WHITE PAPER

The iNtelli-Bill Difference

and an Argument for Flat Fee/Rate per Claim Pricing

www.iNtelli-Bill.com

www.horizonMIS.com

www.flatratemedicalbilling.com

The iNtelli-Bill Difference

In The Beginning

iNtelli-Bill comes from a different time and place. Sounds a little metaphysical, doesn't it? Kidding aside, knowing where we come from may best explain why we're so different from practically any other Medical Billing Service out there. First of all, iNtelli-Bill isn't *just* a billing service, we're also a software developer. iNtelli-Bill is the Billing Service division of American Medical Systems, Inc (a Florida corp), also known as AMS. HorizonMIS is a medical billing and practice management system developed and supported by AMS.

AMS was founded in 1981 by Bob Bortz. At the time, computerized billing systems for physician offices were dominated by mainframe and mini computers and only the largest medical organizations could afford one. Micro computers were in their infancy but were evolving quickly. Bob thought if he could develop a medical billing program that would run on a micro computer, then practically any physician could justify having one. MBS (Medical Billing System) was soon born, but it would take several years to develop into a full practice management system as well. Around 1986, the name was changed to MOM (Medical Office Manager). MOM was sold to physician offices and medical billing services around the country. By the mid 90's, MOM had evolved considerably and the name was changed to HorizonMIS (Horizon) to help set it apart from similarly named products like "Medical Manager". Believe it or not, some of our earliest clients dating back to the early 80's are still using our system. Customer loyalty like that only occurs when you provide excellent support, continually adapt, and provide good value. That, and the fact they haven't died yet also helps.

In the mid to late 90's Electronic Medical Record systems (EMRs) became the craze, but while our competitors jumped on that bandwagon, their PM systems languished and became stagnant. AMS decided we'd rather stick to what we knew best and instead, interface with EMRs that would play nice with us. This enabled us to focus on enhancing Horizon, making it the best Medical Billing and Practice Management system available at any price. Most of our competition's billing and PM systems were acquired, retired, or are no longer in business.

To digress a little, many billing and PM systems included with EMR/EHRs are functionally very thin requiring more work to use them while lacking critically important features which improve office productivity and efficiency. EMR/EHRs from companies like Praxis and Sevocity have focused their efforts on building the best EMR/EHR while allowing you to use any billing and practice management system you want. The idea you're better off having everything from one company is totally false, and there are plenty of bankrupt doctors out there to verify this statement.

You shouldn't have to discard a perfectly good billing system your staff knows, in order to use any particular EHR. If you find an EHR you really like, insist on keeping your existing billing system or billing service. Your EHR vendor should be able to interface for you and in this day and age, their side of the interface should be free. Here's a dirty little secret about EHRs. Many of them use an interface between their own billing systems anyway.

Back to the topic, further developments in technology, including a faster and less expensive Internet, soon made remotely connecting users to computers easier and less costly. It wasn't long before AMS began deploying HorizonMIS as a subscription web based product which is the predominant method of distributing software today. Referred to as SaaS (Software as a Service), it's still just "time sharing", something AMS was doing with HorizonMIS since the mid 1980's using phone lines, dumb terminals, and modems.

Many physicians choosing to use billing services often discover the decision is more costly than imagined, and in more ways than one. As a software developer, we noticed that even billing services using our software with all it's tools, still managed to do a lousy job, in our opinion. "Lousy" might seem a little strong, but it best describes what we witnessed. In some cases, except for reworking denied claims, followup was non existent. They'd skimp on patient statements and they'd take too long to get the claims out. Why? Didn't they care about doing a good job, or were they lazy or ignorant about what needed to be done? We believe the major reason for inadequate followup is simply due to not employing enough people for that task. In fact, physician offices suffer the same problem which is the primary reason they employ billing services to begin with. But more people costs money and if you can get by on less, you make more money, right?

Since many of our clients were billing services, AMS was in a unique situation to witness how the business worked and in many ways, they were like physician offices when it comes to followup. There just aren't enough employees dedicated to the job, and the cost benefit of an extra employee is certainly questionable.

Most billing services still insist on using the old fashioned "pick up and carry" method of doing business. That is, the physician office makes copies of patient registration forms and super bills for the billing service who keys all the data into the computer system. Their sales pitch is "that's what you pay us for", but in reality, your office spends more time photocopying, faxing, or scanning pieces of paper than it would to enter the data directly and eliminate mistakes and shorten the overall billing cycle. Every time the patient moves, changes their phone number or insurance plan, you've got to relay that to the billing service too. While keeping you off their system helps keep you in the dark about the job being done, it's also harder for you to deal with your patients when you see or talk to them. Does the patient have a balance you need to collect? How do you know what the patient's copay or deductible is? While some services may allow offices access to their system for patient inquiry or scheduling, anything else is highly restricted. The typical billing service knows how to submit a claim, but supporting a practice management system, supporting end users in the field or setting up a scheduling system properly just isn't something they're good at.

The Aged Receivables Report, An Outdated and Tedious Tool for Followup

The Aged Receivables Report (ARR) is the primary tool used by billers to work old or unpaid accounts by over 90% of billing services and physician offices alike. It's very nature makes followup time consuming and extremely tedious. While it might have filtering options enabling the restriction of patients selected to those with balances over a certain age, or only insurance or patient balances, it inevitably contains accounts you don't need to look at, and at

the same time, skips over others that need review. If you run a complete report consisting of all accounts with balances, you're going to waste a lot of paper, not to mention ribbons or toner. More paper means more to shred if you're safeguarding privacy properly.

When someone finally determines its time to work the old A/R, the printed A/R report is almost always many pages in length. Not fun. The report is probably printed in account number, alphabetical, or payer order, not by age or amount owed. If you want to work the largest amounts first, you've got to flip through pages to find them, or, start at the top and work your way through. Much time is spent deciding if a phone call is necessary or not. You usually need to review the account on the computer for full details. Then, you get interrupted with other duties or phone calls before you can finish going through and marking up the report. Before long, you discover since the moment the report was printed, many changes to the accounts have occurred. For instance, an account on the report no longer requires working because a payment was processed by someone else, but you wasted time looking at it. The older the report becomes, the less meaningful it is, and you've got to run a new report to stop wasting time. One way to avoid wasting so much time and paper is to only select claims or patients that have balances in the 120+ day column. But what about those claims that are only 30-45 days old and usually pay in under 20 days?

Over the years, AMS developed different and enhanced reports which proved better alternatives to the Aged Receivables Report. They were expressly designed to reduce the time required for followup, but they still required people to take the time to run them and then to work them.

Many billers overuse the "refile" key with no attempt to determine why a claim was never received or paid. Refiling a claim makes your ARR aged by claim date look better, but if you don't do something to correct the problem, you'll likely achieve the same results. iNtelli-Bill billers aren't permitted to refile claims without documenting the reason for the refile and corrective actions taken.

ESTHER Was Born

Something better was desperately needed, but what? Hiring another employee would help, but they cost more money, they require training, they get sick, quit, sometimes they marry the doctor, or they end up being needed for something else like working the front desk should the front desk person quit. Out of necessity, ESTHER was born. We call ESTHER an "artificial intelligence" and ESTHER is actually an acronym but that's not important right now. ESTHER is a program or process that runs continuously in the background examining the entire database identifying issues requiring attention much in the way a virus scan operates. ESTHER looks at accounts the way an expert human would and based upon user defined criteria, ESTHER prioritizes issues onto a list or queue which "she" manages and presents to designated users automatically. A user can push a button and display their list anytime they want, but if they don't, ESTHER reminds them periodically to so they're aware of the issues. ESTHER works relentlessly. When an item on a list gets resolved, it's automatically removed, often times before a biller even sees it. As a biller resolves an item on the list, new items in the master queue will be assigned to that biller in an order which makes sense utilizing their time efficiently. If a user fails to work their list, ESTHER will reassign those items to another

person if one exists. This could happen if a biller goes on vacation without turning off their ESTHER switch.

ESTHER never took time off, didn't require overtime pay, worked relentlessly day in and day out examining all accounts whose situation may have changed and now required attention according to the defined parameters. ESTHER really was the perfect employee. How much would you pay an expert person to do what she does?

The Final Straw

We started offering ESTHER for sale to our billing service and PM software clients. Believe it or not, most billing services weren't interested. One billing service said and we quote "I don't need some bitch named ESTHER finding more work for me to do. I don't have time as it is.".

That did it! Bob decided AMS needed to start a billing service division, but it had to be different. AMS had to do it right. It was a difficult decision because in some cases, we'd be competing with billing services locally that used our software. But compared to other billing services, our business model integrates our PM software into the mix, creating a synergy with the physician staff and providing real transparency. Other billing services prefer the doctors not have that kind of access or role. Wonder why?

Circumstances Change, Life Changes, We All Do

iNtelli-Bill offers you choices and the ability to change how you do business with us, while most other billing services won't or can't offer the choices we do. For instance, if you started out using the Horizon system internally, doing your billing in-house and later decided to outsource the billing portion to us, no problem. It happens. A doctor looses their biller and under normal circumstances they'd make a new hire, or have the front office person trained by us on the billing stuff. But, since we're able to take over the the back office functions, it's an easy transition, and having worked with us, they know they can trust us. Other times, we start out as the billing service, but later, if circumstances warrant bringing the billing in-house, it's not a problem for us. If they want to keep using Horizon, we pretty much flip a switch and now we're your software vendor. In these instances, there's nothing to convert, no retraining, and all your data remains intact, and since we were previously in charge, your data A/R is in good shape. In short, no turmoil and your staff is happy because they really like Horizon and the support they receive from us.

As It Turns Out

By the time AMS started iNtelli-Bill, Horizon had already been in use and development for over twenty years. Horizon had evolved into a pretty substantial system, largely due to the many varied types of practices that had used it thus far. But as it turns out, once we started using it in our billing service setting ourselves, we started thinking of more ways to make it better. It's evolved to a state far beyond where it'd be had we never started iNtelli-Bill. From an end user perspective, we've thought of enhancements typical end users wouldn't, and being able to modify and enhance the software whenever we want., we do. We're constantly on the lookout for ways to streamline processes, save steps, and improve efficiency. You'd expect the developers of a software product to know more about it than anyone else, but dealing with the

day to day operations of a billing service and all that entails, our software is better for it. Being a software developer, our unique insights and technical abilities makes us an even better billing service, which means you get better service and support, better tools, and better cash flow too.

The iNtelli-Bill Difference

Pros and Cons

There are pros and cons to doing your billing in-house, just as there are pros and cons to outsourcing. AMS wanted to keep the pros of both worlds, while at the same time, eliminate the cons. We think we've accomplished that, and our slogan "All Pros, No Cons" and motto "Get it right the first time" is well deserved and hopefully, after reading the rest of our story, you'll agree.

The iNtelli-Bill Difference

Our Promise to Our Customers

iNtelli-Bill promises that regardless of the contracted fee structure, whether based on percentage of receipts or flat rate or flat fee per claim, iNtelli-Bill will process your claims, both primary and secondary, and diligently perform followup on unpaid claims to the highest standard possible without regard to our cost. Maybe that's all we need to say on the matter, but lets first discuss our Flat Rate/Fee business model and how it saves you money.

Our Flat Fee Per Claim Fee Saves You Money

iNtelli-Bill started out charging a fixed percentage of all revenue as does the vast majority of other billing services. Over time, and through benefit of hindsight, we developed a scientific method to calculate the percentage needed to break even on a specific client using our past history and experience with them. The problem with quoting new clients is it's difficult getting enough data from them in order to determine the proper percentage rate to charge. We have our share of clients we're loosing money on because the percentage we quoted to be competitive ended up being too low and doesn't cover our real costs. We'd be okay if we didn't insist on keeping our promise.

Going over the numbers, it was eye opening to discover that with the exception of hospital based physicians and certain specialties which required more paper claims and paper handling, a physician's specialty had almost no bearing on our costs . Simply put, the dollar value of a claim is no factor when determining the actual costs of filing or performing followup so why should you pay more? Physicians that average higher claim amounts warrant a lower percentage fee but that fee ends up being higher than in needs to be to cover costs and make a reasonable profit. We're able to calculate that fee, but it's all based on averaging a flat fee per claim so why not just charge a flat fee per claim? On a percentage basis, we can make more for ourselves charging a cardiologist 2.5% than a family practice 8%. Cardiac procedures or procedures in general produce a higher dollar claim than office visits and that's the only difference, but the cost of filing and following up on an unpaid claim, posting payments, preparing secondary claims, and balance billing patients is the same for the cardiologist as it is for the family practice. For the most part, it's only the billing service who benefits from percentage based fees and you're not likely to find one to change.

iNtelli-Bill decided that charging all standard physicians the same flat fee per claim, regardless of the claim amount was the fairest way to conduct business. A standard physician to us is office based, and office personnel utilize our PM system. Hospital based physicians and those requiring more paper claims filing flat rates will be somewhat different.

Under our flat rate system, we charge a flat fee per claim and a flat fee per patient statement. We separated the two in order to reward offices that do their part in collecting patient payments by reducing the number of statements needed. Our flat fee could be adjusted to cover statement costs, but it's the office who plays the largest role in determining who needs a statement anyway. Patient statements are inevitable, but if the front office performs their job

of collecting copays and patient balances when they see the patient, fewer statements will be needed. It's the office, not the billing service that's in the best position to collect these payments from patients. When a patient has a copay of $30.00 that isn't collected, they'll end up getting a statement after all the insurance has paid for $30.00. If the front office realized a copay was needed, and collects it as they should and as the patient expects, the cost of the statement is completely eliminated and you don't end up with a potential collection problem down the road. The main point here isn't to reduce statements, it's to collect the money you're owed. Just so happens, the physician can save even more with iNtelli-Bill by taking steps to reduce the number of statements needed and that's where Horizon comes in to help.

Some billing services quote flat fees but go about it differently. One charges $2,500 for the first physician, plus postage and EDI fees. If you brought in $30,000 in fees, that $2,500 "flat fee" has an effective percentage rate of 8.3%, not counting the extra fees. Others advertise a very low percentage rate to catch your attention. Be sure to read their fine print because if the low percentage rate seems too good to be true, you're likely to find out there are extra fees to pay for postage, statements, and other miscellaneous items. We believe charging per claim more accurately and fairly bills for the actual work performed and costs incurred. And if you take a 2 week vacation one month, guess what, your fees would be reduced by two weeks worth of claims. Making sense?

Total Transparency

Transparency is critical to a successful relationship with a medical billing service or company.

From Wikipedia, **Transparency**, is operating in such a way that it is easy for others to see what actions are performed. It has been defined simply as "the perceived quality of intentionally shared information from a sender".

Intelli-Bill strongly recommends our clients use our practice management software HorizonMIS for a number of reasons. Even if your practice doesn't use Horizon, you still have access to it which gives you the ability to see everything we're doing. It's our operational policy that every communication with a payor or patient be documented. When viewing a particular patient's ledger or history, besides seeing every financial transaction occuring to that account, you will also see every conversation which has taken place between our billers and the patient or the patient's insurance company.

If a claim hasn't been paid, you'll be able to tell if we're doing anything about it, or not.

At the simple push of one button, you can see how your A/R is trending. This is important because if it's trending up, you need a logical explanation as to why. We make a big deal about A/R days because that's a really good indicator into the overall effectiveness of your RCM. For us, the average time it takes a claim to pay is about 17 days, and that's including Medicare. When secondaries and patient responsibility are considered, the A/R days will naturally be higher. Intelli-Bill strives for A/R days less than 30. Charge latency, the number of days it takes from providing service to the charege being posted and ready for filing will add to the overall A/R aging. Using our various tools, your officee should be able to get charges to us within one day which would make the latency 1 to 2 days. If it takes your billing service 2 weeks to file a claim, your A/R will be at least 2 weeks older than it should be. Every delay in getting a charge billed increases the difficulty of resolving billing issues prior to claim submission.

Our dashboard clearly shows the current latency, A/R days, and issues being or needing work. Our

system makes it very easy in many ways to tell if and when charges were submitted, filed, payed, or followed up on.

The iNtelli-Bill Difference

WHO DOs and Communication

Our proprietary inter-office communication system IS the most efficient means of communicating billing issues on patient accounts between our office and yours. Referred to as the "Who Do" system, it is an integrated "to do" list for we don't care who. Meaning, whenever our billers need additional action or information from your office on a specific patient, we will communicate via a "Who Do Request". Think of the "Who Do" as an outbox with papers stacked in it. Periodically, somebody picks up the stack of papers to see what's in the box, but in our case, instead of picking up a stack of papers, one simple keystroke displays a list of the items in the box. Selecting a patient from the list takes you right to the patient account where the information can be corrected or responded to. This list or stack is graphically displayed on the left side of our Main Menu screen which is visable to everybody using the system. It is color coded to grab your attention if items in the stack are getting old. As your staff responds to these requests, they'll transfer to a stack on the right side of the screen awaiting billing department review and response.

"Who Dos" don't get lost, and are forever in everyone's face until acted upon. Every time a patient is accessed for any reason by the office with an active "Who Do Request" you will be alerted as with any other type of alert. "Who Dos" have the added benefit of automatically placing a claim on hold if necessary until the issue is resolved and then automatically release to billing upon satisfaction. Appropriate "Who Dos" generate documentation in the patient's account too. For instance, if a biller needed a different diagnosis for a procedure, the authorization by office personnel to change the diagnosis by the biller will be documented.

No Offshore Outsourcing

iNtelli-Bill will NEVER outsource anything outside the borders of the United States, no matter what. We're contacted almost daily by companies, mostly from India, promising to reduce our costs by up to 60%! We don't believe it. We don't believe they can improve upon what we're already doing. In addition to the fact we don't believe they'd do as good a job as us, we just aren't willing to risk yours or our data overseas. PERIOD. There're too many physician horror stories choosing the service offering the lowest fee or software supported offshore as well. Your patient's experience with your billing service is also something you need to consider. I (the person writing this) will tell you that if I discover my doctor exports or stores any of my data offshore for any reason, I will find another doctor. Almost everyone has experienced some level of frustration trying to talk to somebody you can't understand, or somebody who's only able to help you within the confines of a script. The offshore companies claim to be HIPAA compliant, but we seriously doubt our judicial system's ability to reach foreign countries. Our parent company is American Medical Systems, after all.

Get a Contract

Handshakes are nice, but one purpose of a contract is to remind all parties what was originally agreed to. The contract shouldn't be one-sided and should provide protections for both parties. One of the most overlooked items often missing from a contract is the termination clause, but more specifically, what are the termination procedures. How much notice must be given? What fees if any are due, especially if the contract is terminated early. In our opinion, early termination should not result in penalty payments. What services will the billing service continue to provide after termination? The most important item and usually absent, deals

with your your data and remaining A/R. How will your outstanding A/R continue to be worked? Can you get your data exported, how, and at what cost? Is it possible for you to continue to have access to the data online? Usually, the only thing most billing services can do for you is give you reports. While better than nothing, we believe we handle that better than anyone. In fact, we tell prospective clients, iNtelli-Bill is the best billing service to leave (if you have to).

Free DATA Export

Whether you choose to use HorizonMIS to do your own billing in-house, or use iNtelli-Bill's billing services, at some point in time, you may decide to take your business elsewhere. iNtelli-Bill addresses this issue right up front and prominently in our contract. Check your current contract to see if this very very very important issue is addressed at all.

In all our experience, we have yet to receive data from a client's existing system easily. If made available, it's largely incomplete. It often costs the physician so much money and takes so much time they'll usually decide against it. Billing services especially make it very difficult because they don't want you to leave them. In fact, since most billing services use some off the shelf software, they have to pay their vendor to do an export and again, it tends to be very costly and time consuming, and you can bet these costs will be yours.

At iNtelli-Bill, we give you your data on a silver platter, literally, for free. Upon termination of services, iNtelli-Bill will export patient demographic and financial transactions into CSV files. CSV files can be imported to a spreadsheet and the first record contains descriptions explaining what the data elements are. For any vendor possessing the ability to import data into their system, it will be very easy for them to map and import as much or as little of this data they desire. We create both a PDF and human readable text file of all patients with their charge, payment, and user notes. These files are placed onto a CD which makes them easily readable and searchable by practically any PC. In addition, arrangements may be made for continued access to your data using our online system. Since we give you access to our system, you have the ability to run reports on your own whenever you want.

Our Promise to Our Customers

iNtelli-Bill promises that regardless of the contracted fee structure, we will diligently perform followup on unpaid claims and provide you with service and support to the highest standards possible. It sounds like we've repeated ourselves on our promise (kinda), but it's important and we want you to realize how much we care about your success. We want your decision to partner with us to be one you'd never regret. Going forward, we're going to talk about features and things, but we want you to have a good understanding how our "Revenue Cycle Management" (RCM) isn't just a buzzword and how our tools help us get the job done.

It's All About the Followup

We know the primary reason so many billing services don't perform followup diligently or timely is because they're not properly staffed to do it. It takes a person to perform followup,

therefore, the more clients a billing service has, the more employees they need and often times, as additional employees are hired, they're just there to perform data entry and file claims, not followup. There absolutely is a correlation between the number of claims processed and the number of FTEs required to perform all the necessary work successfully. Believe it or not, a lot of billers just hit the "refile everything" button and they think they're done. As soon as you do that, if you run an A/R report aged by claim date, it looks pretty good after simply hitting the [REFILE ALL] button. They hit the refile button because they don't want to run an A/R report and review each account and take the proper corrective action.

Remember the "outdated A/R report"? That's probably the only tool most other billing services have for working unpaid claims and old patient balances and you know how time consuming that can be. And when it comes to preparing patient statements it's often an afterthought, and then maybe performed only once monthly.

Enter ESTHER

iNtelli-Bill has ESTHER! With ESTHER, it's totally unnecessary to run a report of any kind to find unpaid claims or other issues requiring a human's touch. Whenever a biller or other designated human is ready to do followup, they pretty much just have to hit one button and ESTHER will display a small prioritized list of tasks to be performed. As an item is selected, ESTHER explains exactly why a patient is on the list. The operator has several options at that point. Most of the time, the necessary action is accomplished right then and there, and provided the action taken resolves the problem, POOF, it's gone from the list! If ESTHER thinks it's been too long since the operator reviewed an item, she'll pop up the list periodically as a reminder. ESTHER never reports a problem that isn't real, and when it comes to follow up, all a person has to do is work what ESTHER tells them to.

ESTHER increases efficiency dramatically. The HorizonMIS billing and practice management system contains many unique features which ESTHER draws upon for decision making. For instance, during routine usage, HorizonMIS learns the quirks of payers such as how long each payer takes to pay a claim, whether primary or secondary. In one practice, the time it takes from claim submission to receipt of payment from Medicare is 16 days if Medicare is primary, but it takes 22 days when Medicare is Secondary. One of ESTHER's user defined parameters is to include unpaid claims older than X days over normal. If X = 7, then using the above example, unpaid Medicare claims make the list at 23 days when primary (16+X) or 29 days when secondary (22+X). X could be set for 14 days if you wanted. The lower X is, the more sensitive ESTHER becomes. This ensures that only those claims which really need review are on the list and they hit the list as soon as practical for a particular payer. It's a waste of time to make a call on a claim that's 30 days old if historically, the payor takes 40 days to pay. That 15 minute wasted phone call will probably result in the payer saying "it's in process, and call back in 30 days". "in Process" doesn't mean it's getting paid. If the learned payment time changes, ESTHER will automatically adjust the list appropriately. To further take advantage of the time a biller is on hold waiting to speak with a person at the payer, ESTHER shows that biller other payer specific unpaid claims if they exist. That way, when the payer asks "Is there anything else I can help you with?", you can say "YES, I have a couple of other claims too.". Don't waste that 15 minute hold time to discuss only one claim, unless that's all there really was. A smart biller will try to group several claims

to inquire about from the A/R report before making the call, but ESTHER does that for you. We could go on and on about ESTHER, but hopefully you get the idea.

Get it Right the First Time

ESTHER isn't enough! While ESTHER certainly helps us deal with issues in a timely manner, it'd be even better if we reduced the number of issues in the first place by "getting it right the first time". Don't you agree? That's why HorizonMIS has a very powerful claims scrubber, but possibly more important than that is the error checking occuring at the point of data entry. It takes less time to correct a mistake "on the fly" than it does to go back and fix something later. That's why wherever possible, HorizonMIS attempts to prevent mistakes from entering the system to begin with. Turns out, this also creates a great learning environment for any biller and anyone using the system as the person entering the data is more responsible for getting it right than someone else that didn't key it. For instance, a CPT4 code for an office procedure won't be accepted if the place of service is a hospital, or a "male only" diagnosis code if the patient is a female. Maybe you got the diagnosis code right, but somebody else registered the patient as a female. HorizonMIS warns if pre authorization is needed or the old one is used up, or you just entered a consult code and you don't have a referring physician.

No matter what the reason for a rejection, denial or refile, HorizonMIS attempts to capture the reason and codify the results to help prevent the problem from being repeated. When a claim needs to be refiled, the user is presented a list of reason codes for the refile. This automatically creates documentation in the patient's file which anyone can see, and is analyzed frequently to determine where help is needed, whether it be additional training with physician or billing staff, or if warranted, additional programming edits.

Best First Pass Claim Acceptance Rate

For years, iNtelli-Bill has earned top scores from our clearing house on our "First Pass Claim Acceptance Rate" (FPCAR). As recent as December 2014, iNtelli-Bill's FPCAR was **99.6**% on all clients including those that do their billing in-house using HorizonMIS. Some clients consistently see a 100% FPCAR. This doesn't mean claims are paid at the same rate though. Payors deny for a host of reasons neither we or the clearing house can check for, but it does mean we're not going to see rejected claims for stupid and preventable reasons taking up valuable time and resources of billing personnel. For instance, the clearing house can't know if the patient's policy is still active, but if the payor provides for electronic eligibility verification, HorizonMIS will verify eligibility when policy data is initially entered, changed, or prior to an appointment if you're using our scheduling system with it's integrated eligibility. Needless to say, our goal is for 100% FPCAR and it shows. Our billing service customers consistently realize A/R days less than 30. A/R days is the average number of days it takes from date of service to full payment. Most practice management consultants would be ecstatic to see a practice's A/R days under 45, but 60-90 is usually the norm. We push for under 30 and investigate when it's not.

Integrated Eligibility Verification

Many systems offer Eligibility Verification (EV), but few if any are as integrated as

The iNtelli-Bill Difference

HorizonMIS. Many PM system's idea of EV is to link you to their clearing house portal requiring you enter patient and policy information to perform EV. That's a lot of unnecessary keystrokes. Many single source billing and PM systems included with EHRs rely heavily on their clearing house's to provide all revenue cycle management (RCM) functions including claims status. Not HorizonMIS.

In HorizonMIS, as soon as a policy is added or modified, the user is prompted to verify the insurance right then. Even if they say no, HorizonMIS will queue it up to be verified as a background task. Other system's integration merely confirm the patient has benefits, but fail to show you the benefit record downloaded from the clearing house. HorizonMIS stores the benefit record enabling it to be viewed instantly any time. Additionally, if the patient's copay is different in the benefit record from that entered in the policy data, the old copay amount will be corrected automatically. Often, a patient's copay increases and the patient doesn't tell the front office staff, or the front office staff doesn't ask. If the integrated EV detects it, it's handled for you. If a deductible remains, it's stored and displayed in the system where appropriate. IF a patient's benefits are terminated, the termination date is stored in the policy record and the system will not permit claims to be filed containing dates of service beyond the termination date.

When a user verifies eligibility from HorizonMIS, it's nearly a single click or key press operation. HorizonMIS will contact the clearing house, sign in, and transfer the patient information stored in the system for you. Besides saving keystrokes, you're verifying eligibility using the same data claims will be filed with. If you have to key any policy or patient data into a separate system, that doesn't guarantee the data in the billing system was entered properly. Electronic Eligibility Verification helps reduce claim denials considerably. You shouldn't be without it.

Integrated Appointment Scheduling

The HorizonMIS Appointment Scheduling System (APS) is a highly integrated and sophisticated system which plays an important role in the successful experience and relationship iNtelli-Bill clients have. APS is literally, the heart of the front office. Suffice it to say, if you see office patients and don't use our integrated scheduler, you're missing out on a lot.

w/Automated Eligibility Verification

HorizonMIS uses APS to verify eligibility prior to a patient being seen so if there's a problem with the insurance on file, you'll know it before you provide service. When you schedule an appointment, you'll know the status of their insurance and can re-verify if necessary. When appointment page is displayed, a colored "e" will display next to the patient indicating eligibility was checked and "eligible". The "e" is green if verified this month since policies are usually paid for a month in advance. A yellow "e" indicates the eligibility was verified last month, a red "e" indicates eligibility was checked 90-120 days ago, and a magenta "e" for over 120 days ago. Colors are used this way though out the system to easily grab the attention of the user. Green is good, Yellow means caution, Red is bad, and Magenta is Very Bad. The user soon learns to pay attention to Red and Magenta items. If a patient's insurance is terminated, a Red "t" will display. They really stand out and help front desk people identify

those patients you need updated information from. The scheduler re-verifies eligibility overnight up to 7 days in advance as appropriate.

Old Patient Balances are Highlighted

The scheduler displays the patient's names in different colors indicating if the patient has a balance due. Yellow, red, and magenta patients have patient responsible balances you can detect at a glance. When scheduling an appointment, viewing, arriving, or performing appointment reminders for a specific patient, it's impossible not to know there's a copay or old balance to collect. When a patient arrives, the front desk user clicks on the name to arrive the patient and will instantly be aware if there's a copay or old balance to collect, or if there are any other alerts requiring action or attention. Patient copays or old balances are collected and receipt printed right then and there.

Charges are Never Missed

The scheduler insures charges have been entered if services were rendered. "Arrived" patients names will change color to Cyan to indicate "arrived". As charges are entered, either manually or imported from an EHR or EMR via an HL7 interface, a green "c" will display in the appointment slot letting you know you captured charges. When charges have been permanently posted, the corresponding appointment slot will appear Green. This allows you and the billers to visually and instantly see who arrived, but more importantly, where charges might be missing. Confirming "no shows" is a simple matter and indicated with a Red "n" in the status column.

Integrated Text Messaging and eMails

Texting has or is becoming a way of life for most Americans. The surest, fastest, and safest way of getting a message to a specific individual is to text them. Most people read a text message as soon as it arrives. If the system contains an email address or cell phone number, the appointment scheduling system will offer those methods of contact for appointment reminders in addition to making phone calls. Horizon allows text and email templates to be created for many purposes. In the case of an appointment reminder, no PHI is sent, but pushing the button to send the patient a text appointment reminder will get to them almost instantly. The text will not only remind them of their appointment, but they'll also be reminded about their copay or any other balance they owe. If no cell phone is recorded, a similar message can be generated via email. For some reason, when a patient gets a text message or email from the doctor's office, they pay attention to it, and if that message tells them they owe money, the response has been very good.

Authorization Tracking

Horizon tracks prior authorization codes and warns when needed. You're warned when you make an appointment, when charges are being entered, when reviewing an account, and prior to claim submission. These patients are specifically highlighted on the scheduling display unless a valid authorization exists. Authorizations along with expiration date, number of visits, and reason for authorization are tracked. If you attempt to make an appointment for a patient that doesn't have a valid authorization, you'll be warned before you see the patient.

The iNtelli-Bill Difference

Seeing patients who require prior authorization without one earns you a fast ticket to denial, no matter how well the claim was filed.

Electronic Payment Processing System (EPPS)

Credit card processing for patient payments is integrated in Horizon. Electronic payments isn't limited to credit cards either. Debit cards, Health Savings Accounts, and checking accounts (ACH) are handled easily within the system, without the need to access a separate web site. When a patient wants to make a payment, the office can swipe the card and the appropriate data is combined with that from the medical billing database to achieve a nearly instant payment transaction.

When a patient calls iNtelli-Bill with a question about their bill, iNtelli-Bill not only answers the questions, but can also take a payment from the patient right then and there. We don't need to refer the patient back to the office.

Recurring Payments

It's a fact that due to changing policies, the ACA, higher deductibles, higher copays, and other factors, a higher percentage of receipts will be coming from patients than ever before. If your office and billing service isn't prepared to address this issue, it's going to end up costing you money. Don't you agree?

One of the nicest payment options Horizon and iNtelli-Bill provides for is the easy setup of a patient payment plan. If a patient can't afford to pay their entire balance all at once, we'll offer to set up a payment plan which they can afford (within the confines of an agreed upon protocol with the office). What sets our recurring payment plan from others is the automated reminders generated to the patient. Lets use the example where a patient owes $500.00 but can only afford to pay $25.00 per month. The patient will initially receive an email detailing a schedule of payments per their agreement. Then, 3 days prior to the $25.00 payment or charge to their account, they'll receive a reminder of the impending transaction, and a note to call the office if they don't want the transaction to occur. If they don't call the office to stop the transaction, the $25.00 payment will automatically occur, the payment will be recorded to their account and they'll receive an email receipt of the payment detailing their new balance. Since these reminders and receipts contain no PHI, and the patient previously agreed to receive them via email, they are completely HIPAA compliant and safe.

A side benefit for everyone is this system saves money by not having to mail a paper statement or receipt each month.

EPPS provides some interesting ideas for concierge practices. It's now easier to offer concierge services by offering your patients a simple automated payment plan rather than having to pay an annual fee all at once. Payments can be set up monthly, quarterly, semi-annually, or annually, all automatically.

We recommend using a "Signature on File" payment option. When a patient registers or comes in for a new appointment, the office can obtain a credit card to be placed on file to be used in the event a patient portion exists after insurance adjudication. Traditionally, patients

sign a statement accepting financial responsibility for what the insurance doesn't pay. With "Signature on File", a maximum amount to be billed monthly can be predefined, or, the same kind of reminders or notices can be sent to the patient alerting them that their credit card will be billed on a future date unless they make other arrangements.

Horizon makes it very easy to review and update patient contact information anywhere interaction with a patient might occur. At the same time, when cell phone or email data is present, the ability to text or email the patient is displayed. You can select a templated message which merges patient information automatically, you can enter a custom message, or you can edit a templated message after selection. All texts or emails sent to a patient are logged in the patient's history and can be viewed in total detail any time in the future.

Conclusion

We believe iNtelli-Bill offers the overall best value for billing services and practice management at any price point. Our company culture and work ethic ensures a smooth and easy working relationship with your office and form a partnership benefiting all parties.

While some say a “Flat Rate” service has no incentive to work as hard for you, we hope this white paper helped dispel that notion, at least for us. We truly believe that billing on a per claim basis is the most fair way to bill for our services, and in most cases, the amount you spend for our billing services will be significantly reduced over the traditional percentage based method. Our incentive to do a good job is that you'll stay with us because you want to.

We've been told by clients there's a lot of things they worry about, but HorizonMIS and iNtelli-Bill aren't one of them. We welcome the opportunity to do the same for you.

For more information, please contact us at 800-769-5554 or 904-737-5554. Our corporate headquarters are located in Jacksonville, Florida at 7400 Baymeadows Way, 32256.