Clinicspectrum
Empowering Cost Effective Workflow

Accounts Receivable

ACCOUNTS RECEIVABLE FOLLOW-UP

Our A/R Follow-Up service is designed to increase revenue collection for physician offices. The process begins after the doctor's biller creates and sends health insurance claims (electronic/paper claims or manual HCFA forms) to various insurance companies. Depending on the transmission type and length of time since submission, we begin our follow up:

Electronic Claims: Follow-Up begins 10+ days after submission

Paper/HCFA Claims: Follow-Up begins 20-45 days after submission

There are two types of claims that require a Follow-Up:

1. No remark claims: Any claim in which absolutely no status is known for the claim.
2. Last remark claims: Any claim which remains unpaid for various reasons. These claims are routinely followed up on a monthly basis.

The Follow-Up process is divided into 3 methods:

1. Online Claims Follow-Up – Using various Insurance company websites and internet payer portals, we check on the status of outstanding claims.
2. Automated Claims Follow-Up (IVR) – By calling Insurance companies directly an Interactive Voice response system will give the status of unpaid claims.
3. Insurance Company Representative – If necessary, calling a "live" Insurance company representative will give us a more detailed reason for claim denials when such information is not available from either websites or automated phone systems.

Once the Follow-Up process has begun, Denied Insurance claims will require extra effort for resolution. Denials management is divided into two categories:

1. Claim Correction and Resubmission: These are the claims which are corrected, modified, and resubmitted as a corrected claim to insurance companies. For such claims every effort is made to resolve the denial to avoid billing the Patient.
2. Patients' responsibility: These are claims which cannot be further worked upon and the final bill is sent to the patient for payment collection. The reasons for sending the patient a bill generally include in-network deductibles and non-covered benefits as per the insurance plan/policy. Patients will receive a statement with a clear explanation for the balance due.

Denial Management

DENIALS AND APPEALS MANAGEMENT

Our Denials and Appeals Management service is designed to increase revenue collection for physician offices.

OUR EXPERTISE INCLUDES MANAGING DENIALS FOR THE FOLLOWING REASONS:

- AUTHORIZATION ISSUES
- REFERRAL ISSUES
- MEDICAL NECESSITY AND MEDICAL RECORDS REQUESTS
- NON-PARTICIPATION WITH INSURANCE NETWORK
- TERMINATED INSURANCE
- COORDINATION OF BENEFITS
- WRONG DIAGNOSIS
- INCLUSIVE PROCEDURES
- PARTIAL PAYMENTS
- OUT-OF-NETWORK CLAIM STATUS AND DEDUCTIBLES
- EDI REJECTIONS
- LETTER OF PROTECTION FROM ATTORNEY CASES
- NO STATUS AND NO CLAIM ON FILE
- WORKERS' COMPENSATION
- PIP CASES

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