



REVENUE CYCLE MANAGEMENT

A Detailed Explanation into RCM and Medical Billing.



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REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT (RCM) IN MEDICAL BILLING

Revenue Cycle Management (RCM) in medical billing refers to the financial process used by healthcare organizations to track patient care from initial contact through to final payment. This process ensures that healthcare providers are reimbursed for their services, which includes both direct payments from patients and insurance reimbursements. Proper RCM is critical for the financial health of healthcare providers and helps optimize cash flow, reduce costs, and improve service delivery.

Definition of Revenue Cycle Management (RCM)

RCM is the process of managing and overseeing the financial aspects of patient care, from the initial contact or appointment scheduling to the collection of payments. This includes:

- Verifying insurance eligibility
- Correctly coding services
- Submitting claims to insurance companies
- Managing accounts receivable (AR)
- Handling patient billing

The goal is to ensure that healthcare providers are reimbursed accurately and promptly for their services, while minimizing delays and denials.

Key Components of RCM

1. Pre-authorization and Eligibility Verification

- **Definition:** Pre-authorization is the process of getting approval from an insurance company before a medical service is provided. Eligibility verification confirms whether a patient's insurance covers the proposed services.
- **Importance:** Ensuring that the patient's insurance is valid and that they are eligible for the required services avoids rejections or denials of claims later in the process.

2. Medical Coding

- **Definition:** Medical coding involves translating healthcare diagnoses, procedures, medical services, and equipment into universal codes. Common coding systems include:
 - ICD-10 (International Classification of Diseases)
 - CPT (Current Procedural Terminology)
 - HCPCS (Healthcare Common Procedure Coding System)
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- **Importance:** Correct coding ensures the right reimbursement from insurers. Errors in coding can result in claim rejections or underpayment.

3. Claim Submission

- **Definition:** After the services are rendered and coded, claims are submitted to insurance companies for payment. Claims can be submitted electronically or on paper, but electronic submission is preferred for faster processing.
- **Importance:** Submitting accurate claims promptly is crucial for ensuring timely reimbursement. Delays in claim submission can lead to delayed payments and financial strain for healthcare providers.

4. Payment Posting

- **Definition:** Payment posting involves recording payments made by patients, insurance companies, or other third-party payers. The payment details are applied to the patient's account, ensuring the balance is up to date.
- **Importance:** Proper payment posting helps track outstanding balances, manage accounts receivable, and avoid discrepancies in financial records.

5. Accounts Receivable (AR) Management

- **Definition:** AR management is the process of tracking and managing outstanding payments from insurance companies and patients. This includes following up on unpaid claims and identifying any issues that need to be resolved.
- **Importance:** Efficient AR management ensures that revenue is collected promptly and any unpaid claims are addressed quickly, helping maintain healthy cash flow.

6. Denial Management

- **Definition:** Denial management involves identifying the reasons why claims are denied by insurance companies and taking steps to correct or appeal the denials. This may include resubmitting claims with corrections or submitting appeals for further review.
- **Importance:** Denial management is critical because insurance denials can significantly delay payments. Effective denial management helps reduce revenue loss and accelerates the reimbursement process.

7. Patient Billing

- **Definition:** Patient billing refers to sending invoices to patients for any remaining balances after insurance payments have been posted. This may include co-pays, deductibles, or any portion of the bill not covered by insurance.

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- **Importance:** Clear and timely patient billing reduces confusion and ensures that healthcare providers receive full payment for services rendered. It also improves patient satisfaction by providing easy-to-understand billing statements.

The Importance of Revenue Cycle Management in Medical Billing

1. Financial Health of Healthcare Providers

Proper RCM ensures that healthcare providers are paid for the services they provide, which is essential for maintaining a healthy revenue stream. Ineffective RCM processes can lead to delays in payments, reduced cash flow, and financial strain on healthcare organizations.

2. Maximizing Reimbursements

RCM plays a crucial role in ensuring that claims are accurately processed and that healthcare providers receive the maximum reimbursement they are entitled to. Proper coding and claim submission reduce the likelihood of denials or underpayment.

3. Patient Satisfaction

Timely and clear communication regarding billing and payments is essential for maintaining positive patient relationships. A well-managed RCM system can help reduce billing disputes and improve the patient experience.

4. Regulatory Compliance

Healthcare organizations must comply with various regulatory requirements, including those from the Centers for Medicare & Medicaid Services (CMS) and the Health Insurance Portability and Accountability Act (HIPAA). RCM helps ensure compliance with these standards, preventing legal or financial penalties.

Challenges in Revenue Cycle Management

1. Coding Errors

Incorrect coding can lead to claim denials or underpayments. It's essential that healthcare organizations have experienced coders who stay up-to-date with any changes in coding guidelines.

2. Claim Denials

Denials can occur for various reasons, such as incorrect patient information, coding errors, or lack of insurance coverage. Effective denial management is essential to ensure claims are resubmitted or appealed quickly.

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3. Insurance Changes

Frequent changes in insurance policies and regulations can complicate the RCM process. Healthcare providers must stay informed about insurance company policies and adjust their processes accordingly.

4. Patient Billing Disputes

Patients may not understand their financial responsibility, leading to disputes or delays in payment. Clear communication about costs, co-pays, and insurance coverage can help reduce these issues.

Conclusion

Revenue Cycle Management is a vital part of medical billing that directly impacts the financial health of healthcare providers. By following best practices, using technology, and maintaining clear communication with both patients and insurance providers, healthcare organizations can streamline their billing processes, reduce denials, and ensure timely and accurate reimbursement. A well-managed RCM system enhances operational efficiency, improves cash flow, and contributes to overall patient satisfaction.

CMS – CENTERS FOR MEDICARE & MEDICAID SERVICES

What it is:

CMS is a federal agency under the U.S. Department of Health and Human Services (HHS) responsible for administering major healthcare programs, including **Medicare**, **Medicaid**, **CHIP**, and the **Health Insurance Marketplace**.

Why it matters in RCM:

- Sets national coding and billing standards
- Defines payment models and reimbursement rates
- Oversees regulatory compliance for claims and audits
- Issues provider enrollment guidelines and NPI requirements

CLIA – CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

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What it is:

CLIA refers to federal standards for laboratory testing on human specimens (like blood, urine, etc.) to ensure accurate, reliable, and timely results, regardless of where the test is performed.

Administered by: CMS, CDC, and FDA (jointly)

Why it matters in RCM:

- Laboratories must have a valid **CLIA certificate** to perform and bill for tests
- Certain CPT codes require a **CLIA waiver/modifier** to be reimbursed
- CLIA levels (waived, moderate, high complexity) impact what services a lab can perform

HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

What it is:

HIPAA is a federal law enacted in 1996 to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Why it matters in RCM:

- Enforces strict rules on how **Protected Health Information (PHI)** is stored, shared, and accessed
- Requires safeguards for electronic health records (EHRs) and billing systems
- Mandates training, access controls, and breach notifications
- Non-compliance can result in hefty **civil and criminal penalties**

ELIGIBILITY VERIFICATION IN MEDICAL BILLING

Eligibility Verification in medical billing refers to the process of confirming whether a patient's health insurance plan covers a particular service, treatment, or procedure before it is provided. This step ensures that the patient is eligible for coverage, helps prevent claim denials, and facilitates the efficient processing of claims.

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Key Elements of Eligibility Verification:

- **Insurance company name**
- **Plan type** (e.g., HMO, PPO, etc.)
- **Coverage limits and benefits**
- **Co-pays, deductibles, and out-of-pocket responsibilities**
- **Whether the service being provided is covered under the patient's plan**

Verification can be done manually by contacting the insurance company or electronically through online tools provided by insurance payers.

Importance of Eligibility Verification

- **Prevents Claim Denials:** Ensures the service is covered before it's provided, reducing the risk of denied claims.
- **Reduces Financial Risk:** By confirming eligibility, the provider ensures that they won't be left financially responsible for unpaid services.
- **Improves Patient Experience:** Patients are informed of their financial responsibility in advance, reducing confusion and dissatisfaction later.

INSURANCE PLANS AND THEIR TYPES

Insurance plans vary in structure and the level of flexibility they offer to both patients and healthcare providers. The main types of insurance plans are:

1. HMO (Health Maintenance Organization)

- **Definition:** HMO plans require members to choose a primary care physician (PCP) who acts as a gatekeeper for all healthcare services. The patient must obtain a referral from the PCP to see a specialist.
- **Features:**
 - Limited flexibility in choosing healthcare providers; must use in-network providers except in emergencies.
 - Typically lower premiums and co-pays.
 - Requires referrals for specialist care.
- **Example:** Kaiser Permanente

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2. PPO (Preferred Provider Organization)

- **Definition:** PPO plans offer more flexibility in choosing healthcare providers. Patients can see any doctor or specialist, in or out of network, without a referral.
- **Features:**
 - Larger network of providers.
 - No need for referrals to see specialists.
 - Higher premiums and co-pays compared to HMO plans.
- **Example:** Blue Cross Blue Shield PPO

3. POS (Point of Service)

- **Definition:** POS plans combine features of both HMO and PPO plans. Patients choose a primary care physician (like an HMO), but can also see specialists and out-of-network providers (like a PPO) with a referral.
- **Features:**
 - Requires a referral from the PCP for specialist care.
 - You can see out-of-network providers, but it will usually cost more.
 - More flexibility than HMO, but less than PPO.
- **Example:** Aetna POS

4. EPO (Exclusive Provider Organization)

- **Definition:** EPO plans are similar to PPOs, but they only cover services provided by in-network providers, except in emergencies. EPO members do not need a referral to see a specialist.
- **Features:**
 - Must use in-network providers for all non-emergency care.
 - No referral needed to see a specialist.
 - Typically have lower premiums than PPOs but less flexibility.
- **Example:** Cigna EPO

IN-NETWORK AND OUT-OF-NETWORK

In-Network

Definition:

In-network refers to healthcare providers, hospitals, and medical facilities that have contracted with an insurance company to provide services at negotiated rates. These providers have agreed to accept a certain payment amount from the insurer, and patients usually pay a lower share of the costs (e.g., lower co-pays, deductibles).

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Advantages:

- Lower out-of-pocket costs for patients
- Insurer has pre-negotiated rates with providers, so the claim process is typically quicker and smoother

Examples of In-Network:

- A healthcare provider listed on the insurer's provider directory
- A specialist who has a contract with the insurance company

Out-of-Network

Definition:

Out-of-network refers to healthcare providers or facilities that do not have a contract with the insurance company. If a patient seeks care from an out-of-network provider, the insurer may pay a lower percentage of the bill, or in some cases, not cover the cost at all, leaving the patient responsible for a larger share of the expenses.

Advantages:

- Patients have the option to see any provider they choose, even if they are not part of the insurance network

Disadvantages:

- Higher out-of-pocket costs for the patient
- Claims may be processed at a lower reimbursement rate
- Possible balance billing, where the patient is billed for the difference between what the insurance pays and what the provider charges

Summary of Key Terms

- **Eligibility Verification:** The process of confirming insurance coverage for a patient before providing medical services.
- **HMO (Health Maintenance Organization):** Requires a primary care physician and referrals for specialists, with a limited network.
- **PPO (Preferred Provider Organization):** Offers more flexibility and no referral requirements but with higher costs.
- **POS (Point of Service):** Combines features of HMO and PPO with a need for referrals for specialists and the option to see out-of-network providers.

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- **EPO (Exclusive Provider Organization):** Similar to PPO but with stricter rules about using only in-network providers.
- **In-Network:** Healthcare providers or facilities that have contracted with an insurance company, offering reduced costs to patients.
- **Out-of-Network:** Healthcare providers or facilities that do not have a contract with the insurance company, leading to higher costs for the patient.

PATIENT'S RESPONSIBILITY IN MEDICAL BILLING

Patient's Responsibility refers to the out-of-pocket expenses that the patient is required to pay for their medical care, even after their insurance has processed the claim. These expenses are not covered by the insurance policies and typically include the following:

Co-payments (Co-pays)

- **Definition:** A fixed amount that the patient must pay for a healthcare service, typically due at the time of the visit.
- **Example:** If a patient's insurance requires a \$20 co-pay for a doctor's visit, the patient is responsible for paying that amount.

Deductibles

- **Definition:** The amount a patient must pay out-of-pocket for healthcare services before their insurance begins to pay.
- **Example:** If a patient has a \$500 deductible, they must pay the first \$500 of their medical costs before the insurance starts covering the services.

Co-insurance

- **Definition:** The percentage of the cost of a healthcare service that the patient is responsible for after the deductible has been met.
- **Example:** If a patient has a 20% co-insurance on a \$1000 bill, they will be responsible for paying \$200, while their insurance covers the remaining \$800.

Non-covered Services

- **Definition:** Services that are not covered under the patient's insurance plan, such as certain elective procedures or treatments.

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- **Example:** If a patient undergoes a procedure not covered by their insurance, the patient will be responsible for paying the full cost of that procedure.

Out-of-Network Charges

- **Definition:** When a patient receives care from a provider who is not part of their insurance plan's network, the patient may be responsible for higher costs. In some cases, the patient may be fully responsible for the entire bill.
- **Example:** If a patient sees a specialist who is out-of-network, they might face higher co-pays, deductibles, or even the full amount if the insurance does not provide coverage for out-of-network care.

Balance Billing

- **Definition:** When a provider bills the patient for the difference between the amount charged and what the insurance is willing to pay.
- **Example:** If a patient receives care from an out-of-network provider, and the insurance pays a portion of the bill, the provider may bill the patient for the remainder.

PRIMARY, SECONDARY, AND TERTIARY INSURANCE IN MEDICAL BILLING

When a patient has multiple insurance policies, these insurances work in a specific order to ensure that medical costs are covered. Below is a breakdown of how these insurance layers work:

1. Primary Insurance

- **Definition:** The primary insurance is the first insurance that is billed for medical services. It is the insurer that pays first, according to the patient's benefits and coverage.
- **How It Works:**
 - The primary insurance processes the claim and pays its portion of the bill.
 - The patient is responsible for any remaining costs such as co-pays, deductibles, or co-insurance, depending on their plan.
- **Example:** A person with employer-sponsored health insurance has that plan as their primary insurance.

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2. Secondary Insurance

- **Definition:** The secondary insurance is billed after the primary insurance has paid its share. It helps cover the remaining medical costs that the primary insurance did not pay, depending on the terms of the secondary insurance plan.
 - **How It Works:**
 - Once the primary insurer processes the claim, the remaining balance is sent to the secondary insurer.
 - Secondary insurance may cover co-pays, co-insurance, and even the deductible, depending on the policy.
 - **Example:** A person may have secondary insurance through their spouse's employer-sponsored health plan. After the primary plan has paid, the secondary plan will cover part or all of the remaining balance.
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3. Tertiary Insurance

- **Definition:** Tertiary insurance is the third layer of coverage that comes into play after both the primary and secondary insurances have paid their portions.
 - **How It Works:**
 - Tertiary insurance is used when a person has three or more insurance plans. After the primary and secondary insurances have processed the claim, the tertiary insurance is billed for the remaining balance.
 - **Example:** A patient with primary insurance through their employer, secondary insurance through their spouse, and tertiary coverage through a supplemental plan (such as Medigap) would have the tertiary insurance pay any leftover amount after the primary and secondary insurances have paid.
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How Primary, Secondary, Tertiary Insurance and Patient's Responsibility Work Together

Example Scenario:

- **Primary Insurance:** The patient's employer-sponsored insurance pays \$600 for a medical service.
- **Secondary Insurance:** The patient's spouse's insurance pays an additional \$300 for the remaining balance.
- **Tertiary Insurance:** A supplemental policy covers the remaining \$100, leaving the patient with no out-of-pocket costs.

Note: The patient might still be responsible for co-pays, deductibles, or co-insurance depending on the insurance terms. For example, if the total cost of the service is \$1000 and the patient's

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primary insurance has a \$50 deductible, the patient might still need to pay the \$50 deductible, even though the secondary and tertiary insurances cover the rest.

Conclusion

- **Primary Insurance** pays first and covers a portion of the medical costs.
- **Secondary Insurance** comes into play after the primary insurance, covering some or all of the remaining balance.
- **Tertiary Insurance** is the final layer of coverage, helping to pay the remaining balance if both primary and secondary insurances have already paid.
- **Patient's Responsibility** includes co-pays, deductibles, co-insurance, and costs for services not covered by insurance, such as out-of-network care or non-covered services.

Understanding these roles and responsibilities helps ensure that patients and healthcare providers know how billing works and what costs will fall to the patient. By properly coordinating benefits across multiple insurance policies, the patient's out-of-pocket expenses can be minimized.

HOW A MEDICAL CLAIM IS CODED: UNDERSTANDING PROPER CODING IN MEDICAL BILLING

Medical coding is the process of translating healthcare services, diagnoses, and procedures into standardized codes used for billing and insurance purposes. Proper coding ensures that healthcare providers are reimbursed accurately, claims are processed efficiently, and patients are billed correctly.

What is Medical Coding?

Medical coding involves assigning specific codes to a patient's diagnosis, procedures, treatments, and services provided by healthcare professionals. These codes are essential for billing, insurance claims, and maintaining accurate health records. The main types of codes used in medical billing are:

1. **ICD Codes (International Classification of Diseases)**
2. **CPT Codes (Current Procedural Terminology)**
3. **HCPCS Codes (Healthcare Common Procedure Coding System)**

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Each type of code represents a different aspect of medical care and is used in combination to accurately describe a patient's medical encounter.

1. ICD Codes – Diagnosis Codes

- **Definition:** ICD codes represent a patient's diagnosis, signs, symptoms, or reasons for seeking medical care.
 - **Current Version:** ICD-10-CM (Clinical Modification)
 - **Example:** Type 2 Diabetes – ICD-10 Code: E11.9
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2. CPT Codes – Procedure and Service Codes

- **Definition:** CPT codes describe the medical procedures and services performed by healthcare professionals.
 - **Categories:**
 - **Category I:** Widely performed and accepted procedures
 - **Category II:** Optional codes for performance measurement
 - **Category III:** Temporary codes for emerging technologies
 - **Example:** Routine Physical Exam – CPT Code: 99396
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3. HCPCS Codes – Health Care Procedure Coding System

- **Definition:** HCPCS codes are used for services, supplies, and equipment not covered by CPT codes.
 - **Example:** Oxygen Concentrator – HCPCS Code: E1390
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How Medical Coding is Done

The process of medical coding follows a systematic approach:

1. **Gather Patient Information:** Access medical records, diagnosis, treatment plans, and physician notes.
 2. **Assign ICD Codes:** Review the diagnosis and select the appropriate ICD code.
 3. **Assign CPT Codes:** Assign CPT codes for the procedures or services performed.
 4. **Assign HCPCS Codes:** Use HCPCS codes for any non-physician services or supplies.
 5. **Ensure Code Accuracy:** Review for completeness and accuracy before submitting the claim.
 6. **Submit the Claim:** Submit the codes to the insurance payer for reimbursement.
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Why Proper Medical Coding is Important

Proper coding ensures:

- **Correct Reimbursement:** Ensures accurate payment for services rendered.
 - **Compliance:** Follows legal and regulatory standards (e.g., HIPAA, CMS).
 - **Prevention of Fraud:** Helps prevent fraudulent billing practices.
 - **Efficient Claims Processing:** Reduces claim rejections and speeds up reimbursement.
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Consequences of Improper Coding

- **Claim Denials:** Invalid or incorrect codes can lead to denials.
 - **Underpayment:** Incorrect coding results in insufficient reimbursement.
 - **Legal Issues:** Fraudulent coding practices can lead to legal consequences.
 - **Delays in Payment:** Incorrect coding leads to delays in processing claims.
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Examples of Proper Coding

- **ICD-10 Code:** Hypertension – I10
 - **CPT Code:** Blood Pressure Measurement – 99406
 - **HCPCS Code:** Oxygen Therapy – E1390
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Conclusion

Proper medical coding is vital for ensuring healthcare providers are reimbursed accurately and efficiently. Understanding the coding systems (ICD, CPT, and HCPCS) and ensuring that all codes are correct and complete helps improve the revenue cycle, reduce claim denials, and maintain regulatory compliance

CLAIM SUBMISSION IN MEDICAL BILLING

Claim submission is a vital part of the medical billing process, where healthcare providers submit their bills to insurance companies, government programs (like Medicare or Medicaid), or other payers to receive reimbursement for services provided to patients. Effective claim submission ensures that healthcare providers receive timely and accurate reimbursement. Below is a detailed overview of the claim submission process.

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Steps in the Claim Submission Process

1. Patient Information Gathering

Before any claims are submitted, essential patient information needs to be gathered. This includes:

- **Personal Details:** Name, address, date of birth, and other identifying information.
 - **Insurance Information:** Provider name, policy number, group number, and patient's relationship to the policyholder (if applicable).
 - **Healthcare Services:** Detailed record of the services provided during the visit.
 - **Authorization/Referral Details:** For some insurance plans, especially specialist visits, prior authorization may be required.
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2. Coding the Services

Once the necessary information is gathered, the next step is to assign the appropriate codes for the medical services provided. These codes are essential for billing and processing. The main types of codes used are:

- **ICD Codes (Diagnosis Codes):** These describe the patient's condition, diagnosis, or reason for the visit.
- **CPT Codes (Procedure Codes):** These describe the procedures or services performed.
- **HCPCS Codes (Healthcare Common Procedure Coding System):** These are used for supplies, equipment, or non-physician services not covered by CPT codes.

Proper coding ensures the claim accurately reflects the services provided.

3. Complete the Claim Form

The next step is to fill out a claim form, which includes all relevant patient information, insurance details, diagnosis codes, procedure codes, and any additional information required by the payer. The forms used for submitting claims depend on the service type:

- **Paper Claims:**
 - **CMS-1500:** Used by healthcare professionals (e.g., physicians, nurses, and therapists) for outpatient services.
 - **UB-04 (CMS-1450):** Used by hospitals, nursing homes, and other healthcare institutions for inpatient services.
 - **Electronic Claims:**
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- **EDI (Electronic Data Interchange):** The preferred method for submitting claims due to faster processing and fewer errors.
- **837P:** For professional claims (e.g., physicians, therapists).
- **837I:** For institutional claims (e.g., hospitals, nursing facilities).

4. Review and Validation

Before submitting the claim, it is crucial to review it for accuracy. The review should ensure that:

- All required fields are filled out correctly.
- The codes match the provided documentation and services.
- Patient and insurance details are accurate.
- Modifiers are used when necessary (e.g., if a service has been altered).

Some billing systems or clearinghouses perform real-time validation to check for common errors like:

- Missing or invalid codes
- Incorrect dates of service
- Missing signatures or necessary authorizations
- Mismatched insurance details

5. Submit the Claim to the Payer

After the claim has been reviewed and validated, it can be submitted to the payer (insurance company, Medicare, Medicaid, etc.). There are two main submission methods:

- **Electronic Submission:** Directly submitted to the payer's system via EDI. This method is faster and more efficient.
- **Paper Submission:** Traditional method using CMS-1500 or UB-04 forms, still used by some providers, particularly small practices.

6. Payer Processes the Claim

Once the claim is submitted, the payer processes it by reviewing the information provided to ensure:

- **Eligibility:** The patient is eligible for the services under their insurance plan.

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- **Coverage:** The procedure or treatment is covered by the insurance policy.
- **Medical Necessity:** The treatment is medically necessary and appropriate.
- **Adherence to Policy:** The service complies with the insurance plan's rules (e.g., referral or prior authorization requirements).

The payer might:

- **Approve the claim:** The insurance company will send payment to the provider.
- **Deny the claim:** The payer provides a reason for denial (e.g., ineligibility, non-covered procedures, or coding errors).
- **Request additional information:** If there are missing details or issues with the claim, the payer may ask for more documentation or clarification.

7. Claim Adjudication

Claim adjudication refers to how the payer determines the amount they will pay and what remains the patient's responsibility. The payer's response could include:

- **Explanation of Benefits (EOB):** Sent to the patient, showing the insurer's payment and the patient's portion.
- **Remittance Advice (RA):** Sent to the provider, explaining the payment or reasons for claim denial.

8. Patient Responsibility

Once the claim has been processed, the patient's responsibility may include:

- **Co-pays:** The fixed fee the patient pays at the time of service.
- **Deductibles:** The amount the patient must pay out-of-pocket before the insurance starts covering services.
- **Co-insurance:** A percentage of the total bill that the patient is responsible for after the deductible.
- **Balance Billing:** If the provider's charges exceed the payer's allowed amount, the patient may be billed for the difference.

The patient will be notified of the amount they owe through the **EOB** or a patient statement.

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9. Follow-up and Resubmission

If a claim is denied or underpaid, the medical biller or provider should follow up to:

- **Appeal the Denial:** If the denial was due to an error or misunderstanding (e.g., incorrect codes), the provider may resubmit the claim or file an appeal with supporting documentation.
- **Correct the Claim:** If there were errors in the claim, it may need to be corrected and resubmitted.

Common reasons for claim denial include:

- **Coding Errors:** Incorrect or missing codes.
- **Eligibility Issues:** The patient was not covered on the date of service.
- **Medical Necessity:** The payer determines that the service was not medically necessary.

Conclusion

Claim submission is a crucial aspect of the revenue cycle management in healthcare. By ensuring proper documentation, accurate coding, and timely submission, healthcare providers can ensure appropriate reimbursement for their services. Adhering to the claim submission process helps minimize errors, reduce claim denials, and improve cash flow. Effective claim submission is essential for maintaining a smooth billing process and reducing administrative burdens for providers.

What Are Clearinghouses in Medical Billing?

A **clearinghouse** in medical billing is a third-party intermediary that facilitates the secure transmission of medical claims from healthcare providers to insurance payers. Acting as a bridge between providers and payers, clearinghouses "scrub" claims for errors and format them according to payer-specific requirements, improving claim acceptance rates and reducing delays in reimbursement.

Key Functions of a Clearinghouse:

- **Claim Scrubbing:** Automatically checks claims for errors or missing information before submission.
- **Claim Routing:** Sends the properly formatted claims to the appropriate insurance payers.
- **EDI Translation:** Converts data into the standard Electronic Data Interchange (EDI) format (typically ANSI X12 837).

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- **Status Tracking:** Allows providers to track claim status and receive reports like acknowledgments (999/277CA).
- **ERA Delivery:** Routes Electronic Remittance Advice (ERA) documents back to the provider's system.

Example: Instead of sending claims to hundreds of different insurance companies individually, a provider submits them to one clearinghouse, which then distributes them appropriately.

Why They Matter:

- Minimize claim rejections
- Accelerate payment timelines
- Reduce administrative burden
- Ensure compliance with industry standards

CMS-1500 vs. UB-04 Claim Forms

In medical billing, two standardized forms are used to submit healthcare claims to payers, depending on the type of service provided and the billing entity.

CMS-1500 Form (Professional Claims)

- **Used by:** Individual healthcare providers (e.g., physicians, outpatient clinics, labs, therapists)
- **Also known as:** HCFA-1500
- **Purpose:** To bill for professional services, such as office visits, lab tests, and outpatient procedures
- **Submitted to:** Medicare Part B, commercial payers, and Medicaid (for professional services)
- **Key Fields Include:**
 - Provider's NPI (National Provider Identifier)
 - Diagnosis codes (ICD-10)
 - Procedure codes (CPT/HCPCS)
 - Place of service (POS)
 - Patient demographic and insurance details

Tip: CMS-1500 is typically submitted in a red-ink paper version for some payers, but most use EDI format (837P).

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UB-04 Form (Institutional Claims)

- **Used by:** Hospitals, skilled nursing facilities, home health agencies, and other institutional providers
- **Also known as:** CMS-1450
- **Purpose:** To bill for facility charges (e.g., inpatient services, surgeries, room & board, emergency visits)
- **Submitted to:** Medicare Part A, Medicaid, and commercial payers (for institutional services)
- **Key Fields Include:**
 - Revenue codes
 - Type of bill (TOB)
 - Condition codes and occurrence codes
 - Service dates and charges
 - Patient discharge status

Example: A hospital submitting a bill for a 3-day inpatient stay would use the UB-04 form, while the consulting physician would bill their portion on a CMS-1500.

At a Glance Comparison Table

Feature	CMS-1500	UB-04
Type of Claim	Professional	Institutional
Used By	Physicians, labs, clinics	Hospitals, SNFs, HHAs
Standard EDI Format	ANSI 837P	ANSI 837I
Governing Body	National Uniform Claim Committee (NUCC)	National Uniform Billing Committee (NUBC)
Submission Format	Paper or Electronic	Paper or Electronic
Form Color (Paper)	Red-ink OCR format	Red-ink OCR format

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PAYMENT POSTING IN MEDICAL BILLING

Payment posting is a crucial part of the revenue cycle management (RCM) in medical billing. It involves recording payments made by insurance companies, government programs (like Medicare and Medicaid), and patients for healthcare services rendered. This process ensures that payments are accurately applied to patient accounts, helping healthcare providers manage their finances, track revenue flow, and resolve discrepancies.

Key Steps in Payment Posting

1. Receipt of Payments

The first step in payment posting is receiving the payments, which can come in various forms:

- **Insurance Payments:** Payments made by third-party payers such as private insurance companies, Medicaid, Medicare, etc.
- **Patient Payments:** Payments made directly by the patient, including co-pays, deductibles, or any out-of-pocket expenses.
- **Other Payments:** Payments from workers' compensation claims, government programs, or other sources.

These payments can be received via:

- **Electronic Funds Transfer (EFT):** A faster and more efficient method, commonly used by payers.
 - **Checks:** Payments received by check, often from insurance companies.
 - **Credit Card or Cash:** Direct payments made by patients at the time of service.
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2. Explanation of Benefits (EOB)

After the insurance payment is received, the payer issues an **Explanation of Benefits (EOB)** or **Remittance Advice (RA)**. This document details:

- The total amount billed.
 - The amount paid by the insurer.
 - The patient's responsibility (co-pays, co-insurance, and deductibles).
 - Reasons for any denials or adjustments to the claim.
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The EOB helps in understanding how much the payer covered and what the patient owes.

3. Matching Payments with Claims

The most crucial part of payment posting is ensuring that payments are matched with the correct claims and patient accounts.

- For **insurance payments**, the **EOB** or **RA** is used to determine which claims were paid and the corresponding payment amount.
- For **patient payments**, the amount paid is applied to the patient's outstanding balance.

Accurate matching ensures that payments are applied to the correct patient and claim.

4. Recording Payments

Once the payments are matched, the details need to be entered into the **practice management software** or **billing system**. The following payment details are recorded:

- **Amount paid by the payer.**
- **Patient responsibility** (balance due, co-pays, deductibles, etc.).
- **Adjustments** (contractual adjustments, denials, or discounts).

This step updates the **accounts receivable (AR)** and ensures each payment is reflected in the correct patient's financial record.

5. Handling Adjustments and Denials

Insurance companies may apply adjustments to payments, such as:

- **Contractual Adjustments:** Differences between the billed amount and the amount allowed by the insurance company. These adjustments do not require action from the patient.
- **Denials:** The payer may deny part or all of the claim. In these cases, the biller must determine the reason for the denial and decide whether to resubmit the claim or appeal the decision.

Handling these adjustments and denials efficiently ensures that the revenue cycle remains smooth.

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6. Updating the Accounts Receivable (AR)

After posting the payments, the **accounts receivable (AR)** is updated to reflect:

- The remaining balances due from either insurance or the patient.
- Outstanding balances are flagged for follow-up, and future actions are scheduled for unpaid claims.

The status of the claim is updated in the system (e.g., from **pending** to **paid** or **partially paid**).

7. Patient Billing

Once the insurance payment is posted, the **patient's responsibility** (co-pays, deductibles, etc.) is billed to the patient. A **patient statement** is generated and sent to the patient, showing:

- The total amount owed.
- Insurance payments received.
- The remaining balance (patient responsibility).

This step ensures that patients are notified of any outstanding amounts they need to pay.

8. Reconciliation

Reconciliation ensures that the payments posted match the actual payments received. This step is important to verify that there are no discrepancies. If any discrepancies are found (e.g., a missed payment or incorrectly posted payment), they must be investigated and corrected promptly.

Benefits of Proper Payment Posting

- **Accurate Financial Records:** Ensures that payments are recorded accurately, reducing errors in financial reporting and account reconciliation.
 - **Improved Cash Flow:** Timely posting helps healthcare providers track revenue and quickly identify any outstanding amounts.
 - **Clear Patient Accounts:** Patients' accounts will be up-to-date, with accurate balances and amounts owed.
 - **Faster Follow-up on Denied or Underpaid Claims:** Proper posting helps identify claims that require follow-up, reducing delays in revenue collection.
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- **Compliance:** Adheres to billing and accounting standards, as well as payer regulations, ensuring proper documentation and reporting.

Challenges in Payment Posting

- **Payment Reconciliation:** Sometimes payments may not match exactly with the billed amounts, requiring time-consuming investigation to identify the cause.
- **Insurance Denials:** Denied or partially paid claims complicate payment posting. These need follow-up, resubmission, or appeal.
- **Patient Balances:** Tracking patient balances, especially when they are responsible for portions of the bill, such as co-pays or deductibles, can be challenging.
- **Posting Delays:** Payments made by paper checks may be delayed, which could slow down the posting process and impact cash flow.

Conclusion

Payment posting is a vital part of the medical billing and revenue cycle management process. By ensuring that all payments, whether from insurance companies or patients, are accurately recorded and applied to the correct patient accounts, healthcare providers can maintain clear and accurate financial records. Effective payment posting improves cash flow, helps identify discrepancies, and ensures that claims are paid promptly, contributing to the overall financial health of the practice. Additionally, by handling denials and adjustments efficiently, providers can ensure smoother billing operations and faster resolution of any issues.

WHAT ARE EXPLANATION OF BENEFIT & ELECTRONIC REMITTANCE ADVICE?

EOB – Explanation of Benefits

- A paper document from a payer (insurance company) that explains **how a claim was processed**.
- It's sent to the **provider** and/or **patient**.
- It includes:
 - Patient info
 - Date of service
 - Billed amount
 - Allowed amount
 - Insurance payment

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- Patient responsibility
- Denial reasons (if any)
- Adjustment details (write-offs, etc.)

ERA – Electronic Remittance Advice

- The **electronic version** of the EOB.
- Delivered via an **EDI file** (Electronic Data Interchange, typically ANSI X12 835).
- Automatically posts payments and adjustments into billing software (if set up correctly).
- Faster and more efficient than EOBs.

What are Claim Adjustment and Remark Codes?

1. Claim Adjustment Reason Codes (CARCs)

- These codes explain **why** a claim (or part of it) was **adjusted** (reduced, denied, or not paid in full).
- Appear with an adjustment group code that gives context to the adjustment.

2. Remittance Advice Remark Codes (RARCs)

- Provide **additional explanation** about the adjustment. Think of them as extra notes.
- Paired with CARCs to give full reasoning.

Key Adjustment Group Codes

Code	Meaning	Example
CO	Contractual Obligation	Write-offs due to payer's contract with provider (e.g., insurance allowed less than billed).
OA	Other Adjustments	Includes miscellaneous things not covered by other codes—like interest, penalty, or balance forward.
PR	Patient Responsibility	Deductible, coinsurance, copay—amount the patient owes.
CR	Correction and Reversal	Used when claims are corrected or reversed.

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How to Properly Address Them

1. **Review ERAs/EOBs Daily:**
 - Check if payments match your expectations (based on fee schedules or contracts).
 2. **Understand CO and OA Adjustments:**
 - **CO:** Contractual, must be written off—don't bill patient.
 - **OA:** Depends on context—some may be re-billable, others are not.
 3. **Use CARC + RARC Combinations:**
 - Example:
 - CO-45: Charge exceeds fee schedule/maximum allowable.
 - N290: Missing/incomplete/invalid rendering provider primary identifier.
 4. **Take Corrective Action:**
 - If denial is incorrect or due to a fixable issue (e.g., missing info), submit a corrected claim or appeal.
 5. **Document Everything:**
 - Keep a log of common codes and payer behavior for better tracking and training.
-

Example Denial Scenario

Claim denied with:

- CO-45: Charge exceeds fee schedule
- N130: Consult plan for claim specifics

Action: Write off the CO-45 amount (contractual), but don't bill the patient. If the amount seems off, check the contract or call the payer.

ACCOUNTS RECEIVABLE (AR) IN MEDICAL BILLING

Accounts Receivable (AR) refers to the money owed to a healthcare provider for services rendered, either from patients or third-party payers (such as insurance companies, Medicare, Medicaid, etc.). AR is a key part of the Revenue Cycle Management (RCM) process and indicates how well a healthcare provider is managing its cash flow. In simple terms, AR represents the

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amount of money that the healthcare provider is waiting to collect for services already provided but not yet paid for.

How Accounts Receivable (AR) Works in Medical Billing

When a healthcare provider delivers services (such as medical consultation, surgery, or tests), they submit a claim to the patient's insurance company or the patient directly. The outstanding balance owed for those services is then recorded in the provider's accounts receivable.

Two primary sources of AR:

- **Insurance Payments:** Amounts owed by third-party payers (private insurance companies, Medicare, Medicaid, workers' compensation, etc.).
 - **Patient Payments:** Amounts owed by patients, including co-pays, co-insurance, deductibles, and any balances remaining after insurance payment.
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Key Steps in AR Management

1. **Service Provided and Billing:**
 - The healthcare provider delivers services to the patient.
 - A claim is submitted to the insurance company or the patient.
 - The amount owed is recorded as accounts receivable in the provider's financial records.
2. **Follow-up and Payment Collection:**
 - The provider's billing department follows up with both payers and patients to collect the outstanding amounts.
 - Insurance payments are monitored to ensure claims are processed correctly.
 - If there are delays or denials, claims may need to be resubmitted or appealed.
3. **Monitoring Aging Accounts:**
 - Aging reports track how long each payment has been overdue.
 - Accounts are categorized into different aging buckets:
 - 0-30 days: Payments within 30 days of being billed.
 - 31-60 days: Payments 31-60 days overdue.
 - 61-90 days: Payments 61-90 days overdue.
 - 91+ days: Payments more than 90 days overdue.

The longer an account is overdue, the harder it becomes to collect, making effective AR management essential.

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4. Payment Posting:

- Payments from insurance or patients are posted to the corresponding patient account in the practice management system.
- This updates the patient's balance and reduces AR.

5. Patient Billing:

- If a patient is responsible for part of the bill, the provider issues a patient statement showing the amount owed and payment instructions.

6. Denials and Rejections:

- If a claim is denied, it must be investigated, corrected, and resubmitted.
- Claims rejected due to incorrect information or coding need to be corrected before resubmission.
- Denied or rejected claims increase the AR aging period and may require additional action.

Why AR is Important in Medical Billing

AR management is crucial for the healthcare provider's financial health, ensuring timely reimbursement and operational efficiency.

Key reasons why AR management is essential:

- **Cash Flow Management:** AR represents a large portion of a provider's cash flow, and efficient AR management ensures timely payment for services.
- **Revenue Cycle Performance:** AR is tied closely to the revenue cycle. A high AR balance in the "aged" categories may indicate issues like billing errors or denied claims.
- **Identifying Delays:** By analyzing AR aging reports, healthcare providers can identify delays and take corrective action.
- **Improved Financial Planning:** Effective AR management helps providers forecast revenue, plan budgets, and allocate resources efficiently.
- **Reducing Bad Debt:** By actively managing AR, healthcare providers can prevent unpaid balances from turning into bad debt.

AR Aging Report

An AR aging report categorizes unpaid bills based on how long they have been overdue. It helps billing teams prioritize which claims need follow-up and which should be escalated for further action.

Typical AR aging categories:

- **0-30 days:** Claims considered on-time.

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- **31-60 days:** Claims that need attention, beginning to age.
- **61-90 days:** Claims requiring follow-up.
- **91+ days:** Overdue claims requiring urgent follow-up or intervention.

Best Practices for AR Management

1. **Timely and Accurate Billing:**
 - Ensure claims are submitted promptly and correctly to avoid delays in the AR cycle.
2. **Regular Follow-up:**
 - Follow up on unpaid claims regularly to ensure timely payment.
3. **Claim Appeals:**
 - Appeal denied claims quickly to avoid revenue loss. Address the specific reasons for rejection.
4. **Clear Patient Communication:**
 - Communicate financial responsibility clearly to patients. Send regular patient statements and offer flexible payment options.
5. **Monitor AR Aging:**
 - Regularly review AR aging reports to identify overdue accounts and prioritize collections.

Conclusion

Accounts Receivable (AR) in medical billing refers to the outstanding payments owed to a healthcare provider for services rendered. Proper AR management ensures timely reimbursement, maintains financial stability, and optimizes revenue cycles. By monitoring AR, following up on overdue payments, and addressing denials quickly, healthcare providers can minimize bad debt and improve financial health.

DENIAL MANAGEMENT IN REVENUE CYCLE MANAGEMENT (RCM)

Denial management is a key component of Revenue Cycle Management (RCM) that focuses on identifying, addressing, and resolving claims denied by insurance companies, government programs (e.g., Medicare, Medicaid), or other payers. Denied claims represent unpaid money that healthcare providers are owed due to issues in the claims process. Efficient denial management is crucial for ensuring that healthcare providers are reimbursed for their services.

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Why is Denial Management Important?

1. **Revenue Protection:** Denied claims result in lost revenue. Managing denials helps recover this lost income.
2. **Cash Flow Optimization:** Denials delay payments, impacting cash flow. Addressing them promptly ensures timely reimbursement.
3. **Claim Reprocessing:** Proper denial management involves correcting claims or providing additional documentation to get them paid.
4. **Cost Reduction:** Effective denial management reduces administrative costs by handling claims more efficiently.
5. **Compliance and Accuracy:** Identifying denial causes helps improve future claim submission accuracy, reducing future denials.

Key Steps in Denial Management

1. **Denial Identification:**
 - **Explanation of Benefits (EOB):** Insurance companies provide an EOB or Remittance Advice (RA), detailing the payment status, including any denials.
 - **Billing System:** The provider's billing system flags claims that have been rejected or denied.
2. **Denial Analysis:**
 - Each denied claim must be reviewed to identify the reason for denial, such as:
 - **Coding Errors:** Incorrect CPT, ICD-10, or HCPCS codes.
 - **Eligibility Issues:** Patient not covered or plan expired.
 - **Lack of Pre-Authorization:** Service requiring prior approval wasn't authorized.
 - **Insufficient Documentation:** Missing medical records or supporting documents.
 - **Duplicate Claims:** Claims submitted more than once.
 - **Medical Necessity Issues:** Payer deems the service unnecessary or experimental.
3. **Resolving Denials:**
 - **Appealing Denied Claims:** After identifying the cause of denial, the next step is appealing the claim by:
 - Correcting errors (e.g., resubmitting with accurate codes).
 - Providing additional documentation (e.g., medical records, test results).
 - Resubmitting corrected claims to satisfy payer requirements.
 - **Communication with Payers:** Direct contact with the payer may be needed to clarify the denial and request reprocessing or an appeal.
4. **Resubmitting Claims:**
 - **Corrected Claims:** Billing teams submit corrected claims with necessary changes and additional documentation.

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- **Timely Resubmission:** Claims must be resubmitted promptly to avoid delays in payment, as many payers have strict deadlines for resubmission (often 30-45 days).
- 5. **Follow-Up and Monitoring:**
 - **Regular Follow-Up:** Continuous tracking is necessary to ensure denied claims are processed after resubmission.
 - **Aging Reports:** Denied claims should be monitored regularly, with aging reports categorizing claims by how long they've been outstanding, highlighting those requiring immediate attention.
- 6. **Preventing Future Denials:**
 - **Root Cause Analysis:** Identifying common denial causes allows healthcare providers to prevent similar issues in the future.
 - **Staff Training and Education:** Educating staff on correct coding and payer-specific requirements reduces coding errors.
 - **Improved Pre-Authorization Processes:** Ensuring proper pre-authorization for services helps prevent denials related to authorization.
 - **Better Documentation:** Ensuring complete and accurate documentation at the time of service helps avoid denials for insufficient information.

Types of Denials in Denial Management

1. **Hard Denials (Permanent Denials):**
 - **Definition:** Denials that cannot be overturned or corrected. The claim is permanently rejected and cannot be resubmitted.
 - **Common Causes:**
 - Non-covered services (e.g., elective procedures).
 - Expired insurance coverage.
 - Incorrect patient information (e.g., wrong insurance details).
2. **Soft Denials (Temporary Denials):**
 - **Definition:** Denials that can usually be corrected and resubmitted for payment.
 - **Common Causes:**
 - Missing or incorrect information (e.g., incomplete billing codes).
 - Eligibility issues (can be resolved by verifying patient coverage).
 - Medical necessity issues (can be addressed with additional documentation).
 - Authorization errors (can be corrected by providing proof of authorization).

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Denial Management Best Practices

1. **Prevent Denials Through Accuracy:**
 - Ensure claims are submitted correctly the first time, including using accurate codes, verifying patient eligibility, and securing necessary pre-authorizations.
2. **Timely Claim Submission:**
 - Submit claims promptly to avoid delays and ensure timely processing, minimizing the risk of denials due to missed deadlines.
3. **Effective Communication with Payers:**
 - Establish strong communication with insurance companies and payers to resolve issues quickly, avoiding denials or delays.
4. **Staff Training:**
 - Regularly train coding and billing staff on the latest coding guidelines, payer requirements, and common denial trends.
5. **Tracking Denial Trends:**
 - Regularly analyze denials to identify recurring patterns (e.g., specific codes being denied) and take corrective actions to prevent future denials.
6. **Appeal Denied Claims:**
 - Develop a structured process for appealing denied claims, ensuring documentation is clear and errors are corrected before resubmitting.
7. **Use Denial Management Software:**
 - Consider utilizing denial management software or RCM tools to track, analyze, and appeal denied claims more efficiently.

Benefits of Effective Denial Management

1. **Improved Cash Flow:** By reducing denials and ensuring faster claim reprocessing, healthcare providers can improve cash flow and reduce outstanding AR.
2. **Higher Reimbursement Rates:** Correcting and resubmitting claims increases the likelihood of receiving full reimbursement.
3. **Reduced Administrative Costs:** Efficient denial management reduces the time and resources spent on handling denied claims.
4. **Better Compliance:** Denial management ensures that claims are processed correctly, helping to comply with payer guidelines and reducing audit risks.
5. **Data-Driven Insights:** Analyzing denials provides insights into areas where billing processes can be improved, reducing future denials.

Conclusion

Denial management is essential in RCM for resolving and preventing claim denials. By promptly addressing denials, healthcare providers can recover lost revenue, optimize cash flow, and

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reduce administrative costs. Effective denial management requires accurate claims submission, timely follow-up, clear payer communication, and continuous improvement based on denial trends. Implementing best practices helps improve denial resolution rates, prevent future denials, and ensure timely reimbursement for services rendered.

DIFFERENCE BETWEEN ACCOUNTS RECEIVABLE (AR) MANAGEMENT AND DENIAL MANAGEMENT IN RCM

Accounts Receivable (AR) Management and Denial Management are integral components of Revenue Cycle Management (RCM) in healthcare, but they focus on different aspects of the revenue cycle. Here's a comparison:

1. Accounts Receivable (AR) Management

Definition: AR management refers to the process of tracking and collecting payments owed to healthcare providers by both insurance companies and patients. It's about ensuring that the provider is paid for services rendered in a timely and efficient manner.

Key Aspects:

- **Tracking Payments:** Monitoring all outstanding payments, including those from insurance companies and patients.
- **Aging Reports:** Categorizing outstanding balances based on how long they've been due (e.g., 30, 60, 90 days) to prioritize collections.
- **Follow-Up:** Ensuring timely reimbursement by regularly following up on unpaid claims.
- **Cash Flow Management:** AR management helps optimize cash flow by ensuring timely collection of payments and reducing outstanding debts.

Goal: The primary goal is to ensure that payments are collected efficiently and that the AR balance is minimized, thus improving cash flow and ensuring providers are paid.

2. Denial Management

Definition: Denial management focuses on identifying, addressing, and resolving claims that insurance companies reject or reduce. It involves understanding why a claim was denied, correcting the issues, and resubmitting the claims for payment.

Key Aspects:

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- **Claim Review and Analysis:** Denied claims are carefully analyzed to understand the cause of the denial (e.g., coding errors, eligibility issues, lack of pre-authorization).
- **Appeals Process:** Denial management teams appeal the denied claims by providing supporting documentation or correcting errors to meet payer requirements.
- **Prevention:** Identifying recurring issues and taking preventive measures to reduce the chances of future denials (e.g., improving coding practices or ensuring pre-authorization).
- **Tracking Denials:** Categorizing denials based on reasons to identify trends and implement corrective actions.

Key Differences Between AR Management and Denial Management

Aspect	AR Management	Denial Management
Focus	Tracking, collecting, and managing all outstanding payments.	Resolving and addressing denied claims.
Scope	Manages both insurance payments and patient payments.	Addresses only denied claims from insurance.
Activities	<ul style="list-style-type: none">- Posting payments.- Sending patient bills.- Follow-up on outstanding balances.	<ul style="list-style-type: none">- Analyzing denied claims.- Appealing denials.- Correcting errors for reprocessing.
Goal	Ensures timely collection of payments, reduces AR balance.	Aims to overturn denials, ensure claims are paid, and improve acceptance rates.
Timeframe	Ongoing process until balances are settled.	Short-term process focused on fixing specific issues that cause denials.
Outcome	Improves overall cash flow and revenue by ensuring payments are received.	Ensures that denied claims are reprocessed and paid, reducing rejected claims.

How AR and Denial Management Intersect

Although AR management and denial management are separate processes, they are deeply connected:

- **Denials Increase AR:** Denied claims represent unpaid amounts. If claims are denied, they remain in the AR balance until addressed and resubmitted.
- **AR Management Relies on Denial Management:** The AR team must address denied claims through denial management to ensure payment is eventually collected.

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- **Reducing Denials Improves AR:** By addressing the causes of denials and preventing future ones, healthcare providers can reduce their AR balance and improve cash flow.

Conclusion

While AR management is a broad process that involves tracking and collecting payments, denial management is more specialized, focusing on resolving issues that cause claims to be denied. Both are crucial for an efficient revenue cycle. Denial management directly impacts AR management by resolving denied claims, ensuring that outstanding balances are reduced, and ultimately improving cash flow.

Patient Billing in Revenue Cycle Management (RCM)

Patient billing refers to the process of invoicing patients for their portion of medical services after insurance payments and adjustments. This ensures that providers collect what is owed directly from patients for costs such as co-pays, deductibles, coinsurance, and non-covered services.

Key Steps in Patient Billing

1. **Insurance Payment Posting:** Once the insurance processes the claim, payments are posted to the patient's account.
2. **Generating the Patient Bill:** After posting insurance payments, the remaining balance (if any) is calculated and a bill is generated for the patient.
3. **Patient Statement Creation:** A statement is sent to the patient detailing services rendered, payments made by insurance, and the remaining balance.
4. **Payment Collection:** Patients pay via credit card, check, or online portal. Providers may offer payment plans for those who cannot pay immediately.
5. **Follow-Up on Outstanding Balances:** If payment is not received, follow-up actions are taken, such as sending reminders or working out payment plans.
6. **Adjustments:** If any errors are found or if the patient qualifies for a discount, adjustments are made to the balance.
7. **Finalizing Patient Accounts:** Once the balance is paid, the account is closed. If unpaid, it may be sent to collections.

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Importance of Patient Billing in RCM

- **Revenue Collection:** Ensures the provider receives the full payment for services provided.
- **Compliance:** Ensures that billing practices comply with regulations, such as HIPAA.
- **Patient Satisfaction:** Clear and transparent billing improves patient satisfaction by providing clarity on financial responsibility.
- **Efficiency and Accuracy:** Helps reduce errors and improve operational efficiency in collecting payments.

Patient Billing Best Practices

1. **Clear Communication:** Patients should clearly understand their financial responsibility upfront.
2. **Timely Billing:** Ensure patients are billed promptly after the insurance processes the claim.
3. **Flexible Payment Options:** Offer various payment methods, such as online payments and installment plans.
4. **Accurate Billing:** Ensure the bill is correct and free of coding errors.
5. **Regular Follow-Up:** Consistently follow up on unpaid balances to reduce outstanding debt.

Conclusion

Patient billing is an essential process in RCM that ensures healthcare providers receive payment for services provided. Effective billing practices, such as clear communication, timely invoicing, and flexible payment options, can significantly enhance cash flow and patient satisfaction. Combined with AR and denial management, patient billing plays a crucial role in the overall success of the revenue cycle.

REPORTING IN REVENUE CYCLE MANAGEMENT (RCM): ENSURING FINANCIAL EFFICIENCY IN HEALTHCARE ORGANIZATIONS

Revenue Cycle Management (RCM) is crucial for the financial sustainability of healthcare organizations, encompassing everything from scheduling to billing, insurance claims, and payment collection. At the heart of RCM is the process of reporting, which plays a vital role in monitoring, analyzing, and optimizing financial operations. Effective reporting helps healthcare providers improve their financial performance, track trends, ensure compliance, and make data-driven decisions.

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The Importance of Reporting in RCM

In healthcare, where billing and insurance claims are complex, reporting is essential for:

- **Informed Decision-Making:** Reports provide actionable insights that help providers monitor financial processes, identify inefficiencies, and optimize the revenue cycle.
 - **Monitoring Financial Performance:** Reports track key metrics like claim status, payment collection, and reimbursement timelines, helping organizations identify problem areas and take corrective actions.
 - **Ensuring Compliance:** Regular reporting helps providers stay compliant with evolving healthcare regulations and avoid costly penalties.
 - **Reducing Revenue Loss:** Without accurate reporting, organizations risk revenue leakage, billing errors, and financial instability. Reporting helps in identifying and resolving these issues.
-

Key Types of Reports in Revenue Cycle Management

Here's an overview of the essential reports used in RCM:

1. **Claims and Billing Status Reports:**
 - These reports track the status of claims submitted to insurance companies (e.g., submitted, paid, denied, pending).
 - **Purpose:** They help providers understand the progress of claims and identify any roadblocks or delays in the revenue cycle.
2. **Accounts Receivable (A/R) Reports:**
 - These reports track outstanding payments and categorize them based on how overdue they are (e.g., current, 30, 60, or 90 days past due).
 - **Purpose:** They help improve collection strategies by identifying aged receivables and prioritizing follow-up actions.
3. **Denial Management Reports:**
 - Denial reports analyze the reasons behind claim denials, such as coding errors, documentation issues, or payer-specific requirements.
 - **Purpose:** These reports help reduce denial rates by identifying recurring issues, allowing providers to fix them and recover lost revenue.
4. **Payment Reports:**
 - These reports track all payments made by both patients and insurance companies.
 - **Purpose:** They provide insights into cash flow and help identify delays or discrepancies in payment processing.
5. **Cash Flow Reports:**

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- Cash flow reports track revenue inflows and outflows, showing the organization's ability to meet financial obligations.
- **Purpose:** These reports help ensure the organization has the liquidity needed for daily operations and long-term growth.
- 6. **Patient Financial Responsibility Reports:**
 - These reports detail patient obligations, including co-pays, deductibles, and out-of-pocket costs.
 - **Purpose:** They help providers manage patient collections more effectively and improve patient satisfaction by clarifying billing expectations.
- 7. **Revenue Cycle Key Performance Indicators (KPIs):**
 - KPIs like **Days in Accounts Receivable (AR)**, **Denial Rate**, and **Collection Rate** are crucial for measuring the effectiveness of RCM processes.
 - **Purpose:** Tracking KPIs helps providers set benchmarks and identify areas for improvement.
- 8. **Audit Reports:**
 - Audit reports track discrepancies or irregularities in the billing and claims process that could lead to regulatory violations or legal issues.
 - **Purpose:** They help mitigate the risk of audits, penalties, and legal consequences by ensuring compliance with billing laws.

The Benefits of Effective Reporting in RCM

Effective reporting offers numerous benefits, including:

1. **Enhanced Financial Performance:**
 - By identifying inefficiencies, healthcare organizations can improve processes like billing and claim resolution, which leads to better cash flow and financial health.
2. **Data-Driven Decision Making:**
 - Accurate and comprehensive data from reports allows healthcare providers to make informed decisions about operations, staffing, and resource allocation, driving improvements in efficiency.
3. **Better Compliance and Risk Mitigation:**
 - Regular reporting ensures compliance with healthcare regulations and minimizes the risk of legal issues, audits, or penalties.
4. **Improved Patient Experience:**

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- Clear reporting helps providers better understand patient financial responsibility, allowing them to communicate billing expectations clearly and reducing confusion or frustration.

Reporting Tools in RCM

Healthcare organizations use specialized tools to generate these reports. These tools typically include:

- **Electronic Health Records (EHR) Systems**
- **Practice Management Software (PMS)**
- **Dedicated Financial Reporting Platforms**

These systems enable real-time data tracking, automated report generation, and integration with other financial management processes. With features like dashboards and data visualizations, these tools make it easier to interpret complex data, streamline RCM tasks, and act quickly on insights.

Conclusion

In Revenue Cycle Management, reporting is not just about tracking financial data—it's about ensuring that healthcare organizations operate efficiently, remain compliant with regulations, and optimize their revenue streams. With comprehensive and accurate reports, healthcare providers can identify bottlenecks, reduce claim denials, improve cash flow, and enhance patient satisfaction. Robust reporting provides the foundation for a financially healthy and sustainable revenue cycle, ultimately contributing to better care and improved operational efficiency.

Incorporating effective reporting into the daily operations of an organization is essential for success in today's complex healthcare landscape.

KEYWORDS IN REVENUE CYCLE MANAGEMENT (RCM)

1. **Accounts Receivable (A/R):**

The money owed to a healthcare provider for services rendered, including payments from both patients and insurance companies. Monitoring A/R is critical for tracking outstanding payments and enhancing collections.

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2. **Denial Management:**

The process of analyzing, tracking, and resolving denied or rejected insurance claims to ensure timely reimbursement. Effective denial management helps reduce claim denials and prevents revenue loss.

3. **Claims:**

Requests submitted to insurance companies for reimbursement after healthcare services are provided. Claims are tracked throughout the revenue cycle (paid, denied, or pending).

4. **Reimbursement:**

The process by which healthcare providers receive payment from insurers or patients for services rendered. Reimbursement rates (from private insurance, Medicaid, Medicare, etc.) are crucial for RCM success.

5. **Coding:**

The process of assigning standardized codes (ICD-10, CPT, HCPCS) to diagnoses and procedures for accurate billing and insurance claim submissions. Correct coding is necessary for claim acceptance and reimbursement.

6. **Charge Capture:**

The accurate recording of all charges for healthcare services provided to ensure the provider receives proper reimbursement. Charge capture prevents revenue leakage and billing errors.

7. **Cash Flow:**

The movement of money into and out of a healthcare organization, which is critical for maintaining financial health. Cash flow management ensures the organization can meet its financial obligations and continue operations smoothly.

8. **Insurance Verification:**

The process of confirming a patient's insurance eligibility and coverage before services are provided. Insurance verification helps prevent billing errors and ensures accurate reimbursement.

9. **Patient Financial Responsibility:**

The portion of healthcare costs that a patient is responsible for paying, such as co-pays, deductibles, and out-of-pocket expenses. Clear communication of financial responsibility helps with patient collections.

10. **Revenue Cycle KPIs:**

Key performance indicators (KPIs) that measure the efficiency and effectiveness of the revenue cycle, including metrics such as Days in Accounts Receivable (A/R), Denial Rate, and Collection Rate.

11. **AR Days (Days in Accounts Receivable):**

A metric used to track the average number of days it takes to collect payments owed to a healthcare provider. Shorter AR days indicate more efficient collections.

12. **Payer:**

An entity, such as an insurance company, government program, or employer, responsible for reimbursing the healthcare provider for services rendered. Efficient payer management is crucial for RCM.

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13. Patient Billing:

The process of sending bills to patients for their share of healthcare costs, including co-pays, deductibles, and non-covered services. Timely and clear billing is essential for patient satisfaction and collections.

14. Collections:

The process of securing payments from patients and insurance companies. This includes sending invoices, following up on overdue payments, and employing debt collection strategies if necessary.

15. EHR (Electronic Health Record):

A digital version of a patient's paper chart, which stores patient data (including billing information). EHR systems are integral to RCM, facilitating coding, claim submission, and payment tracking.

16. Practice Management Software (PMS):

Software used by healthcare organizations to manage operations such as scheduling, billing, and financial reporting. PMS integrates with EHR systems to streamline the RCM process.

17. Payment Posting:

The process of applying payments received (from patients or insurance companies) to the corresponding patient accounts. Payment posting helps track outstanding balances and update financial statuses.

18. Auditing:

The process of reviewing financial and billing practices to ensure compliance with regulations and to identify errors, discrepancies, or potential fraud. Auditing is critical for maintaining financial integrity and avoiding penalties.

19. Third-Party Payer:

An entity (such as an insurance company, Medicare, or Medicaid) that reimburses healthcare providers for medical services provided to patients. Managing third-party payer claims is a key component of RCM.

20. Compliance:

Ensuring healthcare billing practices adhere to legal and regulatory requirements, such as HIPAA (Health Insurance Portability and Accountability Act), ICD-10 coding standards, and payer-specific rules.

21. Eligibility Verification:

The process of confirming a patient's health insurance coverage before services are provided. It helps prevent claim denials and ensures payment for services.

22. Front-End RCM:

The initial phase of the revenue cycle, which includes patient registration, insurance verification, and pre-authorization of services.

23. Back-End RCM:

The post-service phase of the revenue cycle, involving coding, billing, claims submission, payment posting, and collections.

24. Denial Rate:

The percentage of claims denied by insurance companies. A high denial rate often

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signals issues with coding, documentation, or insurance policies that require corrective measures.

25. Clearinghouse:

A third-party service that facilitates the submission of electronic claims between healthcare providers and insurance payers. Clearinghouses can help validate claims and provide status updates.

26. Charge Master:

A comprehensive list of all billable items, services, and procedures offered by a healthcare provider. The charge master ensures accurate and consistent billing for services rendered.

27. Out-of-Pocket Expenses:

The portion of healthcare costs that patients are responsible for paying, including co-pays, deductibles, and coinsurance.

28. Patient Portal:

An online platform that allows patients to access their health information, including billing details, appointment schedules, and payment history. It enhances patient engagement and simplifies the billing process.

29. Financial Counseling:

The practice of providing patients with clear information about their insurance coverage, payment options, and financial responsibilities. Financial counseling helps improve billing transparency and patient satisfaction.

30. Pre-Authorization:

The process of obtaining approval from an insurance company before a service is rendered to ensure that the treatment or procedure will be covered under the patient's insurance plan. Pre-authorization helps prevent claim denials.

31. Claim Scrubbing:

The process of reviewing and correcting insurance claims before submission to ensure that they are accurate, complete, and compliant with payer requirements. Scrubbing helps reduce claim denials and rejections.

32. Patient Payment Plans:

Structured arrangements between a healthcare provider and a patient to pay off outstanding medical bills over time. These plans are designed to make payments more manageable for patients and improve collections for providers.

33. Underpayment:

When an insurer reimburses a healthcare provider for less than the agreed-upon amount for services rendered. Underpayment analysis is important for identifying discrepancies and recovering lost revenue.

34. Medical Necessity:

A standard used by insurance companies to determine whether a service or procedure is appropriate and necessary for the patient's condition. Claims may be denied if a service is deemed not medically necessary.

35. Revenue Integrity:

The practice of ensuring that all aspects of the revenue cycle are accurate, compliant,

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and efficient. Revenue integrity aims to prevent errors and fraud and ensure that healthcare organizations receive the appropriate reimbursement for services provided.

36. Out-of-Network:

Refers to healthcare providers or services that are not part of an individual's insurance plan's preferred network. Out-of-network claims typically result in lower reimbursement rates for providers and higher costs for patients.

37. High-Risk Claims:

Claims that are likely to be denied or flagged for audit due to factors such as high-cost services, complex billing, or potential issues with documentation. Identifying high-risk claims early in the process can help prevent denials and delays.

38. Patient Demographics:

Key information about a patient, such as age, gender, address, insurance information, and medical history, that is essential for accurate billing, coding, and claim submission.

39. Payment Gateway:

A technology that allows healthcare providers to securely process patient payments online or through other electronic methods. Payment gateways streamline collections and improve the patient experience.

40. Charge Capture Software:

Software used to accurately document and track all billable charges for services provided, ensuring that the provider is reimbursed appropriately and minimizing revenue leakage.

41. Health Information Exchange (HIE):

The electronic sharing of health-related information across different healthcare organizations to improve care coordination and streamline billing and reimbursement processes.

42. Medicare/Medicaid Billing:

The process of submitting claims for reimbursement under government insurance programs like Medicare and Medicaid. This involves strict compliance with government regulations and specific billing codes.

43. Self-Pay:

Refers to patients who pay out-of-pocket for their healthcare services instead of relying on insurance. Managing self-pay patients requires clear communication and payment strategies to ensure prompt collections.

44. Integrated Revenue Cycle Management (IRCM):

The integration of various RCM functions (front-end and back-end processes) into one seamless system, allowing for more efficient and streamlined billing, coding, and claims management.

45. Fee Schedule:

A list of fees for healthcare services provided by a provider, which outlines the charges for specific procedures, treatments, or tests. Fee schedules are important for accurate billing and reimbursement.

46. Claim Adjudication:

The process by which an insurance company reviews a claim to determine whether it

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will be paid, denied, or adjusted. Claim adjudication involves the verification of services, coding accuracy, and medical necessity.

47. Patient Financial Responsibility (PFR) Estimation Tools:

Software or tools used to provide patients with an estimate of their out-of-pocket costs for medical services, helping them plan for future payments and improving collections.

48. Bad Debt:

Amounts owed by patients that are unlikely to be collected, often due to non-payment or inability to pay. Managing bad debt involves identifying at-risk accounts early and employing collection strategies.

49. Healthcare Compliance Officer:

An individual responsible for ensuring that the healthcare organization adheres to all applicable healthcare regulations, billing laws, and payer guidelines. Compliance officers play a crucial role in preventing fraud and ensuring proper reimbursement.

50. Overpayment Recovery:

The process of identifying and recovering overpayments made by insurers or patients for healthcare services. This often involves reviewing past claims to find discrepancies and ensuring refunds are issued appropriately.

In conclusion, effective Revenue Cycle Management (RCM) is essential for the financial health of healthcare organizations. By optimizing processes such as claims management, patient billing, denial resolution, and cash flow monitoring, providers can improve operational efficiency and ensure they receive the reimbursement they are owed. Clear communication, adherence to regulatory requirements, and the use of advanced technology are key to streamlining these processes and enhancing the overall patient experience. With a well-managed RCM system, healthcare organizations can not only secure timely payments but also maintain financial sustainability and improve the quality of care they provide to their patients.

Thank you for taking the time to read through this! If you have any questions or need assistance in the future, don't hesitate to reach out. I'm here to help!

There is a self-assessment test also available at the end. Hope it will help you understand the basics and importance of Revenue Cycle Management.

Wishing you the best in your work with Revenue Cycle Management. Take Care & always remember, in Medical Billing, accuracy is paramount—because the only thing worse than a denied claim is a denied vacation request!

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MEDICAL BILLING – GENERAL KNOWLEDGE ASSESSMENT

Instructions: Choose the best answer. This test includes 25 multiple-choice questions across various specialties and billing scenarios.

1. **What is the primary function of the revenue cycle in healthcare?**
A) Patient engagement B) Managing finances of a hospital
C) Billing and collecting payment for services D) Scheduling surgeries
2. **Which department is primarily responsible for charge entry and claim submission?**
A) Compliance B) Billing
C) Collections D) Registration
3. **What is the best way to reduce denials related to eligibility?**
A) Send all claims as self-pay B) Call patients after the visit
C) Verify insurance coverage before the service D) Wait for denial and appeal
4. **Which form is used to submit professional healthcare claims to payers?**
A) UB-04 B) CMS-1500
C) IRS-1040 D) W-9
5. **In a surgical setting, who is responsible for documenting the procedure and any complications?**
A) Medical coder B) Patient
C) Surgeon D) Billing clerk
6. **What is the purpose of a prior authorization?**
A) To confirm a provider's license B) To reduce documentation needs
C) To obtain payer approval before providing certain services D) To ensure lab test accuracy
7. **What role does the clearinghouse play in medical billing?**
A) Audits internal operations B) Maintains patient records
C) Edits and routes claims to payers D) Collects copayments
8. **What is typically the first step in the billing process?**
A) Posting payments B) Denial appeal
C) Patient registration and insurance verification D) Claim correction
9. **Which of the following can cause a claim to be denied as duplicate?**
A) Invalid NPI B) Late filing
C) Submitting the same service more than once D) Missing modifier
10. **Why is timely filing important in medical billing?**
A) It reduces audit risk B) It ensures patient satisfaction
C) It allows claims to be paid within payer deadlines D) It eliminates the need for appeals
11. **What does medical necessity refer to in billing?**
A) The patient's preference for a service B) Payer requirement that services be justified by clinical need
C) What the provider feels is best D) How quickly the service is rendered
12. **When should patient copayments typically be collected?**
A) After insurance pays B) At the time of service
C) During claim appeal D) After the claim is denied

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13. **Which of the following is a protected health information (PHI) item?**
A) Provider's license number B) Patient's birthdate and diagnosis
C) CPT description D) Lab panel order
14. **In radiology billing, what is the global service made up of?**
A) Physician only B) Facility only
C) Technical and professional components D) Registration and discharge
15. **What happens if a patient's insurance is inactive on the date of service?**
A) Claim is paid partially B) Claim is denied
C) Payer adjusts the service D) Service is re-coded
16. **What is the main goal of an internal audit in medical billing?**
A) Marketing strategies B) Physician satisfaction
C) Identifying billing errors and ensuring compliance D) Recruiting new patients
17. **Who determines the allowable amount for a covered service?**
A) Patient B) Billing staff
C) Payer D) Provider's accountant
18. **Why might a lab claim be denied for missing documentation?**
A) Lab equipment failure B) Results not reviewed
C) Missing physician order or diagnosis D) Test performed too quickly
19. **Which of the following is an example of up-coding?**
A) Using a modifier incorrectly B) Assigning a higher-level code than the service performed
C) Submitting without insurance D) Sending a corrected claim
20. **What should be done when a payer issues a partial payment without explanation?**
A) Close the account B) Bill the patient immediately
C) Review remittance and contact payer if needed D) Refile with a different provider
21. **In what situation is an ABN (Advance Beneficiary Notice) typically required?**
A) When the provider is out-of-network B) When a patient refuses care
C) When Medicare may not cover a service D) When an HMO is billed
22. **Who is legally responsible for the accuracy of documentation in a medical record?**
A) Biller B) Insurance rep
C) Rendering provider D) Front desk staff
23. **What does coordination of benefits (COB) ensure?**
A) Only primary insurance is billed B) Patient pays in full
C) Multiple payers cover the correct portions of a claim D) Deductibles are waived
24. **Why might a claim be rejected instead of denied?**
A) Missing patient signature B) Invalid format or incomplete data
C) Lack of medical necessity D) Insurance paid zero
25. **Which area is most impacted by incorrect use of modifiers?**
A) Eligibility B) Demographics
C) Reimbursement accuracy D) Appointment scheduling

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ANSWER KEY

- 1) C – Billing and collecting payment for services
- 2) B – Billing
- 3) C – Verify insurance coverage before the service
- 4) B – CMS-1500
- 5) C – Surgeon
- 6) C – To obtain payer approval before providing certain services
- 7) C – Edits and routes claims to payers
- 8) C – Patient registration and insurance verification
- 9) C – Submitting the same service more than once
- 10) C – It allows claims to be paid within payer deadlines
- 11) B – Payer requirement that services be justified by clinical need
- 12) B – At the time of service
- 13) B – Patient's birthdate and diagnosis
- 14) C – Technical and professional components
- 15) B – Claim is denied
- 16) C – Identifying billing errors and ensuring compliance
- 17) C – Payer
- 18) C – Missing physician order or diagnosis
- 19) B – Assigning a higher-level code than the service performed
- 20) C – Review remittance and contact payer if needed
- 21) C – When Medicare may not cover a service
- 22) C – Rendering provider
- 23) C – Multiple payers cover the correct portions of a claim
- 24) B – Invalid format or incomplete data
- 25) C – Reimbursement accuracy