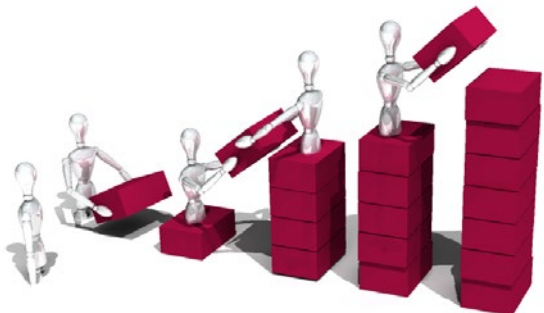


What is Full Service?

Process & Manpower



Client Services Manager
Billing Accounts Manager
Onboarding Team
Two 24 hour Operation Centers
Team based processing
Standardized workflow
Six Sigma checks and balances ensure consistency
Total transparency
Monitor your practice and our Operations Team

Expertise

Quality Assurance
Certified Coding Team
Chief Medical Officer
Detailed Revenue Cycle Analysis
Physician Advisory Board of Directors
Front Desk Process Review
Mini Coding Review
Mini Credentialing Review



Technology

State-of-the-art software
Your choice of a top tier Practice Management System
eBridge - HIPAA Compliant Scanning
Automated V.O.B. and Eligibility
Bank Lock Box
Custom management reports



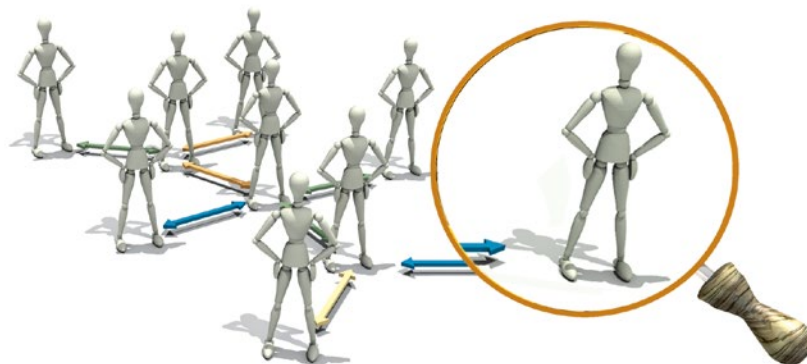
Quality Assurance before Claim Submission

Each claim undergoes a four-tier QA process within 36 hours

Billing agents convert Superbills and Reports to a claim

Coding Specialists review and verify claim

Code correct software tools scrub each claim



Denial Management/ Claim Follow-Up & Appeals

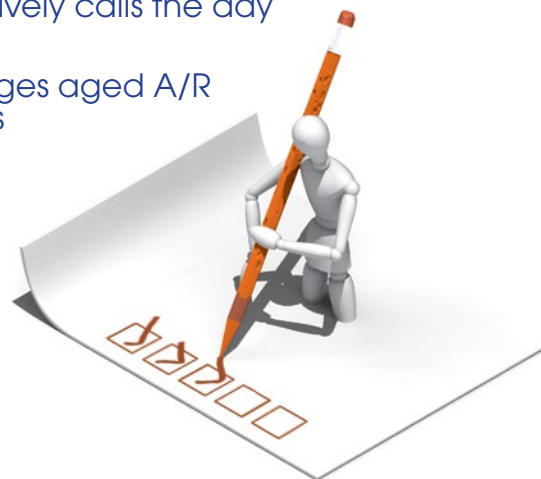
Line item processing is utilized until the full claim is resolved

Level I Collection Team proactively calls the day after EOB / ERAs are posted

Level II Collection Team manages aged A/R collection efforts every 21 days

360 degree feedback to the origin of the denial for corrective action

No write-offs are done without Client review and authorization



Scope Of Services

Systems and Setup:

- Process map the revenue cycle workflow
- Document billing and coding nuances
- Establish communication protocols
- Establish write-off protocols
- Review the clearinghouse system
- Review the setup of the Practice Management System
- Assist Client in setting up a bank lockbox service
- Review fee schedules
- Review the coding compliance process

Billing:

- Provide quality checks
 - Ensure patient demographics are complete
 - Ensure procedure codes and diagnosis codes are valid and make logical sense
 - Correct any claims that are rejected by the clearing house edits
- Enter charges into the PMS within 36 hours of receiving coded procedures
- Process claims electronically
- Provide Client a method of auditing files to ensure proper billing practices

Posting:

- Post payments for each procedure based on ERA and EOB data
- Make contractual adjustments
- Reconcile monthly deposit data and all payments

Denial Management:

- Follow-up on all denials received at the Posting stage within 48 hours of receipt

Collections, Appeals and Follow up:

- Appeal, fix and re-bill denied, low pay claims based on EOB data
- Send balances deemed uncollectible to Client for next steps/write off approval
- Provide corrective action feedback to Client

Patient Bills:

- Coordinate statements on a monthly basis
- Establish protocol for patient statements

Reports:

- Send Detailed Claim Issue (DCI) reports on a daily to weekly basis as required identifying:
 - Services provided that were unable to bill due to missing information, illegible information etc.
 - Uncollectible accounts
- Send Month End practice performance reports
- Provide a synopsis of old AR in the system and forecast of expected collections
- Provide ad hoc management reports as required by Client (Subject to Service Fees)

Account Management and Customer Service:

- Provide a Front Desk Process review and identify opportunities to implement best practices
- Provide a Credentialing review to identify gaps and/or opportunities for improvement
- Provide a Summary Coding review to identify opportunities for improved coding and documentation of services
- Provide account management support, meetings, and onsite visits
- Provide toll free and direct access to MediGain's account management and customer service team to answer any questions between 8.30am and 5.30pm CST, Monday through Friday



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