**The AccuMed Group**
**Medical Claims Management Process (MCMP) Details**

## Pre - Dispatch / Ongoing Consultation

The AccuMed Group and the department will complete the following to insure the desired results are being produced. We suggest on-site incident document training as needed:

- Initial on-site incident documentation training (how to develop a compliant incident report that maximizes recovery).
- Ongoing incident report documentation review and training.
- Establishment/analysis of:
  - » Collection Policy
  - » Incarcerated Patient Policy
  - » Compliance Plan
  - » HIPPA Privacy Plan
  - » Intercept Agreements
  - » Hardship Policy
- Charge & reimbursement analysis to optimize revenue.
- Compliance reviews (Internal and External).
- Review, analysis and recommendations regarding contractual relationships with third party payers.
- Reasonable cost-free access to the national EMS law firm of Page, Wolfberg and Wirth, LLC.
- Support of the annual budget process.
- Reporting and monitoring tools.
- Technology – electronic data management support.

## Incident Import & Management

The AccuMed Group currently works with over 205 EMS providers. Our approach to ePCR is vendor-neutral, so we will work with any NEMSIS compliant vendor.

## Insurance Verification / Development

At this point, the incident data file and named attachments have been pushed from your ePCR vendor to the AccuMed Group. We now create a trip in Zoll Data Systems RescueNet Billing. The incident is now in the The AccuMed Group's domain and moves through our proprietary Pre-Processing routine.

Our Pre-Processing solution is revolutionary because within hours of completion of the PCR, data is passed through The AccuMed Group's pre-processing software where an automated process verifies scope and accuracy of insurance coverage and fast-tracks the incident to a certified coder for processing. Accounts are also identified for skip-tracing in the event the data provided by the Department is void of required information to advance the trip through the billing process.

The high-level objective of the insurance verification function is to confirm active insurance coverage and payment eligibility through all possible insurance verification sources, including identification of previously unknown insurance coverage through extensive front end editing and skip tracing. When successful, a clean claim will be electronically delivered to the payor on the initial submission and limit submission to payment times (days in A/R).

The AccuMed Group also utilizes the following supplemental resources:

- ↘ Emdeon – Insurance verification clearinghouse, claim delivery (electronic and paper).
- ↘ TransUnion – Skip tracing database (Search Criteria: Name, address, telephone number, date of birth, social security number).
- ↘ Patient Account Services – AccuMed Group associates contact patients and responsible parties via highly effective voice over data calling technology to obtain & confirm insurance information.
- ↘ National Mail Services – tools through the United States Postal Service, "national change of address directories", "address standardization" and "electronic return mail".

By design, our MCMP is comprised of multiple editing checkpoints to ensure all patient, demographic and billing information is accurately represented. As underscored throughout this response, we believe that only through a symbiotic relationship can high-level contract success be achieved. It is critical that when and where possible, complete and accurate incident reports, which satisfy all signature requirements, are developed by the Department.

**Claim Generation / Edit and Submittal - Insurance Billing**

At this point, the trip has been verified, and we have identified the payor. The trip now flows from Insurance Verification to our accredited coding Department.
Our coding staff creates a compliant claim form, which includes the required ICD-10 procedure codes, modifiers, narratives and supplemental information. Our coding staff determines the level of service: ALS, ALS II, SPC, BLS based on the data recorded on the run report, PCS, ABN forms and dispatch records. The following is a sampling of the support tools used by our coding staff to develop compliant claim forms.

- International Classification of Diseases (ICD-10)
- CMS Ambulance Program Transmittals
- CMS National Coverage Provision AMB-001
- CMS Part B guidebook
- Insurance payor specific guidelines (i.e. Medicaid payable diagnosis)
- Monthly insurance company bulletins, website updates and newsletters
- Page Wolfberg & Wirth, LLC Consulting
- The The AccuMed Group Group Compliance Manual

When preparing claims for insurance payment consideration, expert and complete ICD-10 coding, CPT coding and medical terminology is used. This commitment to detail and precise coding will maximize collectability without deviating from transport circumstances. By end measurement, AccuMed's commitment to compliance is perfect. Our clients have not refunded and any amounts due to over coding and remain in the good graces of all regulatory entities.

The accurately coded claim form is now electronically submitted to all primary payors. The overwhelming majority of all claims are submitted electronically. A small minority of the time, a paper claim is the best solution to position the claim review for the best outcome (attached with a ePCR to demonstrate medical necessity). In this case, AccuMed will generate and deliver the paper claim, with all necessary attachments.

**Private Pay Billing:**

After the Department's and The AccuMed Group's efforts to obtain insurance information have been exhausted, the trip is billed to the patient, consistent with the Department's charge policy. Our focus is to successfully deliver a private pay billing on the initial mailing, which is customer friendly and effective.

Private-pay statements are also sent to the patient when the insurance carrier sends the payment directly to the patient or when the patient simply does not have active insurance coverage. Through the Insurance Verification process, we make every reasonable effort to identify the patient's possible insurance coverages prior to billing the patient.

Private Pay Statement Cycles: Private pay statements are cycled every 30 days, or a minimum of 2-3 private pay statements are delivered (or attempted to be delivered) to the responsible party. These carefully worded statements solicit insurance information from the patient in a user-friendly format. Our goal is to procure insurance information and motivate qualified self-pay patients to honor their financial obligation with the Department, consistent with the Department's compliant collection policy.

Private Pay Statement Monitoring: All accounts are monitored at each cycle change until the account is paid (including payment arrangements), or the patient is qualified as unable or unwilling to voluntarily pay.

Statements Include: a) an easy to understand insurance questionnaire to ensure procurement of exact information for accurate billing b) Our email and fax numbers are listed to expand upon compliant methods to communicate their insurance to The AccuMed Group c) Return envelope is enclosed for patient convenience d) our 800 number is provided for immediate, cost-free access to our trained patient account representatives and e) Credit card payment options are presented if authorized. Our patient account representatives will keep in contact with patients who require special assistance.

Prior to sending the initial Private-Pay statement, we access the National Change of Address Directories, utilize Dual Address Standardization (DAS), Electronic Return Mail (ERM) and Address Element Correction (AEC), to confirm the address provided by the Department is the most current as compared to the aforementioned data bases. We focus on getting your letters delivered. The AccuMed Group's Private-Pay billing practices are fully HIPAA compliant.

**Accounts Receivable / Denial Management**

At this point, all claims and private pay statements have been issued and payments and responses are flowing in.

Our Accounts Receivable (A/R) Group will post payments and contractual adjustments to trips. A/R will also process denials, pended accounts and patient correspondence. Records are scanned, indexed and associated with the trip in RescueNet as to create a single, comprehensive record.

Payments, denials, rejections and like correspondence are processed and posted to our billing system in an expedient manner. Secondary and tertiary insurance payors are billed immediately after the primary carrier pays on the claim (or denies as the case may be).

We closely trend payment history and promptly follow-up with insurance carriers that are not responding in a timely period. In the event the claim is denied, without good cause, we appeal the claim and provide supporting documentation to resolve the claim through payment. In the event the claim is denied with good cause (applied to deductible, not a contract benefit, etcetera), we move the claim to secondary or tertiary payors. If no additional insurance is available, the balance is transferred to the patient, consistent with the Department's charge policy.

Financial reports are produced and delivered to the Department, consistent with the Departments reporting preferences. Deposit activity balances exactly with bank activity.

**Statusing / Claim Review & Follow-up**

At this juncture, all payors have been billed and we are monitoring the Department's aged A/R and engaging insurance carriers to render final payment. This includes the conversion of private pay accounts to payable insurance claims, or, resolution of the account through payment by the patient (in accordance with the Department's collection policy). Daily statusing by our Team includes the following process:

- Actively monitor all aged A/R and re-submit claims to carriers at 30-day intervals.
- Contact carriers by phone, status requests at 45 days in A/R to determine disposition of a claim.
- Contact patients through auto dialer technology to secure payment or payment arrangements.

- If no response from carrier, transfer balance to private pay where allowable by law (in accordance with the Department's collection policy).
- If no response from the patient / responsible party, flag the account for placement with a third party debt collection agency consistent with the City's collection policy.

**Insurance:**

After the initial claim submission, we follow-up with appeals, which are comprised of resubmission of claims, status forms, letters and phone contact with the insurance carrier. This includes evaluating claims to ensure reimbursement was made in accordance with all applicable fee schedules. When the claims are processed through our insurance billing procedures to no resolve, we transfer balances to patients where allowable by law or otherwise by contractual agreement (in accordance with the Department's collection policy). Often, slow paying insurance carriers are more responsive to the patient with respect to processing the claim for payment or rejection. The principle is rather simple - the insurance carrier is paid by, and works for the patient, not the medical provider. Multiple insurance carriers will issue payment benefit directly to the insured. In this case, the Department's ability to recover payment sent directly to the insured necessitates billing the insured. We balance this dynamic with the Department's collection stance regarding residents.

Private Pay:

All accounts are monitored at each cycle change until the account is paid (including payment arrangements), or the patient is qualified as unable or unwilling to voluntarily pay.

**Pre-Collection / Auditing**

Pre-Collection / Auditing is the final step in the MCMP. At this juncture, trips have benefited from a very comprehensive nine step process and resolution through payment is unlikely. Nonetheless, we scrub/audit the trips one additional time and will make a recommendation to the Department of what we believe to be the next logical step. This includes, routing the delinquent private pay trips back through Medicaid repositories to identify retroactive coverage and attempting a call to the patient through dialer technology.

Private-Pay: We will provide the Department with a comprehensive in-house, private-pay management system. Our private-pay, in-house pre-collection system is executed by trained accounts receivable specialists. The AccuMed Group does not represent itself to be a "Collection Agency" rather a solution for patients whom wish to satisfy their obligation with the Department and need guidance and structure to do so. This includes supporting the Department's selected third party debt collection agency.

In addition, our pre-collection system acts as a filter, categorizing patients by placing them into one of the following four categories:

1. Able and willing to pay. For this patient group, we secure balance in full and or establish payment arrangements when necessary. We recommend allowing acceptance of credit card payments to increase overall recovery.
2. Willing to pay, but, currently destitute, unemployed or on disability: For this patient group, our Patient Account Representatives schedule follow-up dates to contact the patient to offer payment solutions. Typically, this patient category requires long-term follow-up and patience.
3. "Skip" patients: Patients whom have moved and left no forwarding address or "John Doe" patients unreachable by phone. For this patient category, we attempt to access National Change of Address Directories utilize Dual Address Standardization (DAS), Electronic Return Mail (ERM), Address Element Correction (AEC) and demographic information through Transunion. If new information is found, the Private Pay billing process is again activated. If we are unable to locate the patient, we flag the account as uncollectible and will follow the Department's collection policy.
4. Able to pay, but unwilling: This patient category is uncollectible. We recommend continued use of a third party debt collection agency for accounts that fall within this category.

Patient follow-up is managed in part through private pay statements and in part through leading edge voice over data technology. We currently subscribe to a voice over data dialer system through Global Connect.

We will redirect all correspondence to the "Estate Of" after we exhaust all insurance payment sources in the event we are notified that the patient is deceased. Chapter 7 bankruptcy claims will be "written off" to cease billings as required and an outstanding balance notification will be sent to the attorney of record handling chapter 11 and 13 bankruptcies.

The AccuMed Group will at all times use "positive collection techniques" and work with and assist private-pay patients in satisfying their debt and shall refrain from using threats or intimidation as a collection technique, and comply with all laws and regulations regarding debt collection practices.