START

Patient presents to facility

PRECLAIMS SUBMISSION

COLLECT

patient's and responsible parties' information

DETERMINE

appropriate financial class or account type

EDUCATE

patient about fiscal responsibilty for services rendered

VERIFY

data prior to procedures or services being performed and submitted for payment

> Services are rendered to patient

CLAIMS PROCESSING

Order Entry

captures the charge at the point of service delivery. Charge is automatically added to the patient's account.

Charge Description Master

Database used by facilities to house billing information for all services and supplies

Hard Coding

HCPCS code is added to the patient's claim without the intervention of a coding professional

Soft Coding

Coding professionals review medical record documentation. All diagnoses and procedures are identified, coded, and then abstracted into the HIM coding system.

Auditing & Review

Claim is reviewed for accuracy and completeness. Scrubbers are used to audit claims before submission. Flagged claims are returned to a coding professional for review and correction.

Claims Submission

After being reviewed and corrected, claim is submitted to the third party payer for payment.

ACCOUNTS RECEIVABLE

Insurance Processing

Once a claim is received by the third party payer, insurance processing, or adjudication, begins.

Medicare Administrative Contractor

Contractor
Claims for Medicare
Parts A and B are
submitted to a
designated MAC
who determines costs
and reimbursement
amounts, conducts
reviews and audits,
and makes payments
to providers for
covered services.

Benefits Statements

EOBs and MSNs are part of the Transactions Rule and are provided to the facility via electronic data interchange (EDI) and are sent to the patient via postal mail.

Explanation of Benefits (EOB)

TPPs prepare this statement to be delivered to the patient that describes services rendered, payments covered, and benefits limits and denials.

Medicare Summary Notices (MSNs)

Statement for Medicare patients detailing amounts billed by the provider, amounts approved by Medicare, how much Medicare reimbursed the provider, and what the patient must pay the provider by way of deductible and copayments.

Remittance Advice (RA)

Report sent to provider by TPPs after a claim is processed that outlines claim rejections, denials, and payments to the facility.

CLAIMS RECONCILIATION AND COLLECTIONS

ANALYZE

Remittance Advice for rejected or denied claims or line items

RECONCILE

accounts to ensure proper payment was received

MANAGE

claims corrections and resubmission processes

Account is settled

END