Peace of mind
with our Strategic Medical Business Solutions

VISION INFONET

MEDICAL
CODING & BILLING

www.vinfonet.com

Vision Infonet Inc. is legendary in contributing high quality Medical Coding and Billing Services to healthcare providers across the United States. We have dedicated team of certified coders and billers who have expertise in providing highly accurate as well as compliant coding & billing services to clients for several years.

Our Coding team comprises of CPC (Certificate of Professional Coding) credentialed coders certified by American Academy of Professional Coders (AAPC) who ensure compliant coding in accordance with NCCI (National Correct Coding Initiatives) and LCD (Local Coverage decision and medical policies) as per the rules set for each state across the country.

- Highly experienced billers certified by AAHAM (American Association of Healthcare and Administrative Management)
- Highly experienced in Accurate and Convergent Billing in compliance with HIPAA (Health Information and Portability Act)
- Experienced in different segments of billing like Super bill Analysis, Claim Submission, Practice Analysis, denial management, etc
- Dedicated in delivering complete billing services
- Striving for a stabilized Practice Revenue System for the healthcare providers

BILLING CYCLE

01 SCHEDULE CONFIRMATION

02 INSURANCE VERIFICATION

03 SUPERBILL ANALYSIS & CHARGE ENTRY

04 CLAIM SUBMISSION

05 PAYMENT POSTING

06 PRACTICE ANALYSIS

07 INSURANCE FOLLOW UPS

08 DENIAL MANAGEMENT

PRACTICE ANALYSIS

A complete practice analysis is done by our billing team on the Revenue cycle of the practice. In this analysis, a detailed report is prepared and submitted to the client. The type of claims and underpaid will be targeted. Reasons for rejection, denial, or underpayment are outlined. A report on how the denials can be improved and thus reimbursement increased will be discussed and implemented.

SCHEDULE CONFIRMATION AND INSURANCE VERIFICATION

Patient Schedule Confirmation

Vision Infonet is well experienced in providing efficient and effective scheduling process that reduces physicians', administrative staff and patients' dissatisfaction.

It is a call made to patient as a reminder of his/her scheduled appointment. Our experienced callers communicate with patient/patient relatives to remind about the date and time of an impending appointment. Our callers are trained to handle the message conveyed according to the patient's age and nature of problem.

We call the patient 48 hours prior to the scheduled appointment. If the patient is not available, we leave a voice message or a message to the receiver of the call. We again attempt to reach patient 24 hours prior to the scheduled appointment..

Insurance Verification

Vision Infonet can help practices expeditiously reduce their Accounts Receivables and increase revenue by significantly reducing the impact of ineligibility, and increase the number of "clean" claims sent to insurances. ("clean" claims are both complete and are of patients who are eligible for benefits.) Our Verification Team plays a vital role in curbing the claim denials and bringing in more money to the health care providers in the first shot. Less number of denials equal more number of clean claims, which makes a healthy collection practice, leading to a higher inflow of payments in lesser time.

Insurance Verification Service includes

- Verifying Primary and Secondary insurance coverage by phone calls or websites like WebMD, Payer Web, etc.
- Contacting patients for any clarifications
- Obtaining Pre-Authorization Number by phone or fax
- Obtaining referral from PCP
- Reminding patients about POS collection requirements
- Informing patients about coverage or authorization issue

BILLING

Superbill Analysis and Charge Entry

- Coding the Diagnosis and the Procedures.
- Checking the compatibility of the diagnosis with the procedure code.
- Checking for the modifiers in relation to the procedure.
- Assuring best quality before the generation of the claim.
- Accurately assign diagnosis and procedure codes for reimbursement and statistical purposes

Claim Submission:

Once the procedure and diagnosis codes are determined, our billers will transmit the claim to the insurance company (payer). This is usually done electronically by formatting the claim as an ANSI 837 file. Electronic Data Interchange (EDI) is used to submit the claims to the payer directly or via a clearinghouse.

Stringent edits and audits are done by our billing team before the claims are transmitted to ensure submission of complete and clean claims. We have two levels of claim processing. These reduce any underpayments and denials substantially, and provide prompt and accurate settlement of claims.

Level 1: Our QA team does complete checkup of every demographic entry and charge field in the billing software. We audit every detail entered.

Level 2: In this stage, the quality audit entries are randomly checked for errors. The fields and entries such as patient name, DOB, insurance ID and others are verified for demographic accuracy. Charges entry check-up includes fields such as CPT codes, ICD codes, modifiers, service provider, and referring physician. Claims are then submitted electronically to insurance companies.

Payment Posting

All the Insurance and Patient payments are applied accurately to the patient accounts. Our posting services include primary and secondary Insurance payment posting, adjustments and transferring co-insurance to secondary insurance (if available) OR patient, personal payment (self pay) posting.

REVENUE RECOVERY

Insurance Follow-ups and Denial Management

Vision Infonet has extensive experience working on outstanding claims of a practice. The company maintains teams whose core focus is to increase the revenue flow and reduce the number of days in Accounts Receivables. These dedicated teams help a practice accelerate their revenue cycle process, confirm higher productivity, receive payments faster, decrease physicians' costs, and improve the most important aspect, Patient Service.

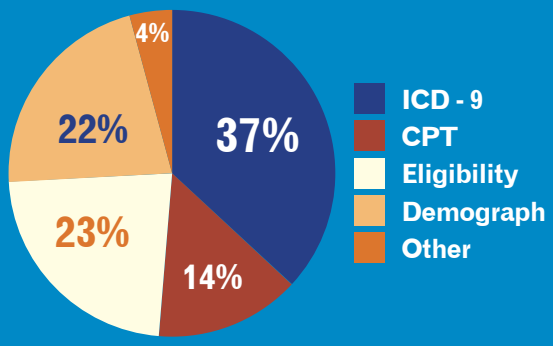
We also interpret the Payers and Providers' contracts, and also analyze, identify the systematic under-payments by Payers..

Our AR process unique expertise

- Conduct an over-all analysis of Insurance companies by the AR teams
- Generate unpaid claims report periodically from a Client's billing software and load it in to our Unpaid claims Tracking software to enable us to track them in a timely manner
- Appeal to Insurance companies for the unpaid claims along with preparing the necessary paperwork and follow up on these claims
- Constant follow-up on Unpaid bills to improve the revenue collection
- Apply accurate coding/billing codes to get reimbursed by insurance companies
- Collect Medical records from the client whenever necessary to submit claims which need information such as medical necessity, and pre-existing information. These will be analyzed and submitted to the payers

DENIALS - MOST COMMON REASONS

- Medical necessity is not met for claim reimbursement
- Improper or Non-usage of modifiers
- Inappropriately bundled services
- Improper demographics or verification of eligibility & benefits, etc
- Necessary/Missing additional information not provided for claim reimbursement
- The pie-chart shows the reasons for denials:



ADVANTAGES BY CHOOSING VISION INFONET INC

- Faster claim submission (usually done within a day)
- Achieve zero denials on claim submissions
- Speedy reimbursements and high efficiency
- Excellent reporting system
- Experienced, professional, and trained Account managers and their teams handle the Revenue Cycle Management
- Compliance to HIPAA guidelines
- Reliable security & confidentiality of patient data
- Decrease the operating costs by as much as 60%

VISION INFONET

www.cardiologybilling.us
www.vinfonet.com

Phone : 1-877-377-8999
Fax : 1-630-788-0634
Email : info@vinfonet.com

1717 Park Street, Suite 110
Naperville, IL 60563
www.vinfonet.com