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Infotech

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End to End Billing Service for Radiology Practice

Our client is located in Florida with 25-year experience and has been at the forefront of diagnostic imaging. Their team of 15 experienced radiologists performs diagnostic procedures, interprets diagnostic images, and works with healthcare providers to diagnose medical problems. With five locations performing CTs, MRIs, ultrasounds, and a wide range of other specialized diagnostic imaging procedures every day, it's crucial for office staff to be able to effectively manage billing and compliance operations.

The Situation

Average charge: Around $800K per month with AR days of 112
Percentage of aged AR above 90 days: Close to 47%
Collections per month: $150K

- Several claims were on hold for want of provider numbers and it was well past the normal processing time of the carriers.
- Since the doctors in this practice were hospital based, several patients, the insurance information obtained through interface was incorrect.
- All country claims were transferred to patient responsibility
- Due to inconsistent follow up on accounts receivable several claims has crossed the filing limits with the carriers

Our Strategy

Credentialing: We found that several claims were on hold for want of provider numbers for Medicaid, Blue Cross Blue Shield and Railroad Medicare and it was well past the normal processing time of the carriers and still provider numbers were not received.

- We followed up with RR Medicare and found that the providers were not enrolled with the group. We filled up the necessary application forms and submitted to the carrier after which we received the RR MCR number. We then submitted the claims and got them all paid.
- With respect to BCBS, two providers did not have provider numbers. We again filled up the necessary forms, submitted them to BCBS and got the provider number. We then resubmitted the claims and got paid.
- Regarding Medicaid, one provider did not have provider number. Upon completing the enrollment form we got the provider number and all claims got paid. In addition, we took up the non-federal carriers and wherever we are non-contracted we filled up the necessary application forms and got the providers contracted with the carriers for prompt payments.

Interface: Since the doctors in this practice were hospital based, they had an interface with the hospital for patient demographic entry into the billing system. In this scenario we identified that for several patients, the insurance information obtained through interface was incorrect. We escalated this issue to the client and obtained access to hospital database and then found that they had the historic insurance information and not the current information sent via the interface. After several discussions with the hospital administration this was corrected and we started receiving correct insurance information through the interface.

County Claims: These claims were never getting paid before we took up this account and all claims were being transferred to patient responsibility. We had the client set up a meeting with the County Administration and after several rounds of talks the county administration agreed to pay for the claims in bulk, periodically. We now regularly receive payments from the County.

RESULTS

- The 90 plus AR percentage reduced drastically from 47% to 22%

- Collections increased from $150K per month to $280K per month with the charges still remaining at an average of $800K per month

- Our team worked diligently and we brought down the AR of this Radiology account from $3.1 million to $1.6 million

- With Oakridge InfoTech handling AR and full service billing, our client was able to allocate all their time and effort into patient care. With extra time on their hands, they were even able to administer their services to more patients

- We managing the end to end billing of our client, reduced their operational cost by 65%

- The medical billing specialists at Oakridge InfoTech were able to remove the variations associated with the client's backlogged medical claims and employee proceeds

- Above all, of the $13 million worth of charges that were entered in 16 months, we wrote off only around $8000 for claims denied for late filing.

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Effective Follow up: The major flaw that we found in the earlier billing was inconsistent follow up on accounts receivable. We found that several claims had crossed filing limits with the carriers. But through our appeals departments we appealed all those claims and majority of them got paid. We have a system wherein we set reminders for subsequent follow-ups and ensure that each claim is paid. All denials are appealed to the carriers appropriately. We ensure that we follow up all claims over 30 days and keep transmission rejections below 2%. We also enrolled ourselves with various websites wherever applicable for checking eligibility and claim status.