Linora SA
Healthcare Solution

Excellence in Healthcare Revenue Management

@LINORASAHEALTHCARE

At Linora SA Healthcare Solution

we are thrilled to offer a comprehensive suite of medical billing services meticulously designed to streamline your healthcare operations and enhance revenue cycle management. With our experienced team and cutting-edge solutions, you can confidently focus on delivering exceptional patient care while we manage the details.

Medical Billing & RCM Services

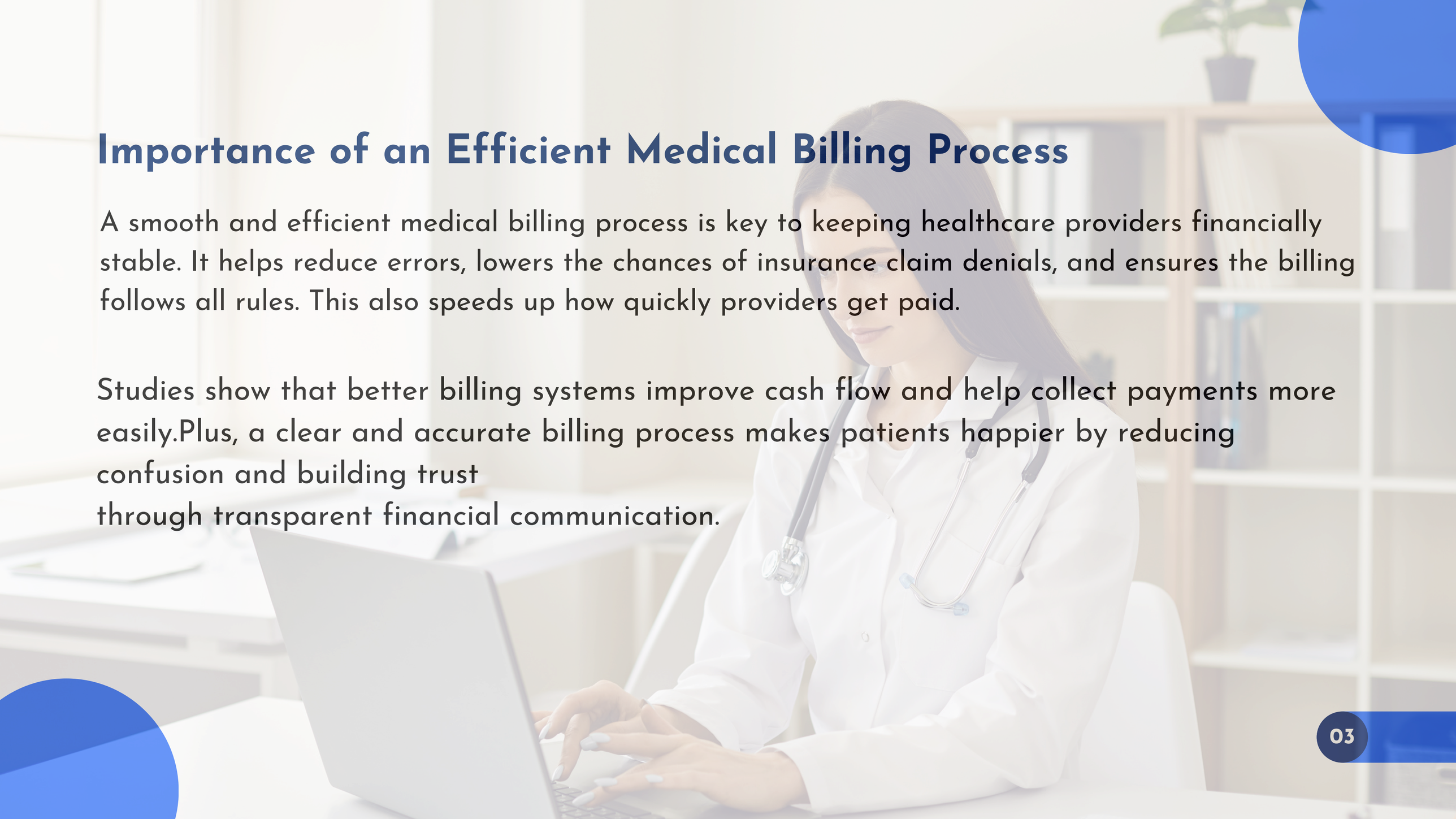
We are thrilled to offer a comprehensive suite of medical billing services meticulously designed to streamline your healthcare operations and enhance revenue cycle management.

With our experienced team and cutting-edge solutions, you can confidently focus on delivering exceptional patient care while we manage the details.

Importance of an Efficient Medical Billing Process

A smooth and efficient medical billing process is key to keeping healthcare providers financially stable. It helps reduce errors, lowers the chances of insurance claim denials, and ensures the billing follows all rules. This also speeds up how quickly providers get paid.

Studies show that better billing systems improve cash flow and help collect payments more easily.Plus, a clear and accurate billing process makes patients happier by reducing confusion and building trust
through transparent financial communication.




Medical Billing Process
1
Patient Registration
2
Front Desk Procedures
3
Charge Entry
4
Claim Submission
5
Adjudication Process
6
Payment Posting
7
Patient Billing & Statements
8
Denial Management
9
Appeals Process
10
Reimbursement

1. Patient Registration

- The first step in the RCM process is patient registration. This includes collecting accurate personal and insurance details such as the patient's name, date of birth, contact information, and insurance provider.

- Why it's important: Accurate data entry minimizes the chances of billing errors and delays. It also reduces the likelihood of claim denials due to incorrect patient information.

- Goal: Establish a clean record from the start, ensuring that no future issues arise due to incorrect data.

2. Front Desk Procedures

The front desk handles appointments, co-pays, and updates to patient info. They also help with the first consultation. When everything is done properly at this stage, it helps prevent billing errors and ensures smoother patient visits.

Initial Consultation

During the first visit, the doctor checks the patient's condition and makes a diagnosis. If the details from this visit are recorded and coded correctly, it reduces the chance of insurance claim denials later on.

3. Charge Capture

Charge capture involves documenting all services provided to the patient during the visit. This includes recording procedures, treatments, and diagnostic services.

01.

Why it’s important

Accurate charge capture ensures that no billable services are overlooked. Every service performed needs to be properly documented for reimbursement.

02.

Goal

Capture every charge to ensure full reimbursement for services provided and avoid revenue loss due to missed charges.

4. Claim Submission

Once coding is complete, we submit the claim to the appropriate payer (insurance company). Claims can be submitted electronically or via paper, depending on the payer's requirements.

- What we do: We submit claims to ensure timely processing, monitor claim status, and follow up on any issues.
- Why it's important: Timely and accurate submission speeds up the reimbursement process, and reduces the chances of delays or claim rejections due to errors.
- Goal: Ensure fast reimbursement and minimize claim rejections by following correct submission procedures.

Rejection Management

01. **Level-1 Rejection**

Description: Initial claim rejections due to minor issues, such as incorrect Patient information or missing details

02. **Level-2 Rejection**

Description: Rejections due to more complex issues, such as coding errors, Eligibility problems, or coverage disputes

5. Adjudication Process

The insurance company reviews the claim to decide if it will be paid, denied, or partially paid. They check patient eligibility, coverage, and service details. A smooth process here leads to faster and correct payments.

Quality Service

24/7

6. Payment Posting

Once the insurance company processes the claim, we post the payment into the system, ensuring it is correctly matched with the respective claim.

What we do:

Post payments received from insurance providers and update patient balances accordingly.

Why it's important:

Accurate payment posting helps maintain clean financial records and prevents billing discrepancies. It also helps in identifying any underpayments or overpayments.

Goal:

Ensure that payments are correctly allocated, and adjust any discrepancies in patient balances for accurate billing.

7. Patient Billing and Statements

Once insurance payments are posted, any remaining balance is billed to the patient. This involves generating clear, itemized statements and providing explanations for insurance coverage.

What we do: We send patient statements with detailed charges, insurance contributions, and what is owed by the patient.

Why it's important: Clear and transparent billing improves patient satisfaction and ensures timely payments. It helps patients understand what they owe and reduces confusion.

Goal: Enhance patient communication and improve collections by sending clear and timely billing statements.

8. Denial Management

If a claim is denied The team finds out why, Corrects the issue, Resubmits the claim, And follows up until the matter is resolved.

involves addressing and challenging denied insurance claims to ensure that the healthcare provider receives proper reimbursement. Key steps include

Identifying Denial Reasons:

Reviewing denial notices to understand the reasons for rejection, such as coding errors, eligibility issues, or coverage restrictions.

This process helps recover payments and avoid future denials.

Detailed List of Medical Billing Denials

1. Coverage/Eligibility Denials

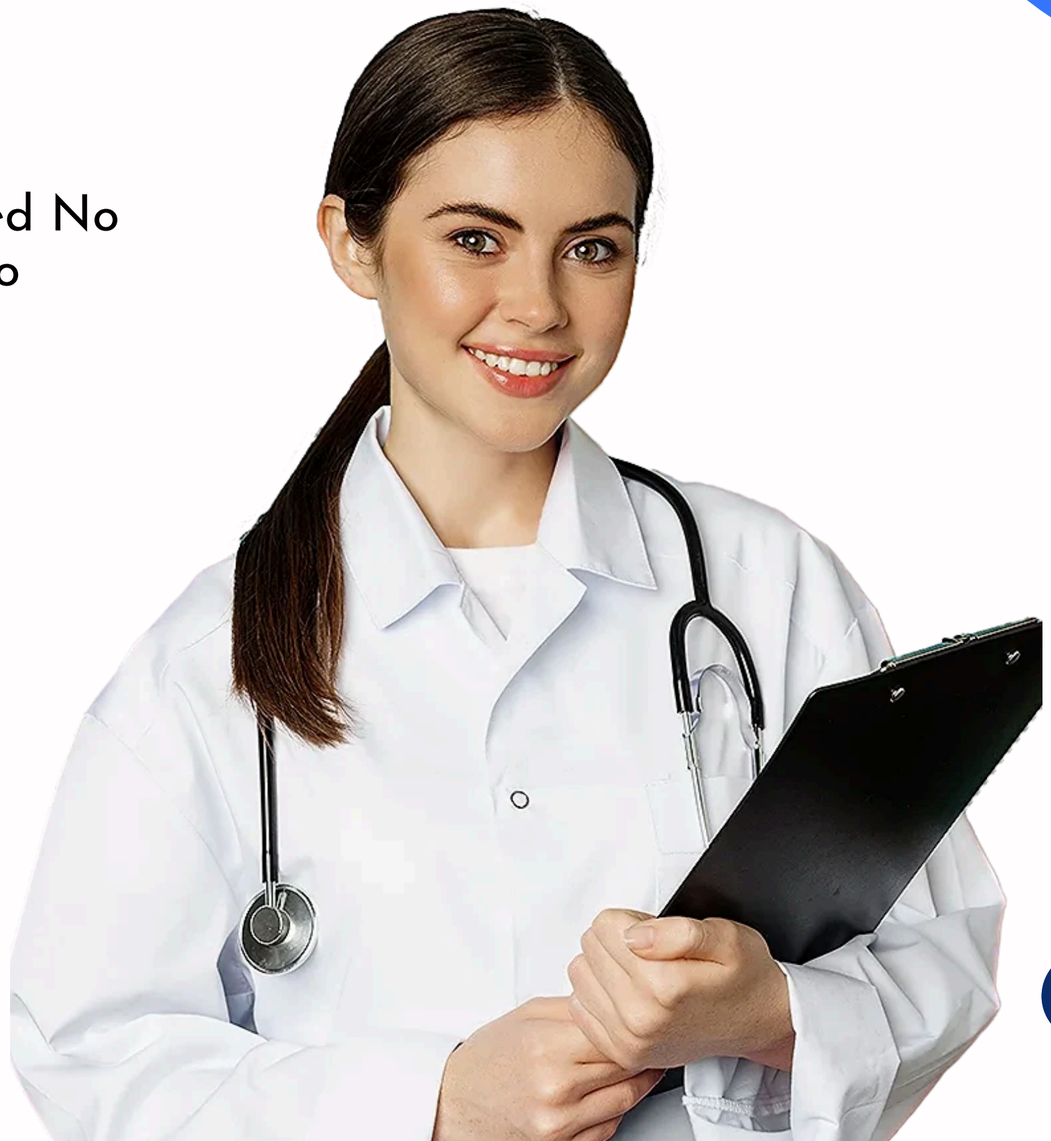
Code Reason Explanation Action/Solution
CO-27 Expenses incurred after coverage terminated Patient's insurance was inactive on DOS Verify eligibility; obtain new coverage info
CO-29 Time limit for filing has expired Claim submitted after payer’s timely filing deadline Appeal with proof of timely filing, if applicable
CO-26 Coverage not in effect on DOS Insurance not active on date of service Resubmit with correct DOS or updated insurance
CO-45 Charges exceed fee schedule/maximum allowed Payment based on payer’s allowable amount Adjust/write-off per contract
CO-24 Charges covered under a capitation agreement Provider paid via capitation; no additional reimbursement Confirm capitation terms

2. Authorization/Referral Issues

Code Reason Explanation Action/Solution
CO-197 Precertification/authorization not received No authorization on file for service Appeal with retro auth or documentation

CO-198 Authorization exceeded Units or services exceed approved amount Request updated authorization or appeal

CO-199 Provider not authorized Unauthorized provider or facility rendered the service Ensure provider is enrolled and credentialed



3. Coordination of Benefits (COB)

Code Reason Explanation Action/Solution
CO-22 COB on file Primary insurance must pay first Submit to primary insurer or obtain EOB

CO-109 Claim not covered by payer Plan deemed secondary; needs primary processing Update COB with patient/payer

CO-23 Payment adjusted due to another carrier Coordination with another insurance needed Request updated COB info

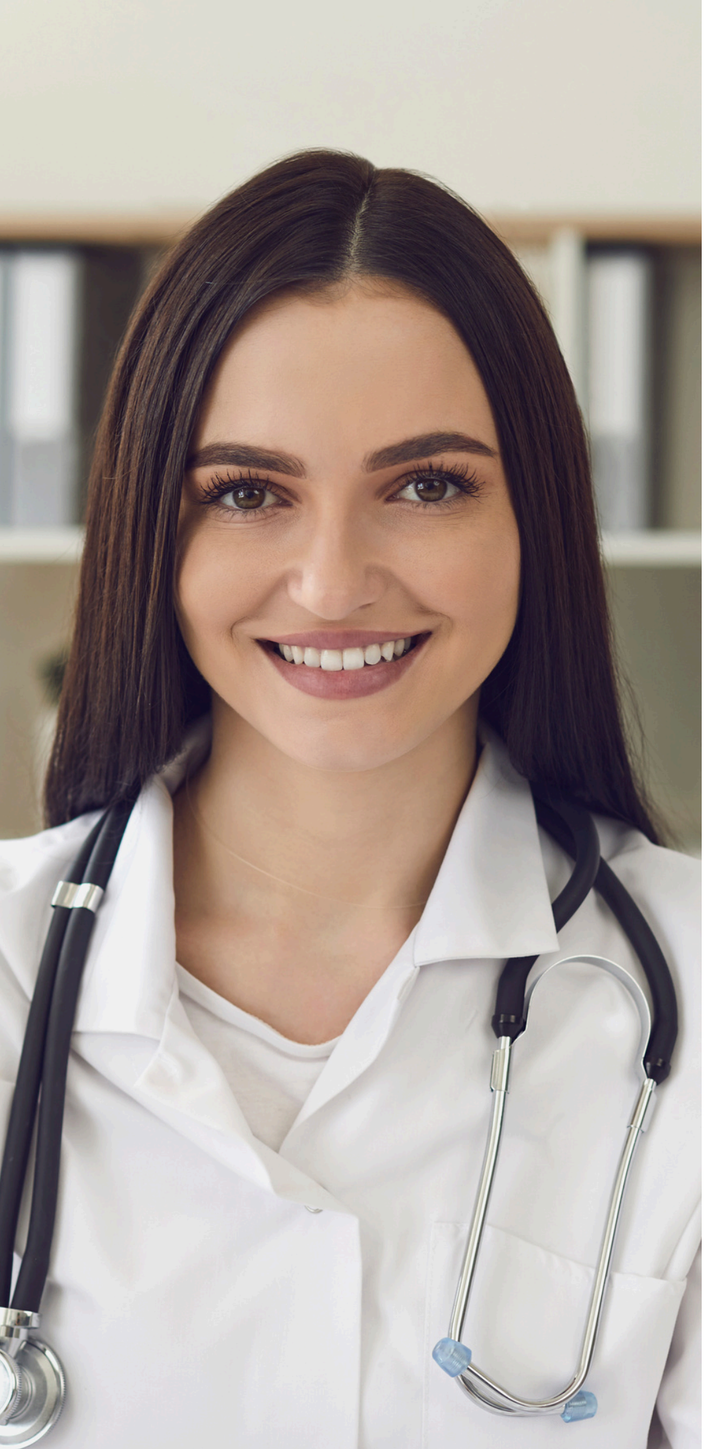
4. Patient Responsibility Issues

Code Reason Explanation Action/Solution
CO-1 Deductible amount Patient has unmet deductible Bill patient or post to deductible

CO-2 Coinsurance amount Patient is responsible for coinsurance portion Bill patient accordingly

CO-3 Co-payment amount Patient owes a co-payment Collect from patient

CO-96 Non-covered charges Charges not covered by payer Bill patient or write-off if contractual



5. Medical Necessity / Coding Issues

Code Reason Explanation Action/Solution
CO-50 Not medically necessary Payer determined service wasn't necessary per policy Submit documentation or appeal

CO-151 Payment adjusted due to invalid diagnosis ICD-10 code not appropriate or mismatched Correct and resubmit

CO-170 Payment denied due to diagnosis/procedure mismatch CPT doesn't support diagnosis Review and correct coding

CO-11 Diagnosis inconsistent with procedure ICD code doesn't justify procedure Recode or appeal with clinical notes

6. Duplicate/Bundling/Unbundling Denials

Code Reason Explanation Action/Solution
CO-18 Duplicate claim/service Same service billed more than once Review and avoid rebilling duplicates

CO-97 Payment included in another service Service is bundled into another procedure Unbundle with modifier if appropriate

CO-151 Procedure not reimbursed separately Considered part of global procedure Use modifier (e.g., -59) or follow payer policy

7. Billing/Submission Errors

Code Reason Explanation Action/Solution
CO-16 Claim/service lacks information Missing key information like NPI, DOB, or modifiers Review and correct missing fields

CO-128 NPI not on file Billing or rendering provider not enrolled Update provider records with payer

CO-208 NPI mismatch Billing and rendering provider info inconsistent Match details in claim to payer records

CO-204 Service not covered under patient's plan Procedure excluded under plan Inform patient or write off

8. Modifier Denials

Code Reason Explanation Action/Solution
CO-4 Procedure inconsistent with modifier Modifier used incorrectly or not needed Correct and resubmit

CO-59 Distinct procedural service issue Modifier 59 not used when needed to unbundle Review CCI edits and add appropriate modifier

9. Appeals Process

If a claim is wrongly denied, the provider can file an appeal with the needed documents. This needs to be done carefully and on time to make sure proper payment is received.

- Preparing Appeals: Gathering necessary documentation, such as medical records, correct coding, or additional information, to support the appeal and justify the claim.

- Submitting Appeals: Filing the appeal with the insurance company, adhering to timelines and protocols, and following up to track the status of the appeal.

10. Reimbursement

Tracking and analyzing income regularly is a key part of managing the revenue cycle and ensuring proper reimbursement. A strong revenue cycle strategy helps improve billing, cut down on errors, and make ongoing improvements for long-term financial health.

By keeping a close eye on reimbursement trends and using effective revenue management techniques, healthcare providers can boost their financial performance.

Reporting & Analytics

Finally, we provide comprehensive financial reports and analytics to help healthcare providers track performance, assess the effectiveness of their RCM processes, and identify areas for improvement.

- What we do: Generate detailed reports such as AR aging, denial rates, collection rates, and payment trends.
- Why it's important: Regular reporting helps identify issues, improve decision-making, and optimize financial performance. It enables continuous process improvement.
- Goal: Ensure ongoing improvements and better decision-making based on actionable insights from financial performance data.

Key Benefits of Linora SA Tech's RCM Services:

Maximized Revenue: By reducing errors and denials, we help you get paid faster and more accurately.

01 Streamlined Processes: Our efficient systems minimize the administrative burden on your team.

02 Better Compliance: We ensure that every step of the revenue cycle complies with regulatory standards.

03 Improved Patient Satisfaction: Transparent billing and timely collections improve overall patient experience.

Medical Coding

Medical coding is the process of translating healthcare services, diagnoses, procedures, and equipment into standardized alphanumeric codes. Common coding systems include ICD (for diagnoses), CPT (for procedures), and HCPCS (for supplies and services). Accurate coding is essential for proper billing, ensuring claims are processed correctly and providers are reimbursed appropriately. Coders must stay updated with coding guidelines, payer requirements, and compliance regulations to prevent denials and audits. High-quality coding also supports data analysis, reporting, and healthcare planning.

Quality Service

24/7

Credentialing & Enrollment

Credentialing is the process of verifying a healthcare provider's qualifications, including education, training, licenses, certifications, and professional experience. It ensures that providers meet the standards set by hospitals, insurance companies, and regulatory bodies. Enrollment refers to the process of registering a credentialed provider with insurance payers so they can bill and receive payment for services. Both steps are essential for compliance and reimbursement. Delays or errors in credentialing and enrollment can lead to claim denials and lost revenue, making accuracy and timeliness critical.

- Payer enrollment & re-credentialing
- NPI, CAQH, licensing support
- Reduce delays, speed up reimbursements

Free credentialing for first provider!

HIPAA Compliance

✅ What We Do:

- Enforce strict data protection protocols aligned with HIPAA
- (Health Insurance Portability and Accountability Act).
- Conduct routine risk assessments, secure data transmissions, and staff training.

Offer audit support and guidance in case of compliance reviews.

✅ Why It Matters:

- A breach of HIPAA can lead to heavy fines, legal issues, and reputational loss. Ensuring compliance protects both your practice and your patients.

✅ Our Edge:

- All systems, communication channels, and staff practices are HIPAA-compliant by default, with built-in safeguards for every RCM touchpoint.

Virtual Medical Assistant (VMA) Services

✅ What We Do:
Provide trained Virtual Medical Assistants for tasks like scheduling, charting, scribing, prior authorizations, and follow-ups.

VMAs integrate with your team to assist with telehealth workflows, patient reminders, EHR updates, and more.

Available full-time, part-time, or flex-time, depending on your clinic's needs.

✅ Why It Matters:
Save up to 60% in staffing costs, reduce provider burnout, and increase patient satisfaction through improved responsiveness and workflow efficiency.

✅ Our Edge:
We match you with VMAs trained in your specific specialty and software systems, ensuring quick onboarding and real results.

Linora SA Healthcare Solution– Best Offer RCM & Support Package

All-in-One Medical Back Office Solution

1. **Included Services:**

- Full Revenue Cycle Management
- Credentialing & Enrollment
- HIPAA Compliance Oversight
- Dedicated Virtual Medical Assistant (VMA)
- Daily Claims Tracking & Reporting
- Denial Management + Appeals
- 24/7 Support & Status Updates

1. **Bonus Offers (Limited Time)**:

- Free Credentialing for First Provider
- Free EHR Audit for Process Optimization
- Discounted VMA Service for 3 Months
- Custom Branded Dashboard Access

Support Center

This comprehensive breakdown of the RCM process provides clear and concise details on each stage, ensuring both clarity and professionalism. If you need to add any more specific information or visual aids for client-facing materials, feel free to ask!

Linora SA
Healthcare Solution

Get In Touch

We are eager to partner with you and support the success of your practice. For more information or to discuss how we can assist you, please don't hesitate to reach out. Your success is our priority.

Phone
(737) 363-3222

Address
Austin TX 78731, USA

Website
www.linorasahealthcare.com

Thank You.

For Your Attention

www.linorasahealthcare.com