Revenue Management Services

MEDICAL OFFICE FORCE

Estd. 2016

We help your practice work as hard as you do!

" BECAME A HIGH-QUALITY LOW-COST PHYSICIAN "

About us

A company founded, advised, and owned by RCM industry experts and Health Care Professionals. A companion in understanding common concerns of medical providers.

Medical Office Force is a Knowledge centric organization, offering integrated Healthcare Revenue Cycle Management services.

We provide 'Accelerators' to overcome process and resource limitations within your Revenue Cycle Management.

Our services encompass Patient Scheduling, Medical Coding and Clinical Documentation Improvement, Medical Billing, Denial Management, and Accounts Receivables follow-up for Physician groups, Individual Practitioners and Hospitals

Medical Office Force has accumulated experience in handling virtually any specialties and consciously provides cost efficient, excellent skills and cutting edge technology to help your practice earnmore for you.

Mission

An end-to-end value-added services partner for Medical Providers, Billing Companies, and Medical Facilities; delivering the highest Quality Services at the Best Price

High Quality, Low cost, Customer Focused.

Key Services Offered

1 Revenue Cycle Management Services

2 Virtual Staffing Services

3 Patient Collection Services

4 Provider enrollment & credentialing services

1 Revenue Cycle Management Services

Eligibility & Benefits Verification

Eligibility before the actual encounters to get more cash flow

Payment/Adjustment Posting

Well versed industry standard payment posting specialists

Prior Authorizations & Referrals

Authorization approval before 48 hours of actual appointments

Aggressive Denial Management

Denials are managed within 48 hours of denial receipts

Coding and Auditing of Clinical Charts

Certified Professional Coders by AAPC

Robust Insurance A/R Follow Up

Skilled professional AR analysts with a know how on collecting maximum from insurance.

Billing / Charge Posting

Billing specialists with expertise in diverse specialties

Customized Reports

Daily, Weekly, Monthly customized reports to better understand any practice's monetary health

2 Virtual Staffing Services

- Appointment scheduling and reminders
- Referral inbound and outbound
- Insurance Authorization
- Fax management
- Email and chat support

3 Patient Collection Services

- Patient Statements
- Soft Call Reminders
- Patient Past Due Letters
- Virtual Payment Collections
- Payment Plans

4 Provider Enrollment & Credentialing Services

We help our providers to establish their startup practices by providing indepth knowledge of medicare & commercial payers.

We take responsibility to add any new provider in your group.

We help you to keep your practice enrolled & active with all the payers & renew your contracts on time.

Our dedicated team consistently collaborates with the AR team to ensure you never lose any revenue from out-of-network benefits.

Importance Of Eligibility Verification

You cannot collect fees from an insurance company for ineligible patients.

01

Ineligibility of just 5% of patients, i.e. 1.5 patients/day assuming 264 working days at an average of $50 per encounter, the physician loses $19,800 annually

02

We ensure that every patient has been screened for Eligibility before their appointment and before a claim is submitted to the insurance company

03

we provide advance notification of patient responsibility prior to the services to increase the clinic's cash flow

Proper Coding

- Coding errors impact your cash flow.
- Proper coding equals proper reimbursement.
- Incorrect codes cause delayed or denied payments.
- We ensure up to date and valid CPT, ICD, and HCPCS codes.

We will integrate your CPT, ICD and HCPCS codes into our proprietary Procedure Code Analysis system and ensure that you no longer lose money due to wrong/invalid codes.

The Bottom Line

Minor Oversights Can Have a Major Impact:

Invalid Codes	10
Frequency of Use	Once a week
Average Charge	$50 per code
Projected Cost	$25,000 of lost revenue in a 50-week year!

Features for Coding Compliance

- Compliance – We make it easier for you to achieve Meaningful Use.
- Quality Reporting System - HCC, MIPS, HEDIS.
- Time – Free yourself from tedious reporting of patient encounters and improve your work-life balance

Charge Entry And Submission

All our staff are trained internally and must have a minimum of 3 years “specialized” medical billing experience.

Our 3-tier Quality Assurance process ensures industry-leading accuracy

- Level 1: QC check by specialized QC team
- Level 2: Validation Check by software
- Level 3: Validation Check by Clearinghouse software

We adhere to strict workflow management processes that make sure there is absolutely no drop in quality standards.

Electronic Claims Transmission

Our target is to electronically transmit all claims within 12 hours from the time the Charge Sheets (Superbills) and correct patient documents are received by our office.

We receive a specialized acknowledgement report after transmission for immediate follow-up

One of the most common denial reasons given by insurance companies is that the claim is not in the system. **We dispute the denial instantly since we maintain the proof of transmission for each claim.**

Two types of reports generated after transmission

L1 Report

Generated 30 minutes after transmission, which does a validation check before forwarding to the insurance company.

L2 Report

Generated 24 hours after transmission, which serves as an acknowledgement that the claims have reached the insurance company.

Industry's Best Practice Benchmark

The total accounts receivable in the **0-30 day aging category** should not exceed **70 % of monthly charges.**

The A/R in the **31-60 day category** should not exceed **15 % of monthly charges.**

The A/R in the **61-90 day category** should not exceed **10 % of monthly charges.**

The A/R in the **91-120 day category** should not exceed **7 % of charges.**

Denial Management

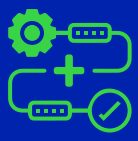
1

Denied claims are worked on, rectified and resubmitted within 24 Hours on receipt of EOB.

2

All Denials which require additional documentation, are sent to the Doctor's office on the same day that the EOB is posted.

3



We specialize in working your old Account Receivables and we are well versed with using correct appeal procedures in conjunction with Healthcare Laws.

Strategic Denial Management

At Medical Office Force
Denial Management is handled by:

- Identification of key denial reasons.
- Identification of non-contractual adjustments due to denials.
- Identification of Problematic Payers.
- Identification of contractual issues.
- Qualification of denial reasons.

Medical Office Force
Optimizes Denial Management by:

- Providing Good Documentation.
- Using accurate Procedure codes and modifiers.
- Utilizing well-informed, trained and qualified staff.

How do Medical Office Force Services help?

- By entering correct and accurate details in the PMS.
- Removing inconsistencies in the system that lead to denials.
- Following up on claims until paid.

Strategic Denial Management

By using a tracking system, Medical Office Force identifies

- Type of Denial.
- Reason for Denial.
- Resolution of the Denial.
- Corrective and Preventive action to eliminate denials in the future.

Benefits Of Denial Management:

- Improved and accelerated cash flow.
- Reduction in write offs.

Aggressive A/R Follow-Up

Our A/R and Denial Management Specialists receive extensive training in AR follow-up.

Aggressive follow-up starts 21 days after claim submission.

Our Specialists are chosen for their analytical skills and are provided with access to all the documentation required to make sure that the claim is paid on the first call.

> **E.g.** When the Insurance rep says that the claim is "Not in system", our Specialists are taught to immediately retrieve the clearinghouse confirmation from our database and fax it while still on the call.

Quality Assurance

- Experienced Quality Assurance team.
- Initial training for all process associates prior to job assignment.
- Monthly training based on continuously identified needs.
- Live monitoring of transactions for each process associate.
- Quality assessments of completed work based on random sampling.
- Redundant Screening through many processes
- Weekly quality review meetings to discuss quality concerns identified by our Quality Audit department
- All employees are required to take refresher courses in respective departments
- Monthly evaluations of all staff

Value Proposition & Principles

- Allowing our customers to focus on Patient Care.
- Superior Service.

- ROI
  - Increased revenue
  - Reduced AR Days
  - Lower Bad Debt Write-offs
  - Reduced operational cost

- On-time Delivery.
- Faster turnaround time.
- Accuracy.
- Process Compliance.
- Information Security Compliance.
- Trend Analysis for Continuous Improvement.

Virtual Staffing Services

Scheduling Services

All patients' calls for appointment booking can be handled by our experienced staff so that you can focus more on your practice.

Customer Service Call Center

We have a large team of well trained multilingual experienced customer care agents who helps you to ensure your patients' satisfaction at the best level.

Thank You!

Contact Us

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