MEDICAID BILLING AND FOLLOW UP

There have been many changes in Medicaid billing and regulations with the implementation of HIPAA causing hospitals cash flow to shrink and receivables to grow.

Whether it is Inpatient, Outpatient, Primary, Secondary or Tertiary billing our office is conditioned to your needs. Our billing system is updated daily with the new regulations to minimize rejections and maximize your cash flow.

Cost/Day Outliers

A representative will come to your office to review your Medicaid Remittance Vouchers to make sure you are maximizing your reimbursement. You will not be charged a fee if nothing is found. As accounts are qualified they will be resubmitted and adjusted to Medicaid for review and full payment.

Spendown

Any inpatient case that comes up with a spendown when checking eligibility has the potential to be converted to eligible coverage. Our staff will contact the Department of Social Services and review each case with the Case Workers.

Conversions/Backdates

Any inpatient cases that are not eligible for the admission date or have outpatient only coverage have the possibility either being converted to full coverage or backdated 90 days (recipients must be eligible within 90 days for backdate). Our staff will review each admission with the Caseworker assigned to adjust the eligibility for billing.

Overrides

Most of the problems Hospitals have with their outpatient Medicaid is when the patient is at service limit. Our staff will review each case; submit the proper override to Medicaid and then resubmit the claim to Medicaid for reimbursement.

Other Insurance

The most time consuming rejection is a claim rejecting for other insurance on file. Our staff will contact social services, review the insurance information and either submit the claim to the proper insurance or report to Medicaid the termination information.