeal processes
- Calls to acquire claim statuses to extract the “Exact Denial Reason”
- Resubmission of claims after taking suitable corrective actions
- Reprocessing with appeal or redetermination letters
- Notify doctor in case of any additional info required for claim processing

Patient Account Receivable

- Extract a report out of the system for patient balances
- Three statements will be sent
- AR team will start calling the patients
- Work with the patients on installment plans
- Offer discounts
- After all efforts made either we write-off or send the balance to collections agency

Reports

- Total Amount Billed to patients
- Total Amount received from patients
- Number of statements sent to patient
- Follow up report of patients

Payment Posting

- ERA set ups with all payers
- 90% of the payments are auto posted
- Low paid claim analysis and resubmission
- Billing to secondary insurances
- Patient responsibility
- Denied EOB's forwarded to AR department

- **Reports**
- **Insurance collection report**
  - Each office
  - Each provider
  - Billed Amount, Paid Amount
  - Top Payers Report
  - Low paid claims report
- **Patient collections Report**
- **Payment Report for each CPT code –All insurances**

Claims

Denials

Common Denials (Commercial, NF & C)

- Medical Necessity
- Additional Supporting Document
- COB (Coordination Of Benefits)
- No Authorization on file
- Authorization Denied
- Not Covered Services
- Bundle or Incidental Services
- IME (Independent Medical Exam) Failed
- IME No Show
- Peer Review
- Benefit Exhausted
- Medical Director Review
- Inappropriate Modifiers

Credentialing

- New contracts
- Re-credentialing
- Applying for a state license
- CDS certificate
- DEA certificate
- New and renewal of privileges with hospitals and institutes
- ERA/EFT Enrollments
- EDI setups
- Contract rate negotiation for new and existing contracts

Summary of Services

- Appointment Reminders
- Eligibility Verification
- Pre Cert/ Pre Auth
- Patient demographics, coding verification, charge posting
- Electronic & Paper submission
- Payment Posting and Reconciliation
- Secondary Billing
- Account Receivable (Insurance Follow ups)
- Denial Management
- Patient billing (Statements, Reminder Calls)
- Credentialing

Benefits to Client

- Corporate Approach
- Process Driven Company
- More manpower allocated on each account
- Defined KPI's that client can measure
- No cross over in staff
- Absolute transparency with reporting enabling you to take intelligent business decisions
- Increased Revenue
- Reduced AR days (Faster reimbursement cycle)
- Onsite availability of one/two resources

Implementation Strategy

- System Preparation
- Credentialing Status
- Enrollments with clearing house
- Fee schedule finalization (Commercial, Work Comp & No Fault)
- Submission of test claims
- Complete billing submission for last two months
- Complete AR follow ups for past 365 days
- Eligibility & Pre Authwill start 15 days prior to Go Live date
- Entry on last two month billing in system without submission
- Actual billing will go live on the decided date
- One/Two dedicated billing resources will be placed in practice for coordination between billing company and practice to ensure smooth flow

Thankyou

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