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A Study On Financial Management In Healthcare Organizations

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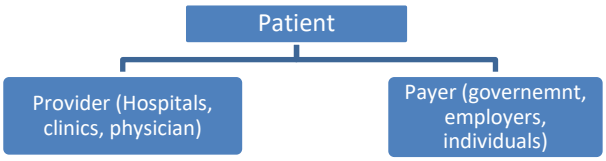
KEYWORDS
Healthcare, Insurance companies, Healthcare Terminology, Financial Implication, Health Insurance, Health Insurance impact on society

ABSTRACT
This paper examines health insurance as a source of healthcare finance from a strategic and business model standpoint. It tracks healthcare financing with the help of the health insurance scheme and to look into developments in the healthcare business and the total disease load. We find that the health insurance market is extremely competitive and that concentrating on key success characteristics might provide insurance firms a competitive edge. The business model for health insurance is distinct, comes in a variety of configurations, and mostly entails strategic decisions and their effects. We provide a list of processes that health insurance providers can use to increase their profitability and secure a long-term competitive edge. We advise insurance businesses to create and implement a cutting-edge business strategy focused on reducing the claim ratio while concurrently raising customer willingness to pay.

1. Introduction

Healthcare facilities are used by the peoples so that they can use it at the time of emergency. The key stakeholder in the U.S healthcare system is the patients, healthcare provider, and payers.

- A patient is someone who is sick or injured and needs medical care. Patients visit physician or hospitals for medical treatment.
- The treating physician and hospitals are referred to as providers because they provide medical assistance.
- In most cases, patients have medical insurance to take care of any huge, unexpected medical costs.
- The health insurance is either sponsored by the government or organization/employer or privately purchased. The government, organization/employer, and third-party insurance providers are known as payers.
- Patients pay a premium to the private insurance providers to ensure that they will be covered when they need to visit a provider. When an insured patient receives medical services from a healthcare provider, the payer is required to pay the medical bill or claim.
- Health insurance in the U.S includes private insurance as well as social and welfare insurance programs for people who cannot afford healthcare. Government- funded programs, such as Medicare and Medicaid, provide insurance to the elderly and low-income groups, respectively.
- The largest groups of people under 65are insured by their employer (or the employer of the family member) while only a small part of the population buys a health insurance on their own. The reminder is uninsured.



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Commencement of Business- 2013

Company headquarters/offices – New Delhi

Product – Legal Advices

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Revenue cycle Management Process-

Any error in the cycle can lead to the provider getting delayed to no payments it all. Most providers turn to RCM companies to collect

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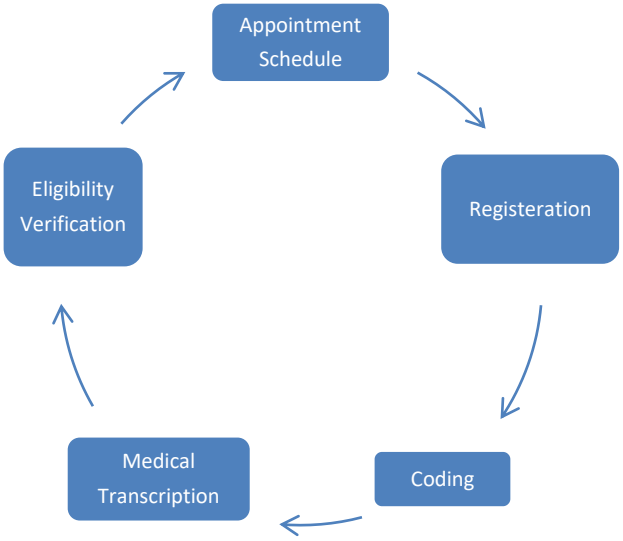
payments effectively, remove errors, and improve the revenue cycle operations.

The key stakeholders in a healthcare system are-

- Patients
- Providers
- Payers

Patients pay a premium to private insurance provider to ensure that they will be covered financially when they need to visit a doctor or hospitals. When an insured patient receives medical services from a healthcare provider, the payer is required to pay the medical bill or claim.



U.S. HEALTHCARE

Patient can have more of 3 policies in U.S and it is mandatory to have at least 1 policy. Every citizen has to pay 26% of tax.

BASIC HEALTH INSURANCE TERMINOLOGY

PROVIDER (hospital)– The physician who provides medical treatment for on illness is the provider. It is called rendering physician.

PAYER- it refer to an entities other than the patient that finance or reimburse the cost of health service in most cases, the term refer to insurance carrier other third party payer, or health plan sponsor.

PATIENT- A patient is any recipient of health care service.

PREMIUM- This is a periodical payment usually, monthly, made to purchase a medical insurance coverage. The premium paid by numerous coverage. The premiums paid by numerous individual to an insurance company contribute to a fund, which protect these individual against the cost of medical care when they require it.

BENEFIT- The money that a patient's medical coverage pays to compensate to the medical service provided to the patient.

BENIFICIARY- A person who is eligible for the benefit under on insurance coverage. He is either the person who pays the premium or dependent.

SUBSCRIBER- the person who pays the premium to purchase insurance policy. This person may either pay the premium himself or in most cases, the person's employer may pay the premium or a part of it on his behalf. It is very common in the US for an employer to provider medical policies for its employees.

DEPENDENT- the spouse and children of the subscriber who eligible for medical care under the insurance contact.

TAX ID NUMBER- A number assigned by the federal government to doctor and hospital for the purpose.

CMS- It is introducein1996 (Center for Medicare and Medicaid number) the federal agency that runs the Medicare program. In addition CMS run with the state to run the Medicaid program. CMS works to make sure that beneficiary in this program are able to get high quality health care.

SSN (Social Security Number) In the US, a social security number is a 9 digit SSN number provided to the US citizen permanent resident and temporary (working) resident (SSN Format XXX-XX-XXXX).

HIPAA- Health Insurance Portability Accountability Act (1996) this federal act sets standards for protecting the privacy of your health information.

PCP (Primary Care Physician)– The PCP is usually a general practitioner. He is the equivalent of a family doctor who when specialized treatment. Is required, refer the patient to a specialist. For this reason he is also called the Referring physician.

Tax ID Number- A number assigned by the federal government to doctor and hospitals for tax purposes. It is 9- digit.

Termination Number- The date on which health insurance coverage ends.

MRN (Medical Record Number)- The number assigned to the patient by the doctor or hospital that identifies the patient's medical record.

Account Number- Number given to the patient by the doctor or hospital for the medical visit.

Effective Number- The date from which a person is eligible for medical benefits under his insurance contracts. The insurance company is responsible for the person's medical bill from this day.

Insurance Identification Number- This is a unique identification number assigned to each subscriber. The claims and any correspondence for that subscriber and his dependent will be sent under his ID. The insurance companies use this number to access the subscriber's account in their computer system.

There are 3 types of insurance-

1- Primary- major part of the insurance.
2- Secondary- process claims on remaining patient response for that they need primary issue of bill.
3- Tertiary- process claim on remaining patient response left by sections for that they need primary + secondary issue of bill.

Coordination of Benefits (COB)-Coordination of benefits is a form to the insurance company and hospitals. COB is a way to decide which insurance company is responsible for payment if you have more than one insurance plan.

Birthday Rule-is a way of decide in which policy baby will be covered among parents. There are several rules for that which is as follows-

1- Among parents whose birthday comes first in calendar.
2- Longer Duration of policy.
3- If parents are divorced legal custody of parents.

In-Patient-a person admitted to a hospital for medical care. When a

patient stays in the hospital for more than 24 hours.

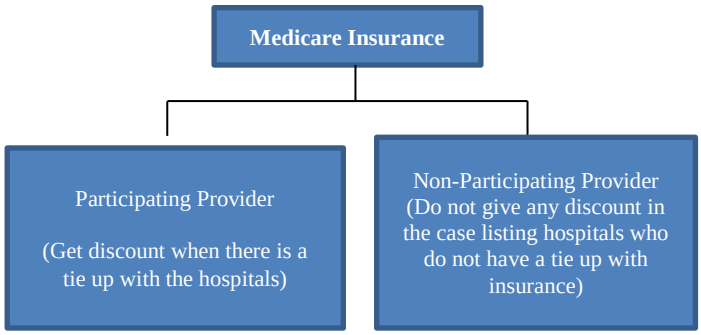
Out-Patient- a person who receives treatment in a physician's office or a hospital but does not require hospitalization. (when a patient stays in hospitals for less than 24 hours).

Insurance Claim Number-a number given to a medical service by insurance company.

Assignment of Benefits (AOB)- It us a legally binding agreements between patient his/her insurance company asking them to send the reimbursement check directly to healthcare provider.

Date of Services (DOS)- the doctor when your payment was provided.

Date of Bill- the date the bill for your service is prepared.



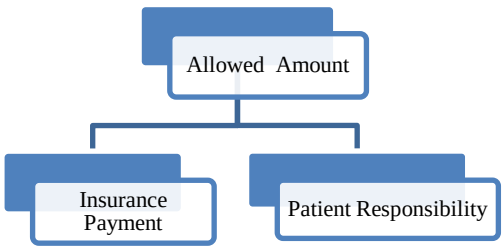
Total billed amount by hospitals - $100.00

Balance bill Provider) ← ↕ → Contractual adjustment - $80.00 (Par

Allowed amount to insurance company – $20.00

Out of Pocket Expenses- a medical bill or a part of medical bill paid by a patient to his own pocket because of non-payment of his insurance company or of instruction from his insurance company is called an out of pocket expenses. Deductibles, co-insurance co-payment and balance bill fall under out pocket expenses. It is a fixed $ amount once this amount meets, insurance companies pays 100% on the claim.

Deductible- this is an initial and fixed amount paid by the patient to the provider as medical expenses before his/her coverage starts paying for the services. Some insurance companies have a yearly deductible which means that money should be paid by patient before his/her insurance stats paying medical bills for that year, other insurance have a lifetime deductibles, which means that the patient will have to pay for his treatment until a certain limit and their insurance would start paying till his coverage is valid.



Purpose of deductible is to avoid the explanation of the policy by the patients.

Cost sharing – Deductible and premium are inversely propositional to each other.

Ex- Medicare Insurance - $12000 coverage
Deductible- $1000
January - $700 (700 deductible patient pay)
February- $500 (300 deductible 200 insurance)
March- $1000 (1000 insurance)

Co-payment- it is a nominal amount that to be consultation fee which a patient need to pay on every visit till out of pocket with an expensed not. Insurance companies use those co-pays in part to share expenses with a subscriber. The concept of giving co-pays upfront helps insurance avoid necessary visit a patient wants to make to a doctor for non-trivial injuries/illness.

Co-insurance- A percentage cost share between a patient and his different insurance payers is called as co-insurance. It is a percentage of the allowed amount that a patient is required to pay which may be in addition of deductible co-pays.

Insurance Payments- is an amount, how much the insurance company pays for the treatment minus any deductible, co-insurance or charge for non-covered service.

Formulae- Total bill- $1000

Allowed Amount= insurance payment + patient responsibility

Par provider = Total bill – Allowed amount

Non-Par Provider = Total bill – Allowed amount = Balance Bill.

For ex- a patient may be covered for $5000 per year for dental surgery. If patient dental surgery bills exceed that amount in a calendar year, he/she will be responsible for the excess.

Referral- approval needed for care beyond that provided by your primary care doctor or hospitals. For ex- managed care plans usually requires referrals from your primary care doctor to see specialists or for special procedures.

Pre-Authorization / Pre-certification- some insurance contracts requires a pre-authorization or a pre-certification for specific services. This is the process of informing the insurance company about a service to be performed. For ex- if a patient comes in for an eye surgery and if his card says that any treatment related to the eye needs to be pre-certified, the desk at the doctor's office will call the insurance company and let them know that an eye surgery is to be performed on the patient. The insurance companies will give a pre-certification number, which is to mentioned on the claim.

Claim Form Types-

1- HCFA 1500/CMs1500 – the Health Care Finance Administration standards form for submitting provider services claims (professional claims) to third party companies or insurance carriers.
2- UB04 (uniform billing) - a standard form used by hospitals to file insurance claims (Institutional Claims) for facility charges, also known as the CMS-1450 form. The federal for Medicare and Medicaid services (CMS) and the National Uniform Billing Committee have approved the UB-04 claim form.

Types of bill (TOB)- a bill that shows what type of care is being billed, such as hospitals inpatient, hospital outpatient, skilled nursing care, etc. there are 3 digit numeric codes used on hospital claims.

Ex- Inpatient (Original Claim) TOB – 111
Inpatient (Correct Claim) TOB – 117
Outpatient (Original Claim) TOB – 121
Outpatient (Correct Claim) TOB – 137

Place of Services- it refers to the physical location where the services performed.

Common place of service codes-

Office (11)
Home (2)
Urgent care facility (20)
Impatient hospital (21)
Outpatient hospital (22)
Emergency hospital (23)
Skilled nursing facility (SNF) (31)
Hospice care (34)
Other place of services (99)

Capitation- capitation is a fixed dollar amount per plan number per month paid to provider regardless of medical utilization. The payment structure shifts the financial risk from the insurance company to the physician or hospital accepting payments.

Ex- Aetna pays Dr. Johnson $20 per month to care for all Aetna patients who have Dr. Johnsons their primary care provider. If Dr. Johnson has 100 Aetna member assigned to him, he will get $200 per month to provide care to the entire member.

ABM (Advanced Beneficiary notice)- is a form signed by the patient, it is a notification to the patient that certain services are non-covered under patient's plan and patient will responsible for those services.

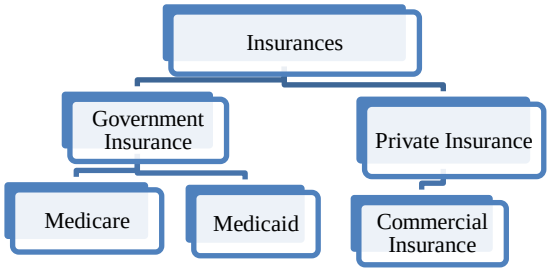
Claim Filing Limit- a time limit under which claim should be filled the insurance companies to qualify for reimbursement. All insurance companies have their own failing limit. The insurance companies would reject the claim/s if they aren't filled or received within the specified time-frame.

Timely failing limit is always calculated from date of services.

Medicare- Medicare is a federal insurance which primarily takes care of the healthcare needs of the elder peoples (above 65 years

It is administered by CMS. It uniform across all the 50 states in US. It is written in 9 voles with suffix Alpha

• Permanent disabled individuals
• End-stage renal diseases.



Medicare Parts-

Part A:

- Facility charges hospitals.
- Inpatient claims.

Part B:

- Outpatient claims.
- Physician charges.

Part C:

- PART A + PART B
- Managed plan choice.

Part D:

- Drug prescription + Durable Medical Equipment.

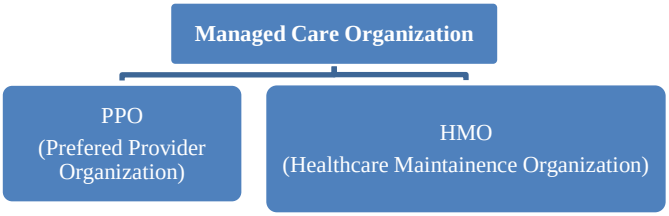
Medicaid-

- It is a federal insurance that is run by the state i.e., norms & guidelines differ from one state to another.
- It is basically for people under poverty line.
- It can never be a primary insurance when the patient has some other insurance with him.
- Income at below federal poverty level.
- Infant born to Medicaid eligible pregnant women.
- Adoption care or faster care assistance programs.

Worker's Compensation-

- It is a program which covers job related injuries and illness.
- Employees who meet their employment related accidents are covered to have their medical costs as well as be entitled for ability.
- An employee takes up the insurance and pays the premium for the policies.

Commercial Insurance- Are the private insurance companies associated with various health care providers and provide Medical Insurance to Individuals in terms of fix premium.



PPO (Preferred Provider Organization)-

• Purchased through employer and employee.
• Large pool of doctors.
• Deductible are present.
• PCP not required.
• Co-payment absent.

HMO (Healthcare Maintenance Organization)-

• Purchased through employer and employee.
• Limit pool of doctor.
• PCP required.
• Co-Payment present.

Ex- BLUE CROSS BLUE SHIELD, AETNA, US HEALTHCARE, UNITED HEATHCARE, OXFORD, etc.

Medical Transcription-

The transcriptionists listed to the recordings dictated by physician and other health care professionals over the tape and transcribe them into

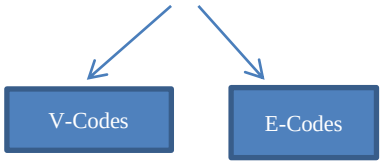
medical reports, office notes, consultations and operative reports.

Coding-

Codes given by the Coder can be broadly classified into two types, procedure & diagnosis-

1- Procedure Codes- represents the procedure/treatment or service done to the patients.
2- Diagnosis Codes- represents the Nature of illness/injury details.
3- It is valid till 09/20/2015
4- It is in 3 digits codes or may requires 12 digits after decimals.

Ex- 4B6 – Pneumonia (3 digits)
401.9 – hypertension (4 digits)
780.50 – chest pain (5 digits)



Preventive code — External injuries

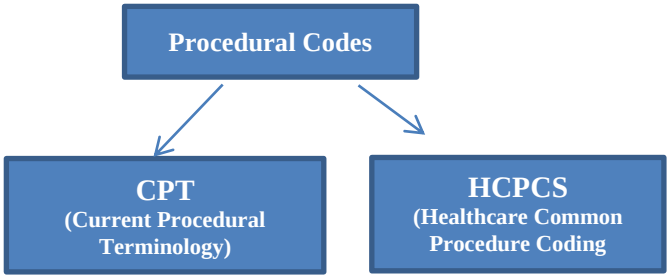
Ex- Cardiac pacemaker — Ex- Dog bite – E605.00

ICD – 10 –

- Effective from 10/01/2015

Format - S 11. 011 D

Contain up to seven characters.



- Numeric codes.
- 5 digits. Ex- 12345 (Capsule tablets)

Healthcare Common Procedure Coding System-

Is commonly referred to as HCPCS codes. It was established in 1988 as a way to standardize identification of the supplies, materials and equipment's, etc. which are not included in the CPT. For ex- injectable drugs, wheelchairs, oxygen, dental, etc.

- Update annually by CMS
- Alphanumeric codes
- Where 1st character is an (A-V), followed by 4 numeric characters. Ex- A1234.

Modifiers-

Are two digit numeric/alpha numeric/ alpha codes which are added with the procedures codes to alter services without changing the procedures codes.

Global Surgical Fee-

- 0-90 days for minor surgery.
- More than 90 days for major surgery.
- A global surgical fee includes all the necessary services performed by the physician before, during and after surgical procedures.

VNA (Voice Accent Analysis)

Expectations-

- Training- all training contents covered with having proper knowledge should know about to each and every employee. Also understanding of user's related queries or issues to know how to resolve by the proper training given.
- Batch- corporate with everyone/s should clear their all the doubts if his/her feel so.
- Trainer- should have proper knowledge with giving examples, clear own doubts.

There are several questions also-

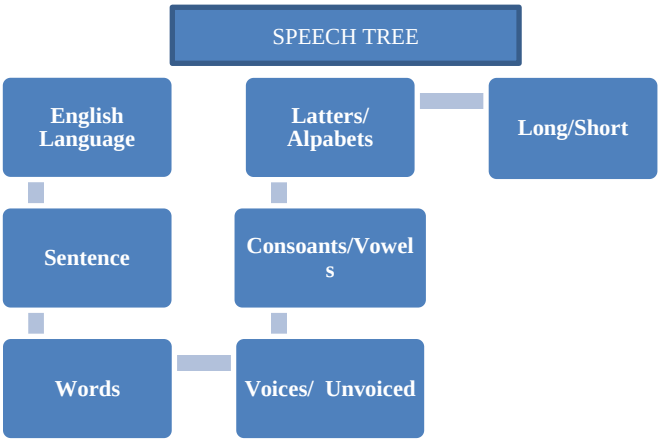
- What is an Accent?
- What is a Neutral or Global Accent?
- What are the challenges faced if not spoken in neutral accent?

1. It is a way of speaking languages with proper pronunciation.
2. An Accent which shows sentence is speaking or Translation of words in global Accent.
3. If not speaking in neutral accent then,

Several issues occurs-

- Unable to understand the problem.
- Not ready for probation parts.
- Unable to find solution.

Therefore, it affects the business needs.



TOOLS

AR Follow Up-

AR (Account Receivables)- we need to following with insurance through different source, like call and website on a submitted claim to know its status.

There could be several status of the claim like payment promised, in-process/pending or derived for any reasons, so maintain jobs on AR executives is to take out the maximum payment from the insurance company on a claim and make the balance zero. Also generate the revenue for the process.

Note- first we need to go through the websites to know claim status, in

case we don't have a websites for a particular payer then we need to call to insurance company to known its status.

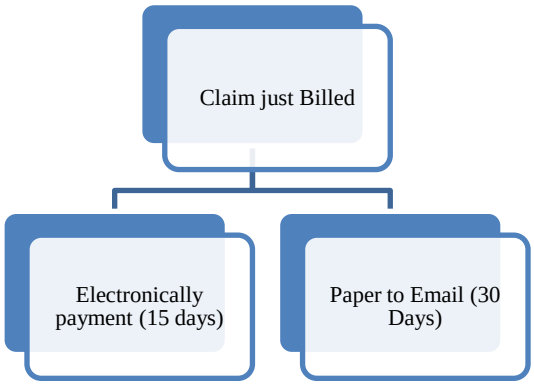
Overview of Tools-

- R1 Decision (R1D)
- Host
- Clearing House and scrubber.
- Electronic Medical Record (EMR)
- E-premise
- Insurance Company Website - Avidity.

R1D-

- Patient demographics – patient name + Date of Birth – Address – Contact details.
- Insurance Details.
- Hospitals Details.
- Total Billed Account.
- Employment and Eligibility.
- Insurance Eligibility.

The host system is a tool on which the onshore (CBO- Core Blended Operations), offshore (BSO- Blended Shore Operation Team), Hospital works.

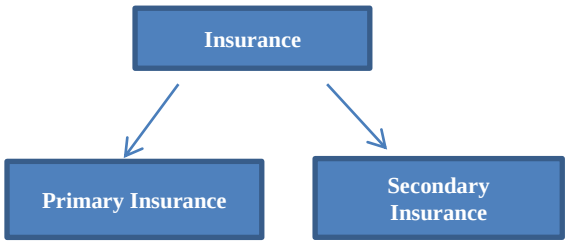


There is a need to ask questions in this scenario.

Timely filling is calculated form Date of Services (DOS).

Claim denied for medical records –

- We need to ask which type of medical records they need to process claim form.
- Need to confirm the Fax no., contact number or mailing address to send medical records.

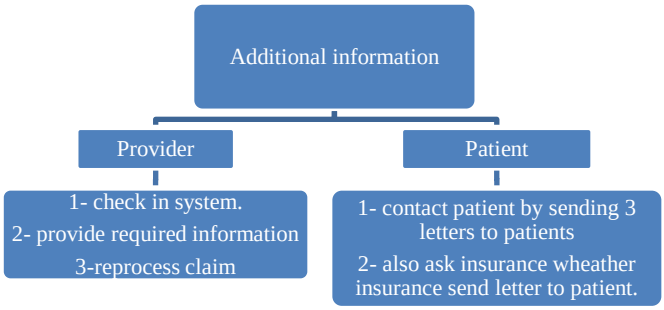


Primary Insurance-

- Other visits in hospitals to conform primary insrance.
- Call to insurance ask representative which insurance is primary.
- Contact patient by sending 3 latters to patient for COB updates.

Secondary Insurance-

- Primary EOB is missing
- Check host forprimary EOB
- Reprocess claim.



Capitation-

Is a fixed dollar amount per plan member per month paid to provide regardless of medical utilization

- Pre-Existing conditions- pre-existing conditions are those conditions which already exist in patient before his/her medical coverage starts. For ex- if patient has a disease like diabetes then for a certain period of time it will not be covered under the policy and the period in which the insurance company does not cover his/her is called as the Waiting Period.

Encounter Tab-

1- Account- In BST we have studies. it represents MRV (Medical Record Number)

2- Encounter- It represents the single visit.

3- Status- a) - Active – Pending balance on insurance. It is workable.

B)- History – If account is already resolved it is non-workable.

4- ABN –

ABN is a form which is sign by patient. It is the notification to the patient that certain services non-covered under potential plan and patient are responsible for those services. (Advance Beneficiary Notice)

4- Hold-

5- a) - Yes- need to check hold sheet.

B) – No- workable.

5- Activity Summary –

- When was the last charge update?
- Compare latest charge with claim form charge.

6- Current Responsibility- It shows on which insurance we need to do follow up.

7- Insurance Pending Balance- it is an outstanding balance on which we need to follow up from insurance.

8- Patient Balance- it contain the patients let over responsibility.

9- Total Balance- we never consider total balance from encounter tab.

10- Statement Cycle- it contain any information any statement sent by the hospital to the patients.
11- Co-payment – is a form of payment for which is responsible for patient balance. It is the part of consultation fees.
12- Granter- is a legal guardian of policy holder or the legal policy holder it. Age is 18 years minimum or if it is 18 years.
13- Begin Date- starts date when a patient get admit in the hospital.
14- End date- when patient got discharge to the hospital.
15- Financial class- it shows the primary insurance information.
16- Type class- types denote the place of service. Ex- office visit, emergency.
17- Outpatient – less than 24 hours visit in the hospital.
18- In patient- more than 24 hours visit in the hospital.
19- Recurring Account- in this Account we never change insurance plan. It is a therapy Account in which encounter will some follow up multiple visit number.
20- DRG- Diagnoses Related Groups. It is payment method or fee method used for inpatient billing by insurance company.
21- Medical Services- the type of service patient take from the hospitals.
22- Location- location represents the physical locations were service performed.
23- Discharge Location- it is a location from where the patient got discharge it may vary.
24- Billing Entity- billing entity and Billing provider shows the hospital name for which we are billing.
25- Admitting and Attending Physician – both represents the performing physician information.
26- Primary Diagnosis Code- it shows for which purpose patient visits to the hospital.
27- Health Plan- it shows the primary plan

Question- where all we can check performing physician information?

BALANCE TAB

Question – What all information we can get in balance tab?

1- We can Check Sequence of primary, secondary or territory?
2- Self-pay line is balance bucket amount received from patient or amount Bill to patient.

Question – What action can be performed?

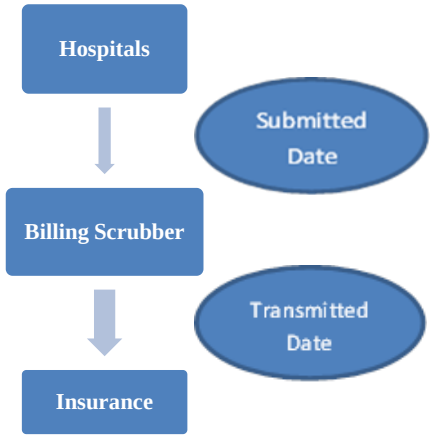
Bill to Patient
Bill / Rebill to insurance
Take Back Amount from patients (self-pay)

CLAIMS

Question – what all information we can get in claims tab?

1. How many times claim bill to insurance.
2. - Red color – Institutional.
   - Black color - Professional.

3- **Internal Claim number -** it is generated by IMH to receive paper or electronic EOB.
4- Total charges is reflect Total bill amount.
5- Check Insurance payment
   - Contractual Adjustment.
   - Patient Responsibility.
6- **Submitted Date –** It is a date when claim is resolved from hospital to Billing Scrubber.



7- Transmitted date- it is a date when claim is released from billing Scrubber to insurance.
   - Action.
   - Apply / Take Back contractual Adjustment

CHARGES

Question- What all information we get in charge Tab?

1- ! Late charge determine
2- $ Credit Suppressed – any line or charge which is deleted by error Due to Billing error and it will not be the part of claim.
3- HCPCS, CPT, Revenue Code, Number of Code, DX, Modifier, NDC (National Drug Code).
4- Performing Physician
5- Action- Single Charge Adjustment.

INSURANCE TRANSACTION

It is also known as Mini EOB.

1- Insurance Payment – Start from 1, 4 Digits.
2- Contractual Adjustment- Start from 2,4 Digits
3- Patient Responsibility – 1 Digit
4- Denial – 2 or 3 Digit

SELF – PAY TRANSACTION –

1- Information get –
   - How much amount we have received from patient with alias (parting code)
   - Patient transaction with code
   - What all information you will get in self-pay transaction tab.

STATEMENT TAB-

Question – What all information you get in statement tab?

1- Any statement which is send by the hospital to patient will be reflected under statement tab

BILLING HOLD TAB

Question- What all information we get in Billing Hold Tab?

1- Whatever hold we get on account is described under billing hold account.
2- We can check the description of hold under billing hold tab.

CORRESPONDANCE

Any correspondence which is issued by insurance company to hospital will be reflected under correspondence tab

IMAGE TAB

Question- What all information we get in image tab?

1- We can get electronic EOB.
2- 2 ID cards
   - Insurance ID cards
   - Patient ID cards
3- ABN Letter
4- Authorization Letter
5- Appeal Letter

Net Reimbursment Amount = Insurance Paymnet

Revenue Code → Which Department Service is Performed?

Always in Hospital Bill

ICN- insurance Claim Number.

- It is permanent
- Issued by the Insurance Company
- Net Reimbursement is insurance payment.
- EOB
- Hospital Name
- Insurance Name
- Patient Demographics
- Contractual Adjustment
- Treatment Charge

HCPCS → Injectable Form
CPT → Capsule and Tablets
Dx → Primary Illness

TIMELINE TAB

Question- What information we get in this-

- R1D is Directly Mapped with Icentra (in timeline Tab)
- Is there is any coding issue then we apply hold and after getting response, we remove hold.
- Client Response
- Complete notes of single visit.

WORKFLOW TAB

1- We can remove hold from Workflow tab after getting response in timeline tab.
2- For rebilling we have to remove hold first.
3- If hold is there then account cannot be released.

RELATED ENCOUNTER TAB

In related encounter tab we can check history of other visits of the patients.

Steps to Bill Amount Tab

If bill to patient then move to Bill Tab
↓
Select insurance line
↓
Right click change status to complete

If we bill to Secondary insurance then-

Check Patient EOB
↓
Right click
↓
Bill to Patient

- To check patient responsible, we can check in-
  - EOB
  - Claims tab.

Question - What all information we get in R1D-

- Patient's information.
- Patients demographics
- Financial information
- Notes information
- R1D and Icentra is inter-related tool.
- In claim and remittance we got EOB

We get SSN no. in-

- Patient last name
- Registration Accounting Tab
- R1D

Uncategorized / Potential deficit-

We select U/PD in-

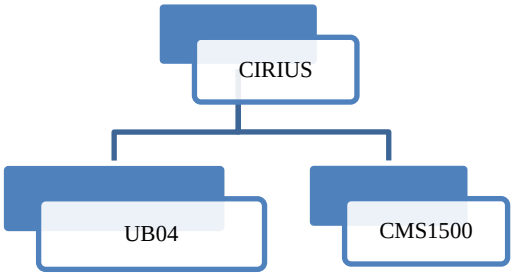
- Bill to patients
- Claim in process
- Contractual Adjustment
- Claim is paid / payment promised.
- Claim just billed
- Rebill/ bill to insurance.

OTG – it is a paper EOB. It is software to review paper EOB throw internal claim number.

CIRIOUS LOGIN

Steps to Login Cirious

- Username and password
- Email address though which we will login



Take back amount from Patient (self-pay)

Go to Balance Tab
↓
Select self-pay line
↓
Right click to Transfer Bill
↓
Add Amount
↓
Benefit Correction
↓
Click on Ok

Bill / Rebill to Insurance (step1)

Go to Claim Tab
↓
Select the Insurance Line
↓
Right click Cancel/Deny

Bill / Rebill to Insurance (step 2)

Go to Balance Tab
↓
Select Insurance line
↓
Generate Claim
↓
Validate
↓
Exit

Status of Clime Tab

1. Denied Pending Review-
   We have EOB Icentra need to verify EOB details for further action.
2. Submitted- billing scrubber to insurance.
3. Transmitted Date- Billing Scrubber to insurance.
4. Denied / Cancel – Rebill claim.

HOLDS

1- If we have any coding issue – HCPCS/CPT/Modifier/Revenue Code/Number of Units/NDC Charge Issue.
   R1- Revenue Integrity department. It code is 6001, take care of all the issue regarding coding like HCPCS, CPT, etc.
2- Dx Issue – (1020) (HIM)
3- LAB Service – 866 (HBS) it is the name of department.

Capitation

Capitation is a fixed Dollar amount per plan member per month paid to provider regardless of medial utilization.

Pre-existing condition

Pre-exiting condition is those conditions which already exist in patient before his/her medical coverage starts. For ex- if potential has a disease like diabetes then for certain period of time it will not be covered under the policy.

Member not eligible on Date of Service

- Effective Date
- Compare effective date with DOS

There are 3 scenarios

A. If patient is eligible on Date of Service then reprocess the claim.

B. We check other visit if found insurance bill direct to that insurance.

Steps to Create Work item

Go to encounter level
↓
Select Identify work item
↓
Add Alias (6001/1020/866)

- Case Study- Check patient age and cross-verify it with age limit.
- If it falls in the age limit, ask to reprocess the Claim.
- If it does not fall, send the claim to onshore coding team for further follow-up.
- Call reference#.

Claim just billed

Whenever DFB is less than processing time by a payer then we need to take those accounts under claim just billed categories.

Claim denied as Procedure Code is inconsistent with the Provider type-

- Denial Date and Claim#.
- What is provider type?
- Call reference#

Case Study-

A. If provider type and CPT/Diagnosis code is appropriate, ask representatives to reprocess the claim.

B. If provider type and CPT/Diagnosis code is not appropriate, send the account to Onshore Coding team for further help.

Information we get in Claim Tab

- How many times claim is billed?
- Insurance payment, contractual adjustment, patient responsibility
- Internal claim number- is a number which is generated by IMH to review paper or electronically EOB.
- Submitted date
- Transmitted Date

Information we get in charge Tab-

- late charges
- To check total balance
- Reverse code, HCPCS, etc.

Information we can get in Medical chart

Go to Task
↓
Power chart
↓
Notes

Steps to Resolve work item

Go to work Flow tab
↓
Select Hold Line
↓
Right Click Apply Action Code
↓
Add 105 (Resolve)
↓
OK

How to resolve incorrect Work item-

Go to work flow tab
↓
Select hold line
↓
Right click on Apply Action Code
↓
Add APR (approve add 105 database),
Add comment and then click on Ok.

Comments

As per timeline notes dates 8/01/2019, correct Dx 418.177 is already update. Hence, rebill the claim from claim tab.

Steps to apply / Take back Contractual Adjustment-
Check insurance transaction tab for insurance payment ALIAS

Go to Claim Tab
↓
Select Insurance Line
↓
Right click Apply Adjustment
↓
Add Amount
↓
Alias (of C.A)

Select to apply / take back single charge adjustment-

Go to Charge Tab
↓
Select Charge Line
↓
Right click Apply Adjustment
↓
Add Amount
↓
Add Alias
↓
Ok

Steps to apply / take back 25% discount to patient

Denials → Services non-covered under patient plan (PR= 204, PR = 96)

Go to encounter level
↓
Apply Adjustment
↓
Add amount
↓
Add Alias
↓
Ok

Conclusion

Health care is the important part in the companies. The Medicare and Medicaid is the organization which provides the insurance policies to the citizen for their welfare. The various claims processes and their denials is the process which involves in the insurance company.

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Declaration:
I have got training from R1RCM and learned all the process from all there. Thank you so much for getting all the information.

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