YOUR CLINIC LOGO

SAMPLE BILLING AUDIT

Billing Analytic Summary

Prepared By

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PAYER COLLECTIONS - LAST 6 MONTHS

Period	Collections-Insurance	Collections-Patient	Total Collections
November 23	$166,450.13	$31,295.46	**$197,745.59**
December 23	$202,485.69	$30,544.75	**$233,030.44**
January 24	$197,944.85	$34,62.52	**$201,407.37**
February 24	$210,333.10	$32,352.65	**$242,685.75**
March 24	$166,434.65	$36,636.82	**$203,071.47**
April 24	$145,472.94	$34,344.54	**$179,817.48**

Total amount collected past 6 months: **$1,257,758.10**

Total visits billed in past 6 months: **13,028**

Average reimbursement per visit: **$96.54**

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HOW IN TOUCH BILLING CAN HELP IMPROVE THE AVERAGE COLLECTIONS PER VISIT FOR YOUR CLINIC

- ✓ At In Touch Billing, we calculate the average collection per visit per payer each month for your clinic, and identify ways to improve this metric.
- ✓ We review every clinical record to ensure clean claim submission, and to minimize denials.
- ✓ A team of coders review every claim to make sure all appropriate modifiers are applied, units are billed as per payer guidelines, CCI edits, LCD are in place and ICD-10 codes reflect a high degree of specificity. This allows us to collect the maximum allowed amount every single time.
- ✓ If a patient‘s benefits reach the maximum threshold for a specific payer, we bill another payer (when applicable) or bill the patient to avoid loss of revenue.

HOW IN TOUCH BILLING CAN IMPROVE THE AVERAGE COLLECTIONS PER VISIT FOR YOUR CLINIC

- ✓ We review the payment for each CPT code, identify the highest and lowest paying payers, payer denial rates, and make recommendations to increase the average reimbursement per visit.

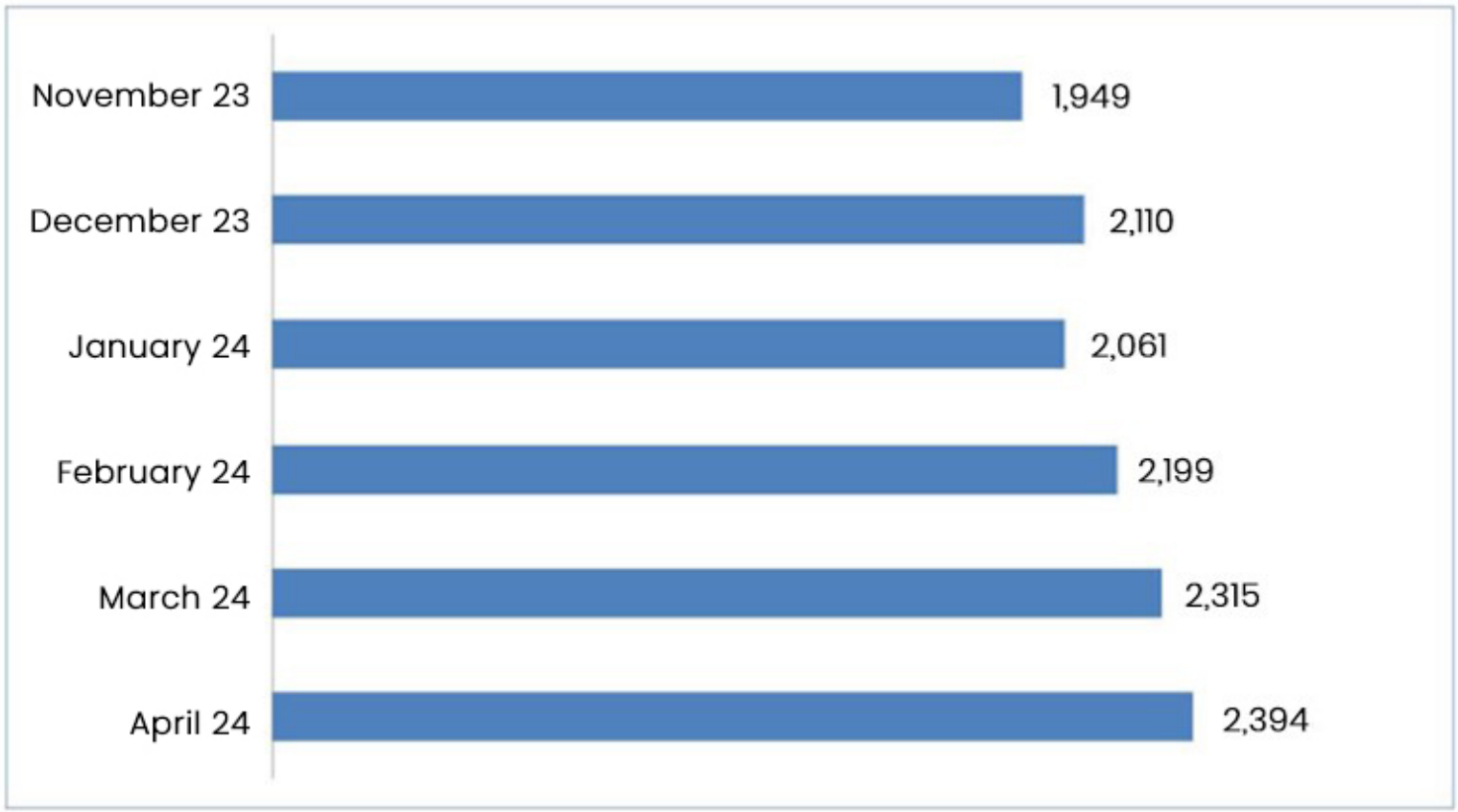
- ✓ Once an EOB/ERA denial is received, our denial management team acts quickly to fix the issue and get the decision reversed with email, phone and certified mail follow up every 5 business days until the claim is paid.

- ✓ Annual contract renegotiation to maximize revenue - A dedicated payer contract renegotiation expert will analyze your current reimbursement rates, compare it with our benchmark data, act as your 'personal PR representative', and 'remarket' you to payers to renegotiate rates. An increase in your reimbursement rate is a win-win for both sides.

THE FOLLOWING METRICS REVEAL IMPORTANT TRENDS FOR YOUR CLINIC.

DATA WAS ANALYZED OVER THE PAST 6 MONTHS NOVEMBER 2023 – APRIL 2024

NUMBER OF VISITS



Average Patient visits per month is 2,171

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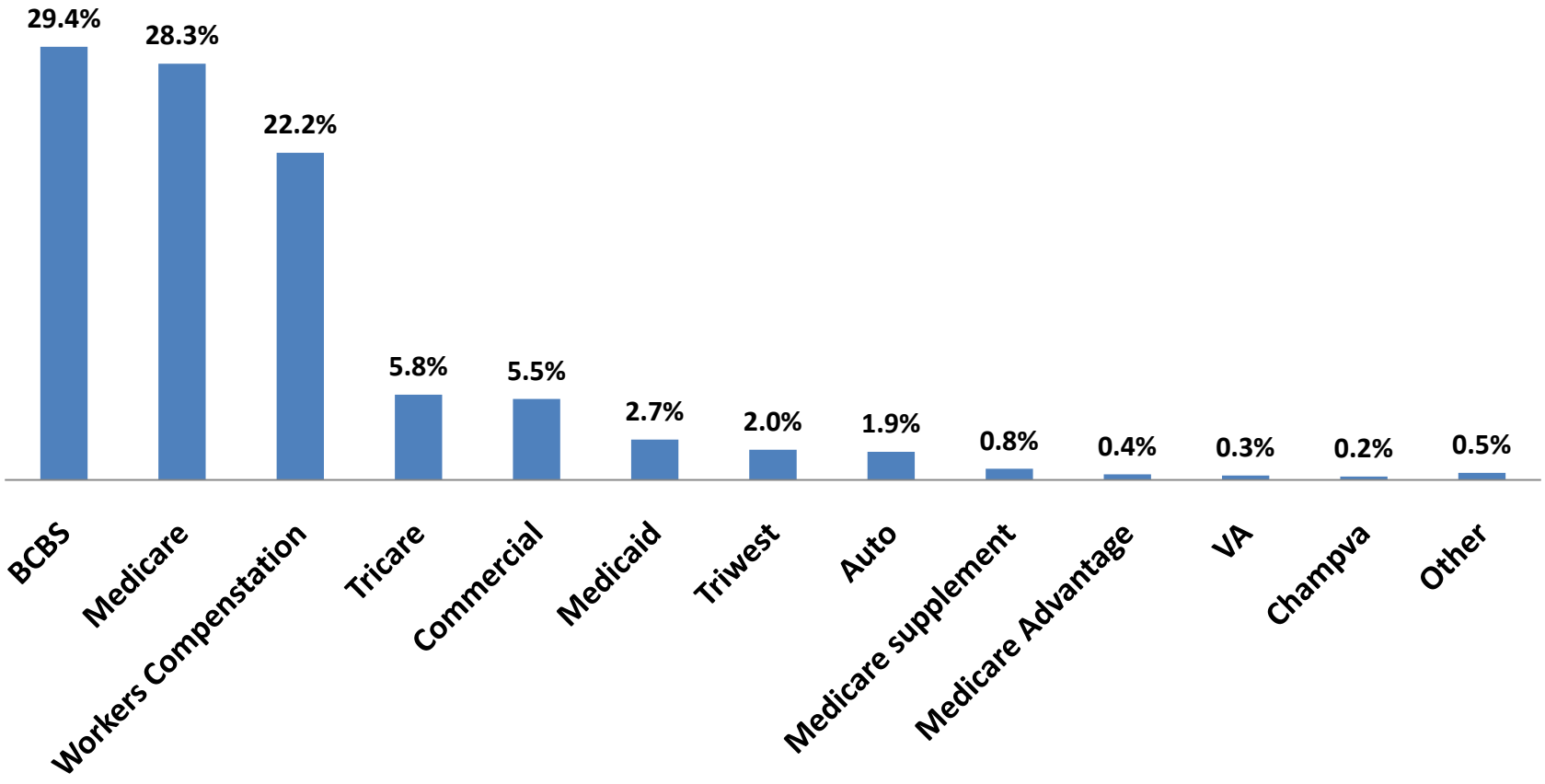
REVIEW OF PRACTICE REVENUE WITH PAYER ATTRIBUTION (HIGH TO LOW)

Insurance -Type	AR Balance	% of Business by payer type
BCBS	$172,704.21	29.4%
Medicare	$165,946.71	28.3%
Workers Compensation	$130,438.33	22.2%
Tricare	$33,987.25	5.8%
Commercial	$32,252.32	5.5%
Medicaid	$16,082.10	2.7%
Triwest	$12,016.23	2.0%
Auto	$11,219.10	1.9%
Medicare supplement	$4,485.05	0.8%
Medicare Advantage	$2,232.55	0.4%
VA	$1,758.00	0.3%
Champva	$1,350.51	0.2%
Other's	$2,796.41	0.5%

TOP 10 PAYERS BY REVENUE (HIGH TO LOW)



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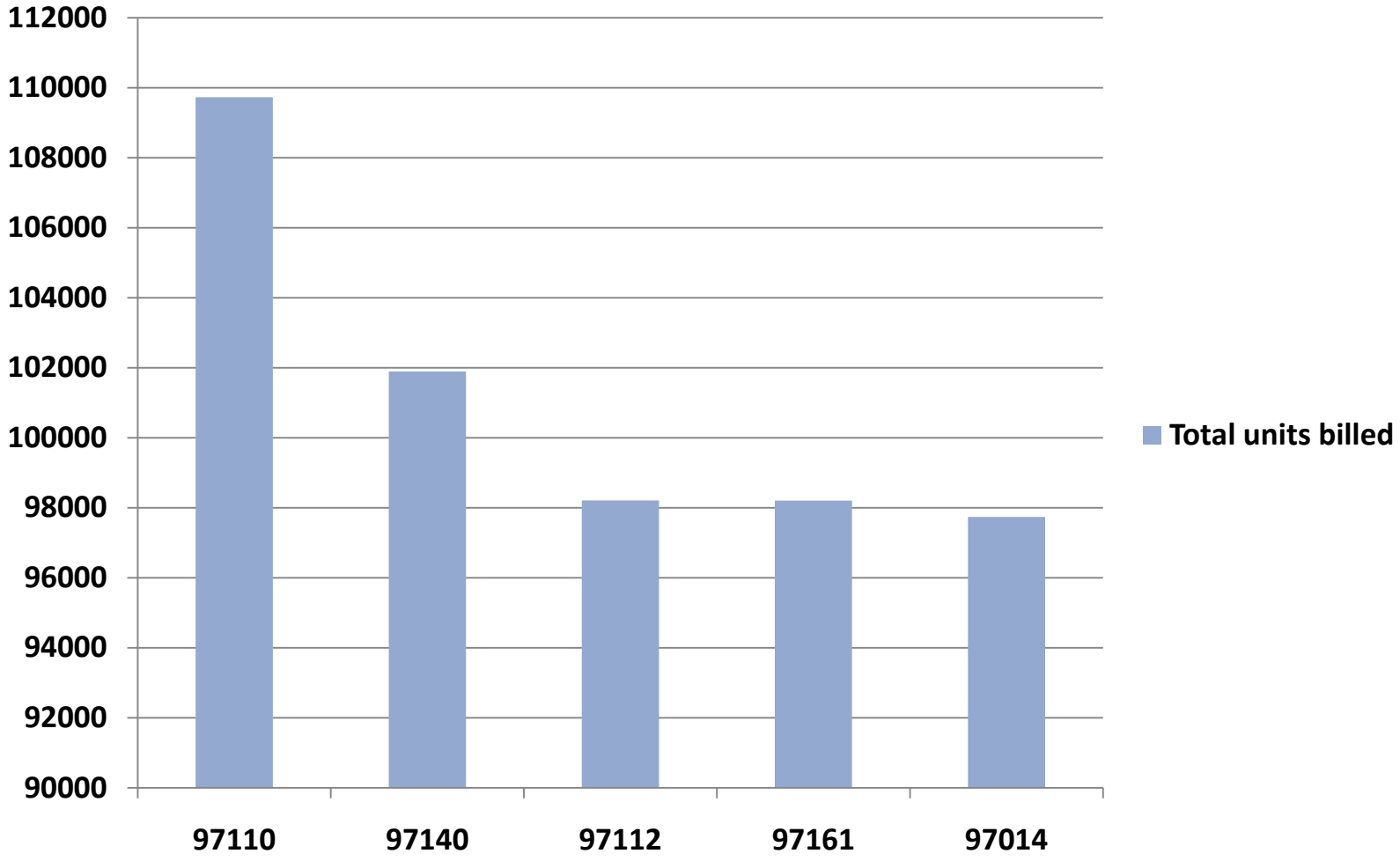
TOP 5 CPT CODES BILLED



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TOP 5 DENIAL REASONS FOR YOUR CLINIC

- DENIED FOR AUTHORIZATION
- DENIED FOR MEDICAL RECORDS
- DENIED FOR MAXIMUM BENEFIT REACHED
- DENIED FOR CLAIMS SUBMITTED TO INCORRECT PAYER
- DENIED FOR MISSING REFERRAL /DAILY NOTES

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AR BY AGING – OVER HALF A MILLION DOLLARS

Current	31-60	61-90	91-120	> 121	Balance
$269,528.26	$75,616.73	$28,688.45	$14,700.38	$191,483.53	$580,017.35
46%	13%	5%	3%	33%	

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ALARMING STATISTIC – 33% OF YOUR CLAIMS IN THE ABOVE 120 DAYS ARE UNPAID

1 IN EVERY 3 CLAIMS ARE UNPAID

ABSENCE OF REGULAR CLAIM FOLLOW UP – THE EFFORT IS SUB-STANDARD

Your biller is not following up with most claims. Most claims do not have insurance call notes in the billing software. These call notes are critical references for future follow ups. We follow up on all submitted claims on day 7, day 14, day 21 and day 28 after the claim is e-submitted/mailed.

Solution:
$47,000 is in limbo with DMERC alone, without any documented follow up. In Touch Billing has been working with DMERC for over 5 years and we have collected over $4.7 million dollars from DMERC and we have dedicated points of contact with them. Quick and proactive effort is needed, now. The longer your clinic waits, the more likely your clinic is to exceed the timely filing limit for these claims.

IRREGULAR CLAIM FOLLOW UP – THE EFFORT IS INCONSISTENT

There are unpaid claims for the following payers (and no documented follow-up):

DMERC Region D, BCBS, WPS VA, Medicare Part B Idaho, Medicaid Idaho, WA L and I, Medicare Part B Washington, Sedgwick Vista Outdoors, Nimiipuu Health, Travelers, Sedgwick, Intermountain Claims, Liberty HealthShare MCS, WA State Hospital Assn, Workers , Compensation Exchange, Christian Healthcare Ministries, UMR Wausau / UHIS and GEICO.

Solution:
At In Touch Billing, we call payers to check the claim status of all submitted claims at regular intervals. If we are not paid by day 28, we threaten to complain to the OIG, and we get a prompt response. We follow up aggressively on every single unpaid claim at regular intervals, until the claim gets paid. We prioritize and work on all unpaid claims based on AR aging, the dollar value associated with the claim, and proximity to the timely filing limit of that claim. Every month, a scheduled AR call meeting with your clinic will take place to discuss the status of the AR claims and best practices. Your existing biller is doing none of this.

BILLING ERRORS

MEDICAL RECORDS MISSING - HUMAN ERRORS COSTING YOU $$

For the payers Sedgwick, CCMSI, Montana State Insurance Fund and ESSI, many claims have been denied for the reason “Medical records not received”.

Examples : James Smith, Maria Garcia, Michael Thompson

Solution:

At In Touch Billing, we recognize this is a common problem with several Auto/WC payers. We have a standard protocol to call these payers (including the use of certified mail) on day 7, 14, 21, 28 after paper claims are mailed. This reduces delays in claims processing.

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BILLING ERRORS

CLAIMS SUBMITTED TO INCORRECT PAYER/REGION – HUMAN ERRORS COSTING YOU $$

There are many BCBS, WPS and TriWest claims submitted to the incorrect payer. Your biller did not verify the claim mailing address / electronic payer ID # before submitting payment. This could have been easily avoided.

Examples : Maria Hernandez, John Smith, Charles Brown and Jay Jailani

Solution:

At In Touch Billing, we verify pre-authorizations for every patient. If any discrepancies are identified, we call the payer to verify the correct mailing address/e-Payer ID before submitting a single claim. We have a 100% success rate of submitting claims to the correct payer at all times. We do all the due diligence on your behalf.

BILLING ERRORS

CLAIMS SUBMITTED WITHOUT REFERRAL / DAILY NOTES – THE EFFORT IS INCOMPLETE AND COSTING YOU $$$

There are several claims denied by Medicare and Employee Benefit Management Svc, on account of “Absence of a proper referral / daily notes”.

Examples: Lisa Johnson, Rosemarie William, Steven Daniel Brown , Mark Williams, Maria Lopez

Solution:

At In Touch Billing, we submit referral notes for all claims to Medicare, since this is a primary requirement by CMS to process claims. For Employee Benefit Management Svc, referral order and daily notes are both primary requirements. Your current biller continues to make this mistake.

BILLING ERRORS

CLAIMS SUBMITTED WITHOUT VERIFYING AUTHORIZATION APPROVED VISITS / UNITS – HUMAN ERRORS COSTING YOU $$

BCBS, WPS, WA L and I, Triwest, Nimiipuu Health and VA Fee basis have denied several claims. This is unfortunate because the biller did not verify the number of visits / units authorized by the payer, prior to submitting a claim.

Examples: Michael Jones, Sarah Smith, Williams Davis

Solution:

At In Touch Billing, a dedicated charge entry executive verifies the approved visits/units (if applicable) authorized by the payer, for the applicable procedure codes. We only submit a claim when we have all the necessary data points and all 200+ items in our 'internal checklist' are verified.

BILLING ERRORS

INCORRECTLY SUBMITTED CLAIMS WITH DME CODES – LACK OF KNOWLEDGE OR EXPERTISE WITH DME CODING

Several claims with DME codes were incorrectly billed to Medicare and Medicaid. They should have been submitted to DMERC.

Examples: Miller Lopez, Davis Taylor

Solution:

At In Touch Billing, our billers and coders are experts on how to submit claims with DME codes under Medicare / Medicaid guidelines.

BILLING ERRORS

BENEFITS MAXIMUM REACHED – A COMMON ERROR WITH A SIMPLE SOLUTION THAT'S IS MISSING CURRENTLY

Payers BCBS, Safeco and Cigna PPO claims have been denied on account of "Benefit maximum reached".

Solution:

At In Touch Billing, we are proactive in communicating with your clinic about such situations. We provide recommendations and collaborate with the clinic to make a joint decision. We proceed to rebill the appropriate payer or bill the patient. The goal is to avoid exceeding the timely filing limit and getting you paid.

CODING ERRORS

MISSING MODIFIER FOR REPEATED PROCEDURE – THE BILLER DID NOT ADD THE CORRECT MODIFIER, THEIR MISTAKE COST YOU $$$

Several claims for ID State Insurance Fund have been denied on account of duplication. Some patients had two different cases, but only one was paid and the second was denied since it was a 'duplicate'. Your billing service should have appended modifiers 76 / 77 to make sure both claims are paid, like we would have done.

Examples: Anderson Smith, David Lee

Solution:

At In Touch Billing, our certified and experienced coders will examine each claim for modifiers and CCI edits. We also follow LCD, bundling and unbundling procedure codes by appending modifier 59, and we ensure the use of specific ICD-10 codes to avoid denials.

CODING ERRORS

DID NOT APPEND KX MODIFIER – THIS ERROR CAUSED DENIALS AND POTENTIALLY COST YOU TENS OF THOUSANDS OF DOLLARS

There are several claims denied by Medicare since they were billed without the KX modifier. The biller/coder has not verified the therapy cap limits for 2019 prior to claim submission.

Examples: Thomas Smith, Harris Johnson, Rachel Young

Solution:

At In Touch Billing, our coding team verifies the therapy cap limit for each date of servic and appends the KX modifier as needed. Only then do we submit claims.

CODING ERRORS

BILLED INCORRECT CPT CODE FOR MEDICARE

The coder has billed CPT 97014 for Medicare which is not a code accepted by Medicare. Medicare alternative code G0283 should have been used G0283 instead of 97014. Several Medicare claims have been denied for this reason.

Example: Allan Walker

Solution:

At In Touch Billing, you get a trained team of billers and coders. Coders are abreast with all current Medicare coding regulations. Regular training programs are conducted to help keep staff current with latest changes/updates in coding.

CODING ERRORS

PAYMENT POSTING ERRORS

Payments from Medicare (primary) not posted for 257 claims.

Solution:

At In Touch Billing, our payment posting team reviews all paid ERAs and EOBs, and if a particular ERA is not received, we ask the payer to provide a duplicate copy of the ERA. This allows us to post payments for the appropriate claims as quickly as possible.

TO GET STARTED:

NITIN@INTOUCHBILLING.COM

973-797-9286

TO REQUEST A SERVICE AGREEMENT

SUGGESTED START DATE : 6-1-2024.

WE WILL MANAGE ALL CLAIMS POST-START DATE
AND ALL PRE-START DATE CLAIMS ALSO.

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