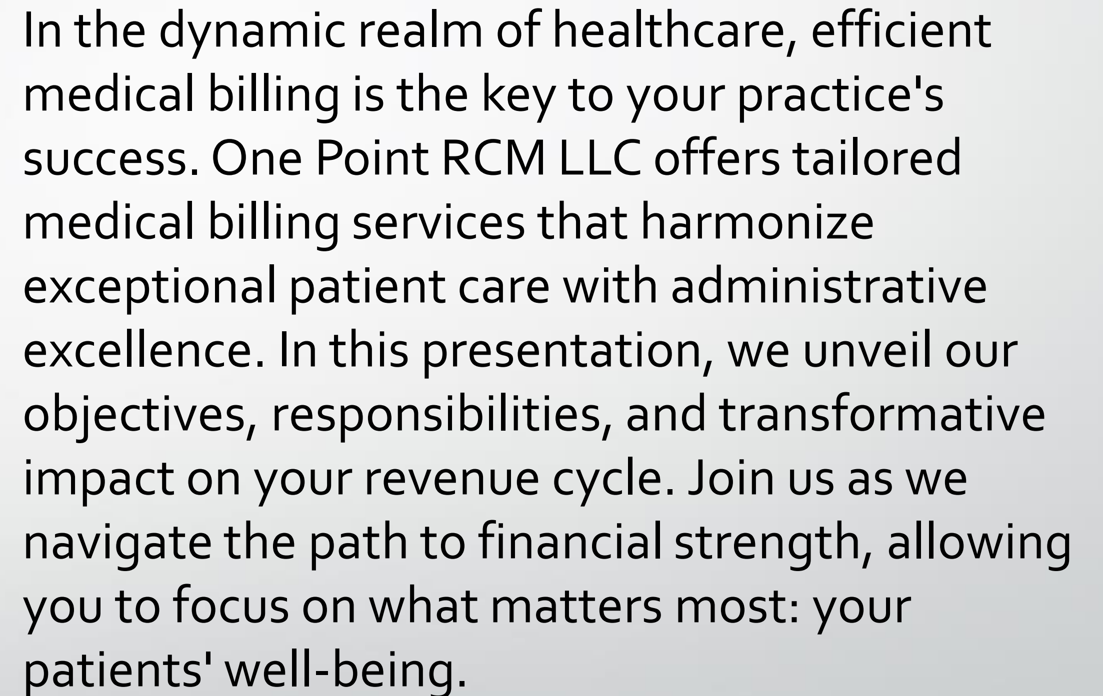
Navigating Billing with the touch of *One Point* RCM:

ONEPOINT RCM LLC

MEDICAL BILLING

- ELIGIBILITY VERIFICATIONS:
- DEMOGRAPHIC ENTRY:
- CLAIMS SUBMISSION:
- FOLLOW UP (A/R):
- DENIAL MANAGEMENT:
- BILLING REPORTS:
- EDI, ERA, AND EFT:
- CLAIM APPEALS:

INTRO



In the dynamic realm of healthcare, efficient medical billing is the key to your practice's success. One Point RCM LLC offers tailored medical billing services that harmonize exceptional patient care with administrative excellence. In this presentation, we unveil our objectives, responsibilities, and transformative impact on your revenue cycle. Join us as we navigate the path to financial strength, allowing you to focus on what matters most: your patients' well-being.

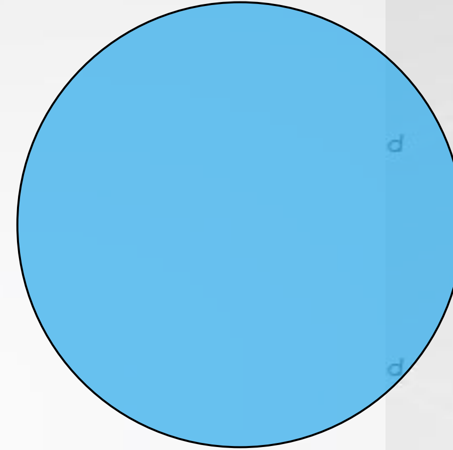
Objective:

To facilitate accurate claims submission by confirming patients' active and valid health insurance coverage, reducing claim denials and improving revenue cycle efficiency.

Responsibilities:

- Collect patient information and insurance details.
- Contact insurance providers to verify coverage, benefits, and eligibility.
- Address any discrepancies promptly and resolve issues to prevent future claim rejections.
- Maintain accurate records of eligibility verifications for reference and audit purposes.

Demographic Entry



Objective:

To ensure correct patient and insurance information is entered into the practice management system for accurate claims processing and reimbursement.

Responsibilities:

- Accurately input patient demographic details, insurance IDs, and policy information.
- Cross-reference information to avoid errors in claims submissions.
- Update records as needed to reflect changes in patient information or insurance coverage.

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Claims Submission

- **Objective:**
- To maximize successful reimbursement by submitting insurance claims accurately and timely, adhering to insurance carrier requirements and minimizing claim rejections.
- **Responsibilities:**

- Prepare and submit electronic claims using accurate patient and service details.
- Adhere to coding standards and guidelines for proper claims submission.
- Attach necessary supporting documentation, such as medical records and prior authorizations.
- Monitor claim status and address any delays or rejections promptly.

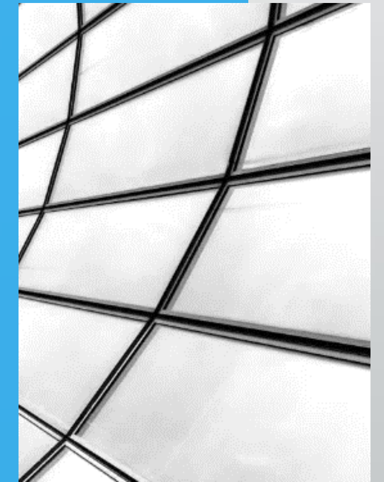
FOLLOW UP (A/R)

Objective:

To expedite revenue collection by effectively managing outstanding claims, addressing denials, and ensuring timely payment from insurance carriers.

Responsibilities:

- Regularly monitor submitted claims for payment processing status.
- Investigate reasons for denials and take corrective actions, including revising claims with accurate information.
- Engage in proactive follow-up with insurance carriers to resolve delays and rejections.
- Maintain open communication with insurers to address claim discrepancies and ensure timely reimbursement.



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Denial Management

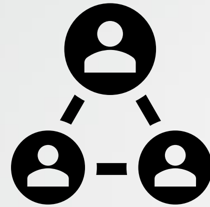
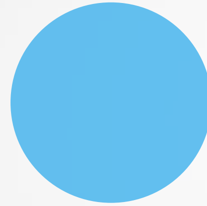
Objective:

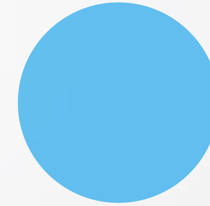
To minimize financial losses and optimize revenue cycle management by addressing claim denials promptly, rectifying issues, and resubmitting claims for payment.

Responsibilities:

- Analyze denied claims to identify reasons for rejection.
- Collaborate with healthcare providers to gather necessary documentation to support claim validity.
- Make necessary corrections to claims and ensure compliance with payer requirements.
- Resubmit claims with additional information or clarifications as needed.
- Maintain a record of denials, actions taken, and outcomes for future reference and improvement.

Billing Reports:



Objective:

To provide actionable insights for enhancing practice efficiency, financial performance, and optimizing revenue collection strategies.

Responsibilities:

- Generate and analyze various billing reports to assess practice financial health.
- Identify trends in payment patterns and patient collections.
- Monitor key performance indicators (KPIs) to measure billing efficiency and effectiveness.
- Use insights from reports to refine billing strategies and improve overall revenue cycle management.

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Setting up Electronic Healthcare Transactions: EDI, ERA, and EFT:

Objective:

To streamline data exchange and payment processes by implementing electronic solutions, reducing manual errors, and ensuring secure and timely transactions.

Responsibilities:

- Implement Electronic Data Interchange (EDI) to enable digital communication between providers and payers.
- Set up Electronic Remittance Advice (ERA) for automated processing of payment information.
- Establish Electronic Funds Transfer (EFT) for secure and direct electronic payments to providers.
- Monitor and manage electronic transaction systems to ensure seamless and efficient communication.

Claim Appeals

Objective:

To offer providers a fair and impartial process to challenge denied claims, ensuring accurate resolution and optimal reimbursement.

Responsibilities:

- Assist in preparing appeals with thorough documentation to support the claim's validity.
- Engage with insurance companies to communicate the grounds for appeal and present evidence.
- Escalate appeals to higher authorities if necessary, ensuring proper review and consideration.
- Provide providers with guidance and updates throughout the appeal process.

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Transparent Billing Solutions

Flexible and Transparent: Our fee structure is designed to cater to your practice's unique needs while ensuring cost-effectiveness.

RCM Services Fee

3.5% of Monthly Collected Revenue

Transparent Computation:

- Your fee is calculated based on your total monthly collection.

Detailed Invoices:

- Receive itemized invoices reflecting our services.

Timely Payment:

- Payment is due within 15 days from invoice receipt.

Enhance Your Revenue:

- Our medical billing services are geared to optimize your practice's financial performance.

Improving Efficiency:

- Our streamlined billing process frees up your time for patient care.

THANK YOU

By fulfilling these responsibilities, our role as a third-party contractor guarantees providers' uninterrupted practice continuity.

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