Surgical/ASC Claims Revenue Cycle Management:

An Introduction to Our Processes and Protocols

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WELCOME TO BUSINESS DYNAMICS RCM: THE LEADERS IN SPINE REIMBURSEMENT

Business Dynamics RCM (BD-RCM) is a spine-specialized firm dedicated to providing revenue cycle management services to spine specialists. To date, the core focus and the foundation of the company continues to be the delivery of outstanding coding, claim generation, collection and appeals services which have resulted in maximized reimbursement for our clients.

SURGICAL CLAIMS RCM SERVICE

Our Surgical Claims Revenue Cycle Management Service provides the client with all of the coding, billing and collection services necessary to maximize reimbursement for their professional fees for spine surgery, spinal injection and diagnostic procedures, and ASC facility fees for spine procedures only. Business Dynamics RCM codes, processes, collects and appeals all surgical cases referred by the client. The result is improved collections dedicated exclusively to spine surgery and interventional procedure claims.

THE BUSINESS DYNAMICS RCM TEAM

OUR RCM TEAM

Each account is assigned to a team who specializes in the coding and reimbursement of spine specialists for certain regions throughout the country. Each team works the day-to-day billing aspects of the submission, collection, and appeals process. This team will work directly with your office to ensure that all claims and payments are accounted for. Within each team, the following members are in place to assist you and your practice:

- **Coder** – Responsible for the coding of all surgical cases and communicates with surgeons and staff relative to documentation of coding concerns.
- **Senior Auditor & Appeals Specialist** – Responsible for reconciling all payments of surgical claims and working through appeal issues with insurance carriers.
- **Auditor** – Responsible for the collection of surgical claims and follow up protocols with the respective insurance carriers.
- **Payment Processor** – Responsible for the receipt and posting of all incoming EOBs; ensure the EOBs are forward to appropriate team members for full audit and appeals review.
- **Charge Processor** – Responsible for the receipt of all incoming work from the practice; work through insurance verification, pre-authorization, data entry, and charge posting to ensure timely submission to the respective insurance carriers.
- **Accounts Receivable Specialist** – Responsible for the follow up on all office visit/consult submissions and patient balances

You will be receiving a Contact Sheet listing all Managers for all departments who you will be able to contact directly if needed.

CONTRACT INCEPTION AND INTRODUCTION

At the onset of the contract, our office would like to schedule an initial conference call to introduce our staff as well as make acquaintance with the contacts established at your practice. This first call would assist in establishing the expectations, requirements, and time-line for information and responsibilities to be completed to allow for the billing setup and transfer of work to our practice. This will also allow for review and clarification of the items required as outlined in the Welcome Packet.

Upon completion of the initial conference call, a second call will be scheduled to confirm the completion of the setup and acknowledge that all requirements have been met. In the interim of the calls, communication between Business Dynamics RCM and your practice will be open to ensure that all the information is shared between both parties to support the setup process and maintain the schedule as outlined.

CONTRACTS AND FEE SCHEDULES

Business Dynamics RCM requests that a complete list of all participating insurance carriers, as well as copies of all contracted fee schedules, be provided so we may upload them into our database at the inception of the Billing Contract between your practice and Business Dynamics RCM. This will allow us to review the contract rates in comparison to the payments received. In addition, we request that any changes in information be provided to our office in a timely manner so we may maintain the most current files within our database.

In instances in which the fee schedules are not available, the reimbursement guidelines outlined by Medicare will be considered as the minimum expected payment for contractual agreements.

PATIENT INFORMATION AND CHARGE ENTRY

Upon receipt of the documents provided by your practice, Patient Information is uploaded into the system at Business Dynamics RCM. Complete information is needed to ensure accurate billing and patient records. Below is a checklist of items needed in our office to be able to complete the various batches of work. Some of these forms will be provided from our office.

<u>SURGICAL CASES</u>

- Complete Operative Notes
- Patient Demographics and Insurance Cards
- Authorizations
- Admission Type (in-patient, out-patient)
- Coding Sheets (client specific)

<u>INJECTION & PAIN MANAGEMENT CASES</u>

- Daily Closeout Log for Injections
- Patient Payment Log
- Daily Schedule to Account for All Patients
- Superbills to include CPT and Diagnosis coding
- Complete Injection Reports
- Complete Patient Demographics
- Insurance Cards and Referrals
- All Claims for each respective date of service must be included in the same batch

Please note that our office will report all charges to your practice for your records. Descriptions of the reports are detailed in the REPORTING section of this packet

SUBMISSION OF WORK

- Your practice is required to provide all of the above information to Business Dynamics RCM to ensure accurate and efficient claim submittal. Any claim in which the necessary information is not presented will be pended; our office will request the information from your practice directly. All responses and/or documentation are required to be provided to our office within five business days, or the pended account may be subject to closure.
- All work must be submitted to Business Dynamics RCM via email. A dedicated email address will be created specifically for your practice only and is managed by the team assigned to your account. Copies of HCFAs and/or daily reports will be scanned and emailed to the designated person within your practice. Your dedicated Email address will be provided in our Company Contact Sheet.

ELECTRONIC BILLING

- Our office will register your practice for electronic billing through our clearinghouse. All eligible claims (excluding surgery when possible) will be submitted electronically to the respective carriers.
- Some carriers require forms and authorized signatures to complete the enrollment process. Such forms will be generated by our office and forwarded to your practice for completion. Our office will submit the completed forms and follow up on the enrollment process with the carriers directly. Claims will be submitted electronically upon approval from the carrier and our clearinghouse.
- Additional charges per the contract will be incurred and included on the monthly invoices submitted from our Finance Department for electronic billing.

PAYMENT ENTRY

ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the electronic exchange, transfer of money from one account to another, for electronic payments and collections. EFT is a safe secure and efficient way to receive payments directly into your bank account and avoid having to actually make check deposits. Medicare, Medicaid and many Insurance Carriers offer EFT as a form of payment. Enrollment is necessary and Business Dynamics RCM can facilitate your enrollment by obtaining the proper documentation and helping you complete the forms.

ELECTRONIC REMITTANCE ADVICE

Electronic Remittance Advice (ERA) is an electronic version of a payment explanation which provides details about providers' claim payments, and if the claims are denied, it would then contain the required explanations. ERA'S are provided by plans to Providers.

Use ERAs and EFTs together and get paid faster, reduce administrative costs and eliminate paper EOBs and checks.

PAYMENT ENTRY

Payment entry and adjustments are made in accordance with the explanations of benefits provided. Contractual obligations are recognized and reviewed based on the paperwork provided from the respective carriers. Patients will be billed for the contractual coinsurance, copayments, and/or deductibles.

Please note that our office will report all payments to your practice for your records. Descriptions of the reports are detailed in the REPORTING section of this packet

CODING AND CLAIM PAYMENT REVIEW

CODING

All Surgical Coding at Business Dynamics RCM is overseen and approved by Certified Professional Coders. We currently have several CPCs on site who work through claims on a daily basis. In addition, all Business Dynamics RCM staff members have gone through extensive training in Spine Coding and Anatomy.

Business Dynamics RCM utilizes the National Coding Guidelines presented by AMA CPT as well as CCI Edits. In addition, several specialized sources are utilized such as the North American Spine Society, AAOS, AANS, and other national coding standards.

Business Dynamics RCM also consults with the surgeons to clarify specific cases and procedures when necessary, as well as maintain an open line of communication, particularly on difficult or extensive cases that include work beyond the descriptors as presented by AMA CPT. Business Dynamics RCM stays current on the ever changing coding and reimbursement protocols. Coding and Reimbursement Advisories are distributed continuously to keep our practices and surgeons abreast of changes affecting coding and payment policies.

CLAIM PAYMENT REVIEW

All surgical and injection claims are reviewed line-by-line. During the EOB review process, we identify the following:

- Surgical and injection claim payments are reviewed upon the receipt of the Explanation of Benefits.
- Each CPT Code and the respective units are reviewed individually to ensure that each line item is accounted for on the Explanation of Benefits and paid in accordance with National Reimbursement Guidelines.
- Payment is evaluated in-line with contractual obligations for participating surgeons.
- Fee schedules are reviewed for the contracted carriers when provided by the client; if the fee schedules are not available, Medicare is used as a guideline for acceptable minimum payments.
- Non-contracted claims are reviewed on a Fee-For-Service basis. Nationally published databases, such as Fair Health, are also utilized as a resource to determine appropriate reimbursement expectations based on specific specialty and region.
- Claims which are paid in accordance with contract stipulations and/or fee-for-service reimbursements are reviewed by an Executive Level CPC to approve as closed.
- Insurance carriers are contacted immediately in regard to any cases in which an improper payment has been identified. Steps to further clarify our appeals process will follow in the Denial and Appeal Management section of this packet.

CLAIM AND APPEAL MANAGEMENT

CLAIM PROCESSES

- Surgical and injection claims are submitted to the carriers within 24-48 hours of receipt in our office, when all information required to process is provided by your practice.

- All eligible claims (except surgery) are submitted electronically to the respective carriers. Claims not eligible for electronic submission (Union/Welfare Funds, Workers Compensation, non-participating claims, etc) are submitted via mail.
- Receipt of each respective claim is confirmed with the carriers within 3 weeks of paper claim submission. Any claims not on file will be resubmitted via fax when permitted to ensure receipt and payment processing.
- Electronic claims are confirmed within 3-5 days via electronic acceptance reports generated by our billing system and clearinghouse.
- Claim payment is expected within the timeframe as directed by the respective carriers, as well as the timeframes defined by the specified State Guidelines.

DENIALS AND APPEALS

- CPT Codes are reviewed line-by-line with the insurance carrier representatives via telephone or web-based explanations of benefits. Any denials and/or underpayments are addressed immediately with a request for reprocessing of the claims when applicable, whether the EOBs have been physically received in our office or have not yet been presented.
- Requests for additional information from the carriers are responded to immediately by our staff. Information is forwarded to the carrier via fax when possible, to expedite the processing of the claims in question. Your office participation may or may not be required.
- When a phone reopening is not available, or when a more detailed approach is required, a formal written appeal is filed to the carriers with the requests for the appropriate CPT Codes to be reviewed and paid. Documentations to support our appeals are included with the submission to the respective carriers.
- When necessary, State and Executive Level requests for intervention are submitted to assist in the review process and compel responses to our appeals.
- Appeals and complaints are followed up with the respective carriers and state agencies to ensure timely review and reconciliation processes.

CLOSED SURGERY CLAIMS

- As noted, each surgical case is reviewed line-by-line for accuracy regarding payments, either in accordance with a contractual obligation or national fee for service expectations by our Senior Auditors and Appeal Specialists.
- When a claim is determined to be paid appropriately by our Appeals Department, it is forwarded to an Executive Level CPT for final review and approval to be “closed.”
- Upon this approval, a copy of the Billing Encounter Form (BEF) will be submitted to the respective surgeon. This BEF will include the line item CPT Codes, units, charge amounts, payment amounts, and payment expectations.
- Additional explanation on codes that are unpaid or appear to be underpaid will be indicated on the BEFs for further clarification.
- Please see the reporting section below for samples of the BEF.

REFUNDS/OVERPAYMENTS

Business Dynamics RCM will handle all refund and overpayment issues. Your practice should immediately direct all correspondence pertaining to refunds to our office upon receipt to allow for the appropriate review and response to the carriers. We will review each refund for appropriateness and issue our response directly to the carrier stating our position. If a refund is warranted, the following protocols are in place:

- Refund requests are sent to your practice via the refund request form, indicating the overpayment amount, including the applicable EOBs and an explanation as to the reason for the over payment.

- Your practice is responsible for issuing the refunds directly to the carriers. Upon issuance of the refund, your practice should also provide Business Dynamics RCM with a copy of the check and return the signed refund request form submitted to allow for appropriate account reconciliation.

NEGOTIATIONS

Business Dynamics RCM will address all requests for negotiations. Any requests, verbal or written, sent to your practice must be redirected to our office.

WRITE OFF POLICY

At Business Dynamics RCM, all claims are reviewed and only closed when all payments meet the parameters and stipulations expected, either based on fee-for-service expectations or contract stipulations. Our office does not "write off" claims due to timeliness or difficulties in collection.

Any claims denied due to failure of your practice or patient to provide complete and accurate information will be returned to your practice with specific denial details and adjusted in our system. Be assured that our staff will work diligently through any and all issues until all efforts have been exhausted prior to the return of any claim. Examples of such claims may include, but are not limited to:

- Failure to obtain appropriate authorization and/or referrals.
- Settlement or closure of Workers' Compensation or Auto Coverage without additional insurance present.
- Patient insurance issues such as termination, coordination of benefits, exclusions specific to patient policy.
- Any service which is not covered under patient and/or physician contract.

PATIENT BILLING

Monthly Billing and Statements

Patient statements are generated in a cycle throughout the month. The balances on these statements incorporate all charges transferred to patient responsibility. Such balances include:

  - Copayment/Coinsurance
  - Deductible
  - Direct Pays
  - Self Pays (e.g. no insurance)
  - Denials for patient insurance issues
    - Terminated coverage
    - Coordination of Benefits
    - Non-covered charges per patient policy

- Immediate patient billing is performed when policy issues must be addressed by the patient/insured directly. This will include a phone call and/or letter being submitted to the patient requesting to contact both our office and their carrier to address the following issues:
  - Direct Payments
  - Insurance coverage terminated

    - Coordination of benefits
    - Request for accident or injury details
- All patient calls will be directed to the appropriate team member to assist and answer any questions in regard to billing. A patient liaison in your office should be available to allow us to work together through patient difficulties.
- The address for patient payments will be the lockbox address to ensure direct payments to your practice.
- Phone payments cannot be completed by this office; requests for phone payments (e.g. credit/debit cards) will be directed to your practice; our office will need copies of any receipts or records for phone payments.
- Our office will bill patients for 2 cycles. Any balances that remain open after the 2 cycles, without a formal payment plan, will be considered delinquent and returned to your practice for collections.

PATIENT COLLECTION PROCESS

- Patients will be billed by Business Dynamics RCM for 2 billing cycles, unless another payment arrangement has been agreed upon. After 2 cycles, the patient accounts will be returned to your practice. It will be the responsibility of your practice to determine if the legal collection process will be pursued in accordance with your state and local laws.

- The following information will be provided to your practice for all collection balances
    - A spreadsheet detailing the patient name, service dates, total balance due, and the reason for balance (i.e. coinsurance, deductible, etc.).
    - Detailed patient journals will be provided for each patient account for the respective dates of service in which a balance remains unpaid
- These packets will be submitted to your practice at the end of each patient billing cycle.
- The balances will be adjusted in our system; any payments made after our office returns the accounts can be reapplied upon confirmation from your practice that payment has in fact been received.

PATIENT REFUND PROCESS

- Patient overpayments are identified in our system upon receipt of EOBs received by the insurance carriers.
- Negative balance/overpayments are first applied to current balances due by patients for other services.
- Refund requests are sent to your practice indicating the overpayment amount, including the applicable EOBs.
- Your practice is responsible for issuing the refunds to the patient directly; upon issuance of the refund, your practice should also provide Business Dynamics RCM with a copy of the check and return the signed refund request form submitted to allow for appropriate account reconciliation.

PATIENT BALANCE AND STATUS INFORMATION

At this time, Business Dynamics RCM allows access to our system from an outside source to review patient account and balance status. If your practice wishes to review any account status, it may be best to consider remote access for your staff. This involves setting up a user or users at your office who would receive log on ID's to enable them to access our software database and view information regarding you patient balances and claim payment status.

REPORTING

Business Dynamics RCM reports claims activities through various different types of reports on a monthly basis that is provided to the client in the month-end billing package.

CLAIM SUMMARY REPORT

- All surgical claims are reported in the Claim Summary Report as a Crystal Report which includes payment and status information for the entire year. The claims are sorted by date of service; then alphabetically.
- This report also includes appeal information when applicable; gray shading identifies claims in which appeals have been submitted.
- Line items in which the "PAID AMOUNT" and "DATE PAID" columns are blank indicate that the claim is still open for collection.

SAMPLE CLAIM SUMMARY REPORT

3/8/2013 6:35:20PM

Business Dynamics RCM
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Claim Summary

Training Account

Update Dates: 01/01/2013 to 12/31/2013

Selected Actual Providers: BD Assist PA, BD Surgeon MD

Selected Locations: BD Hospital

Include Open Items for Previous Year? Y

Patient Name	Patient No.	Voucher No.	Service Date	Billing Date	Original Carrier	Actual Provider	Voucher Fees	Amount Paid	Adjust	% Rec'd	Balance	Voucher Note
CLAIMS 2012												
Hammer, A	120720	640	12/31/2012	01/02/2013	M-NY	BDAssist	21,000.00				20,200	1/3 clm pd $1000 for 63030, 63035 1/2
			Date Paid: 01/07/2013	Remittor: M-NY				800.00	20,200	4%		rcvd eob
Hammer, A	120720	650	12/31/2012	01/02/2013	M-NY	BDSurgeo	11,500.00				11,500	1/2 clm mailed
Hammer, A	120720	641	12/31/2012	01/02/2013	M-NY	BDAssist	3,500.00				3,500	1/7 mailed appeal re denial CPT 22612,
			Date Paid: 01/07/2013	Remittor: M-NY				0.00	3,500	0%		22614
Ray, X	120800	730	12/31/2012	01/02/2013	GHI	BDAssist	21,500.00				21,500	1/1 clm mailed
Senor, C	120760	690	12/31/2012	01/02/2013	BCBS-FL	BDSurgeo	7,500.00				6,300	1/7 clm pd $1200 1/3 rcvd ECB
			Date Paid: 01/07/2013	Remittor: BCBS-FL				1,200.00	6,300	16%		
TRANSFERRED FROM 2012							**65,000**	**2,000.00**				
CLAIMS 2013												
Nut, H	120730	660	01/01/2013	01/07/2013	UHC	BDSurgeo	4,000.00				4,000	
Laxer, A	120010	620	01/02/2013	01/02/2013	Oxf1	BDAssist	11,000.00				11,000	1/2 CLM MAILED
Pain, W	120180	630	01/02/2013	01/02/2013	B-NY	BDSurgeo	11,000.00				11,000	1/2 CLM MAILED
Sember, D	120780	710	01/02/2013		oxford99	BDAssist	0.00				-	
					JAN 2013:		**26,000.00**	**0.00**				

Total Amount Collected for 2013: **0**

ACTIVITY REPORTS

- Activity Reports are a summary of the account activity for the month for surgical claims.
- The individual patient line items are copied from the complete surgical claim summary and listed by date order on the activity sheets to provide a snapshot of the collection and payment activity for the respective month for surgical cases.

SAMPLE MONTHLY ACTIVITY REPORT

3/8/2013 6:48:50PM

Business Dynamics RCM

Revenue Cycle Management for the Spine Professional

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Monthly Payment Activity

Business Dynamics Training Database

Update Dates: 01/01/2013 to 01/31/2013

Selected Actual Providers: BD Assist PA, BD Surgeon MD

Selected Locations: BD Ambulatory Surgery Center, BD Hospital, BD Office Visit

Patient Name	Patient No.	Voucher No.	Service Date	Billing Date	Original Carrier	Actual Provider	Voucher Fees	Amount Paid	Adjust	% Rec'd	Balance	Voucher Note
Hammer, A	120720	640	12/31/2012	01/02/2013	M-NY	BDAssist	21,000.00				200	1/3 clm pd $1000 for 63030, 63035
		Date Paid:	01/07/2013	Remittor:	M-NY			800.00	20,200	4%		1/2 rcvd eob
Hammer, A	120720	641	12/31/2012	01/02/2013	M-NY	BDAssist	3,500.00				3,500	1/7 mailed appeal re denial CPT
		Date Paid:	01/07/2013	Remittor:	M-NY			0.00	3,500	0%		22612, 22614
Senor, C	120760	690	12/31/2012	01/02/2013	BCBS-FL	BDSurgeo	7,500.00				300	1/7 clm pd $1200 1/3 rcvd ECB
		Date Paid:	01/07/2013	Remittor:	BCBS-FL			1,200.00	6,300	16%		

Total Amount Collected: $2,000.00

Balance Due @ 7.0%: $140.00

BILLING ENCOUNTER FORMS

We use Billing Encounter Forms (BEFs) to provide an overview of payment for your surgical claims. BEFs contain information including patient and insurance information, the coding we submitted for your claim, amount charged, amount paid, and payment expectations.

SAMPLE BEF FOR MEDICARE

Billing Encounter Form

Account #:

Patient Name: New Patient
Date of Service: 1/1/2012

Admit Date: 1/1/2012
Place of Service: Spine Surgery Hospital

Primary Insurance: Medicare
Plan Type:
Authorization #:

Secondary Insurance:
Plan Type:
Authorization #:

ICD-9 Codes: 722.10 , _____ , _____ , _____ .

_____
Previous SX

Surgeon: Will B Cutting MD — PAR — FEE SCHED: — CARRIER FEES

P/E	CPT CODE	MOD	FEE	# OF UNITS	TOTAL BILLED	EOB1	EOB2	TOTAL PAID	MIN EXP. PAYMENT
P	63047		$ 1,294.38	1	$ 1,294.38	$1,035.50			$ 1,294.38
E	63048		$ 249.34	2	$ 498.68	$398.94			$ 498.68
				TOTAL BILLED	$ 1,793.06	$1,434.44			$ 1,793.06
	TOTAL ALLOWED $1,793.06								

Patient coinsurance $358.62

SAMPLE BEF / COMMERCIAL

Billing Encounter Form

Account #:

Patient Name: New Patient
Date of Service: 1/1/2012

Admit Date: 1/1/2012
Place of Service: Spine Surgery Hospital

Primary Insurance: COMMERCIAL INSURANCE
Plan Type:
Authorization #:

Secondary Insurance:
Plan Type:
Authorization #:

ICD-9 Codes: 722.10 , _____ , _____ , _____ .

_____
Previous SX

Surgeon: Will B Cutting MD — PAR — FEE SCHED: — CARRIER FEES

P/E	CPT CODE	MOD	FEE	# OF UNITS	TOTAL BILLED	EOB1	EOB2	TOTAL PAID	MIN EXP. PAYMENT
P	63047		$ 20,000.00	1	$ 20,000.00	$5,865.00			$ 5,865.00
E	63048		$ 5,000.00	2	$ 10,000.00	$2,348.00			$ 2,348.00
				TOTAL BILLED	$ 30,000.00	$8,213.00			$ 8,213.00
	TOTAL ALLOWED $8,213.00								

ADDITIONAL REPORTING AND PROJECTS

Requests for additional reporting must be submitted in writing and will be reviewed on a case-by-case basis. Separate charges will be incurred for reporting in addition to the daily and monthly reports included in the contractual agreement. Charges will be based on the report details requested as well as the method of delivery. All charges will be presented to your practice prior to the onset of the reporting project for approval and acceptance. Payment will be due upon delivery of the report and/or project to your practice.

ATTORNEY AND LEGAL REQUESTS

Please note that Business Dynamics RCM will respond to any requests made by attorney or other legal parties in regard to itemized patient statements and billing records directly. The requesting party should be directed to our office. All requests must be submitted in writing and presented with a HIPAA compliant authorization to our medical records department. Each request will be reviewed in a timely manner and responded to accordingly. Please note that Business Dynamics RCM reserves the right to charge the requesting party for such documentation. THE STANDARD CHARGE FOR ITEMIZED BILL STATEMENT FOR ATTORNEY'S IS $25.00. Also, it is our corporate policy, in compliance with HIPAA, that all documentation will be submitted via mail; these requests will not be presented via fax to any requesting party.

TRAINING AND EDUCATION SERVICES

Business Dynamics RCM offers web-based training, consulting and education programs designed directly for Spine Practices and their employees, through our affiliate, The Business of Spine. Please visit their website at www.thebusinessofspine.com for more information.

CARRIER WEB AND INTERNET ACCESS

Business Dynamics RCM utilizes the carrier websites to confirm patient benefits and eligibility, claim payment status, appeal protocols, and carrier specific guidelines when applicable. Our staff will register your practice through our own access created as a billing partner; however there are carriers which will require practice specifics to complete the registration process. We will work with your staff to obtain access to the appropriate carrier sites.