Halcyon RCM Partner Assistant

Complete User Guide for Revenue Cycle Management

Version 1.0 For RCM Organizations & Healthcare Facilities

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1. Introduction

1.1 About Halcyon RCM Partner Assistant

The Halcyon RCM Partner Assistant is a comprehensive revenue cycle management platform designed to help healthcare organizations maximize patient account recovery. The system analyzes patient financial data to identify optimal recovery pathways including Medicaid, Medicare, Disproportionate Share Hospital (DSH) programs, and state-specific assistance programs.

1.2 Key Benefits

- **Maximize Recovery**: Identify the best recovery pathway for each patient account
- **Reduce Denials**: Proactive denial prevention and appeal management
- **Streamline Operations**: Automated work queues and prioritization
- **Improve Efficiency**: Batch processing for high-volume accounts
- **Ensure Compliance**: Built-in eligibility verification and documentation tracking
- **Gain Visibility**: Real-time analytics and performance dashboards

1.3 Who Should Use This Guide

This guide is designed for:

- **RCM Specialists** who process patient accounts daily
- **Eligibility Coordinators** who verify insurance coverage
- **Denial Management Teams** who handle appeals
- **Hospital Administrators** who oversee revenue cycle operations
- **Financial Counselors** who assist patients with coverage options

2. Getting Started

2.1 Logging In

1. Navigate to your organization's Halcyon portal URL
2. Enter your email address and password
3. Click **Sign In**
4. Complete two-factor authentication if enabled

2.2 First-Time Setup

Upon first login, you may need to complete initial setup:

1. **Profile Configuration**: Update your name and contact information
2. **Notification Preferences**: Choose email and in-app alert settings
3. **Default Settings**: Set your preferred date format and export options

2.3 Navigation Overview

The main navigation menu provides access to all features:

Menu Item	Description
Dashboard	Overview of key metrics and recent activity
Assessments	Patient account analysis and recovery pathways
Eligibility	Medicaid/Medicare screening tools
Import	Single file data import with mapping
Batch Import	High-volume data processing
Work Queue	Task management and prioritization
Denials	Appeal management and analytics
Price Estimate	Patient cost transparency tool
Reports	Analytics and performance dashboards
Settings	System configuration and preferences

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3. Dashboard Overview

3.1 Summary Statistics

The dashboard displays four key performance indicators:

Total Assessments

The total number of patient accounts analyzed in the system. This includes all assessments regardless of status or outcome.

Total Charges

The aggregate dollar amount of charges under assessment. This represents the potential revenue being analyzed for recovery opportunities.

Estimated Recovery

The projected total recovery amount based on identified pathways. This figure updates as assessments are completed and pathways are confirmed.

Recovery Rate

The percentage of charges expected to be recovered. A higher rate indicates more successful pathway identification and execution.

3.2 Recovery by Pathway

A visual breakdown showing recovery distribution across:

- **Medicaid**: State-funded healthcare coverage
- **Medicare**: Federal healthcare for seniors and disabled
- **DSH (Disproportionate Share Hospital)**: Federal supplemental payments
- **State Programs**: State-specific assistance programs

3.3 Recent Assessments

A quick-view table showing the six most recent assessments with:

- Patient identifier
- Total charges
- Recommended pathway
- Confidence level
- Assessment date

3.4 Quick Actions

Shortcuts to common tasks:

- **New Assessment**: Create a manual assessment
- **Import CSV**: Upload patient data
- **View Reports**: Access analytics

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4. Patient Assessments

4.1 Understanding Assessments

An assessment is a comprehensive analysis of a patient account to determine:

- Eligibility for coverage programs
- Optimal recovery pathway
- Required documentation
- Estimated recovery amount
- Confidence level of recommendations

4.2 Creating a New Assessment

Step 1: Navigate to New Assessment

Click **Assessments** > **New Assessment** from the navigation menu.

Step 2: Enter Patient Information

Complete the required fields:

Field	Description	Required
Patient Name	Full legal name	Yes
Date of Birth	MM/DD/YYYY format	Yes
SSN (Last 4)	Last four digits only	No
Address	Street, City, State, ZIP	Yes
Phone	Primary contact number	No
Email	Contact email address	No

Step 3: Enter Financial Information

Provide household and income details:

Field	Description
Household Size	Number of persons in household
Annual Income	Gross annual household income
Employment Status	Employed, Unemployed, Retired, Disabled
Assets	Total household assets (if required by state)

Step 4: Enter Insurance Information

Document current or prior coverage:

Field	Description
Insurance Status	Insured, Uninsured, Underinsured
Carrier Name	Insurance company name
Policy Number	Insurance policy ID
Coverage Type	Commercial, Medicaid, Medicare, Self-Pay

Step 5: Enter Account Information

Add the charges to be analyzed:

Field	Description
Date of Service	When services were provided
Total Charges	Gross charges for the encounter
Facility	Location where services were rendered
Account Number	Internal patient account number

Step 6: Submit Assessment

Click **Analyze** to process the assessment. The system will:

1. Verify patient demographics
2. Calculate income-based eligibility
3. Identify applicable programs
4. Recommend optimal pathways
5. Generate confidence scores

4.3 Viewing Assessment Results

Recovery Pathways

Each assessment displays recommended pathways ranked by likelihood of success:

Pathway Card Information:

- **Program Name**: Medicaid, Medicare, DSH, or State Program
- **Estimated Recovery**: Dollar amount expected
- **Confidence Level**: High (80%+), Medium (50-79%), Low (<50%)
- **Reasoning**: Explanation of the recommendation
- **Requirements**: Documentation needed to pursue

Confidence Scoring

Confidence levels are calculated based on:

- Data completeness
- Eligibility criteria match
- Historical success rates
- Documentation availability

Required Actions

Actions are categorized by urgency:

Category	Timeframe	Examples
Immediate	Within 24 hours	Missing critical documents
Priority	Within 1 week	Eligibility verification needed
Follow-up	Within 30 days	Appeal deadline approaching

4.4 Exporting Assessments

Individual Export

From any assessment detail page:

1. Click the **Export** button
2. Choose format: CSV, PDF, or Excel
3. Select data fields to include
4. Click **Download**

Bulk Export

From the assessments list:

1. Select assessments using checkboxes
2. Click **Export Selected**
3. Choose export format and options
4. Click **Download**

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5. Eligibility Screening

5.1 Overview

The Eligibility Screening tool performs comprehensive analysis of patient eligibility for:

- **Medicaid** (state-specific rules for all 50 states)
- **Medicare** (age, disability, and condition-based)
- **Dual Eligibility** (combined Medicare/Medicaid)
- **Presumptive Eligibility** (temporary coverage)
- **Retroactive Coverage** (backdated eligibility)

5.2 Performing an Eligibility Screen

Step 1: Access the Screening Tool

Navigate to **Eligibility** from the main menu.

Step 2: Enter Demographics

Field	Description
Date of Birth	Patient's birthdate
State of Residence	Current state (determines rules)
Citizenship Status	US Citizen, Permanent Resident, etc.
Residency Duration	How long in current state

Step 3: Enter Household Information

Field	Description
Household Size	Total persons in household

Gross Monthly Income	Before-tax monthly earnings
Employment Status	Current employment situation
Employer Coverage	Whether employer offers insurance

Step 4: Enter Special Conditions

Check applicable conditions:

- ☐ Pregnant
- ☐ Disability (SSDI recipient)
- ☐ End-Stage Renal Disease (ESRD)
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Blind
- ☐ Age 65 or older

Step 5: Review Results

Medicaid Eligibility Results:

- MAGI calculation and Federal Poverty Level percentage
- Medicaid expansion eligibility (if state expanded)
- Traditional Medicaid categories
- Spend-down requirements (if applicable)

Medicare Eligibility Results:

- Age-based eligibility (65+)
- Disability-based eligibility (SSDI 24+ months)
- Condition-based eligibility (ESRD, ALS)
- Part A, B, C, D coverage details

Dual-Eligible Analysis:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI)
- Full Dual Eligible status

5.3 State-Specific Rules

The system automatically applies state-specific:

- Income thresholds (FPL percentages)
- Asset limits
- Covered populations
- Application procedures
- Retroactive coverage windows

Medicaid Expansion States: Income up to 138% FPL qualifies for adult Medicaid coverage.

Non-Expansion States: Traditional categorical eligibility applies (pregnant, disabled, children, elderly).

5.4 Next Steps and Documentation

After screening, the system provides:

- Required application forms
- Supporting documentation checklist
- Application submission instructions
- Estimated processing timeframes
- Appeals process (if denied)

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6. Data Import & Batch Processing

6.1 Single File Import

Overview

Import patient data from CSV files with intelligent column mapping.

Step 1: Prepare Your File

Ensure your CSV file:

- Has headers in the first row
- Uses UTF-8 encoding
- Contains no merged cells
- Has consistent data formatting

Step 2: Upload File

1. Navigate to **Import**
2. Click **Upload CSV** or drag and drop
3. File preview displays first 3 rows

Step 3: Select Mapping Preset (Optional)

Choose a preset for common RCM systems:

- Availity
- Change Healthcare
- Waystar
- Optum
- Custom presets

Step 4: Map Columns

For each required field, select the matching column from your file:

System Field	Your Column
Patient Name	[Select...]
Date of Birth	[Select...]
Account Number	[Select...]
Date of Service	[Select...]

Total Charges	[Select...]
Insurance	[Select...]

Step 5: Configure Options

- **Skip duplicate accounts**: Prevent re-importing existing records
- **Continue on errors**: Process valid rows even if some fail
- **Date format**: Match your file's date formatting

Step 6: Execute Import

Click **Import** to begin processing. Monitor progress:

- Records processed
- Records skipped
- Errors encountered

Step 7: Review Results

Download the import report showing:

- Successfully imported records
- Skipped duplicates
- Error details with row numbers

6.2 Batch Import (High Volume)

Overview

Process large files (100,000+ records) with optimized performance.

When to Use Batch Import

- Files larger than 10MB
- More than 10,000 records
- Overnight processing preferred
- Minimal manual oversight needed

Step 1: Prepare Large File

Batch import supports:

- File size up to 100MB
- 100,000+ rows
- Processing speed: 100-500 rows/second

Step 2: Upload and Configure

1. Navigate to **Batch Import**
2. Upload your file
3. Select or create mapping preset
4. Enable/disable options:
    - Continue on errors
    - Duplicate detection
    - Email notification on completion

Step 3: Start Background Processing

Click **Start Batch Import** to queue the job. You can:

- Close the browser
- Work on other tasks
- Receive email when complete

Step 4: Monitor Progress

Return to Batch Import to view:

- Percentage complete
- Estimated time remaining
- Rows processed/remaining
- Current error count

Step 5: Download Results

When complete, download:

- Success report (imported records)
- Error report (failed records with reasons)
- Duplicate report (skipped records)

6.3 Creating Custom Presets

Why Use Presets

- Eliminate manual mapping each import
- Ensure consistency across users
- Save time on recurring imports

Creating a Preset

1. Navigate to **Settings** > **Mapping Presets**
2. Click **Create New Preset**
3. Enter preset details:
    - Name (e.g., "Epic Export Format")
    - Vendor (optional)
    - Description
    - Date format
    - Delimiter (comma, tab, pipe)
4. Define column mappings
5. Save preset

Sharing Presets

Presets can be:

- **Personal**: Only you can use
- **Organization**: All users in your org
- **System**: Built-in, read-only

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7. Work Queue Management

7.1 Overview

The Work Queue organizes patient accounts into actionable task lists, ensuring:

- Nothing falls through the cracks
- High-priority items are addressed first
- Team workload is balanced
- Deadlines are tracked

7.2 Queue Types

New Accounts

Freshly imported or created assessments requiring initial review.

Pending Eligibility

Accounts awaiting eligibility determination or verification.

Denials

Claims denied by payers requiring review or appeal.

Appeals

Active appeals at various stages of the process.

Callbacks

Accounts requiring follow-up communication.

Compliance

Items flagged for compliance review or documentation.

7.3 Working with the Queue

Viewing Queue Items

1. Navigate to **Work Queue**
2. Select queue type using tabs
3. Items display with:
    - Patient/Account identifier
    - Priority level
    - Due date
    - Assigned user
    - Status

Claiming an Item

1. Click **Claim** on an unclaimed item
2. Item moves to your assigned list
3. Status changes to "In Progress"

Completing an Item

1. Open the item details
2. Perform required actions
3. Add notes if needed
4. Click **Mark Complete**

Releasing an Item

If you cannot complete an item:

1. Click **Release**
2. Item returns to queue
3. Add reason for release

7.4 Priority Levels

Priority	Description	Example
Critical	Immediate attention required	Filing deadline today
High	Complete within 24 hours	Appeal deadline this week
Medium	Complete within 1 week	Standard processing
Low	Complete within 30 days	Non-urgent follow-up
Lowest	No deadline	Optional review

7.5 Queue Statistics

Monitor team performance:

- **Pending**: Items awaiting work
- **In Progress**: Currently being worked
- **Overdue**: Past due date
- **Completed Today**: Finished items
- **Average Time**: Mean completion time

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8. Denial Management & Appeals

8.1 Understanding Denials

When a claim is denied, the system captures:

- Denial reason code (CARC/RARC)
- Denied amount
- Denial date
- Payer information
- Timely filing deadline

8.2 Denial Analytics Dashboard

Key Metrics

- **Total Denials**: Count of denied claims

- **Denied Amount**: Dollar value at risk
- **Appeal Success Rate**: Historical win percentage
- **Preventable Denials**: Avoidable denial count

Top Denial Codes

Identifies your most common denial reasons:

- Code and description
- Frequency count
- Total dollar impact
- Prevention recommendations

Appealable Amount

Shows total recoverable funds through successful appeals.

8.3 CARC Code Reference

Search the Claim Adjustment Reason Code database:

1. Navigate to **Denials** > **CARC Lookup**
2. Enter code number or keyword
3. View:
    - Code definition
    - Common causes
    - Resolution steps
    - Appeal likelihood

8.4 Analyzing a Denial

AI-Powered Analysis

For each denial, the system provides:

Appeal Recommendation:

- Should you appeal? (Yes/No/Maybe)
- Confidence percentage
- Expected recovery if successful
- Success factors

Required Documentation:

- Missing information identified
- Supporting documents needed
- Medical records requirements
- Authorization documentation

Timeline:

- Denial received date
- Appeal deadline
- Days remaining
- Recommended action date

8.5 Creating an Appeal

Step 1: Select Denial

From Denial Management, click **Create Appeal** on the denial.

Step 2: Choose Appeal Level

- **Initial Appeal**: First-level reconsideration
- **Second Appeal**: After initial denial upheld
- **External Review**: Independent review organization

Step 3: Enter Appeal Details

Field	Description
Appeal Reason	Why denial should be overturned
Supporting Evidence	Documentation being submitted
Requested Action	Specific outcome sought
Expedited?	Emergency/urgent request

Step 4: Attach Documentation

Upload supporting files:

- Medical records
- Prior authorizations
- Clinical notes
- Supporting letters

Step 5: Submit Appeal

Click **Submit** to:

- Generate appeal letter
- Track submission date
- Set follow-up reminders
- Monitor deadline

8.6 Tracking Appeals

Monitor all active appeals:

- Current status
- Days since submission
- Expected response date
- Required follow-up actions

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9. Price Transparency & Estimates

9.1 Overview

The Price Estimate tool helps patients understand their expected costs before or after service, supporting:

- Price transparency compliance
- Patient financial counseling
- Payment plan discussions
- Self-pay pricing

9.2 Creating a Price Estimate

Step 1: Search Services

1. Navigate to **Price Estimate**
2. Search by:
    - CPT code
    - Service description
    - Shoppable service category

Step 2: Select Services

Add services to the estimate:

- Click **Add** for each service
- Adjust quantities if needed
- View gross charges

Step 3: Enter Insurance Details

For insured patients:

Field	Description
Insurance Carrier	Payer name
Plan Type	PPO, HMO, EPO, etc.
In-Network?	Network status
Deductible	Annual deductible amount
Deductible Met	Amount already paid
Out-of-Pocket Max	Maximum patient pays
OOP Met	Amount toward max
Coinsurance	Percentage patient pays
Copay	Flat fee per visit

Step 4: Generate Estimate

Cost Breakdown:

Line Item	Amount
Gross Charges	$X,XXX.XX

Insurance Adjustment	-$XXX.XX
Insurance Payment	-$X,XXX.XX
Patient Responsibility	**$XXX.XX**

Patient Responsibility Detail:

- Deductible: $XXX.XX
- Coinsurance: $XXX.XX
- Copay: $XX.XX
- **Total Due**: $XXX.XX

Step 5: Export Estimate

- **Print**: Paper copy for patient
- **PDF**: Digital document
- **Email**: Send to patient directly

9.3 Confidence Levels

Estimates display confidence indicators:

Level	Meaning
High	Complete information, reliable estimate
Medium	Some assumptions made
Low	Limited data, estimate may vary

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10. Reports & Analytics

10.1 Available Reports

Summary Dashboard

Overview of all key metrics with trend indicators.

Recovery by Pathway

Detailed breakdown of recovery amounts and percentages by program type.

Geographic Analysis

Recovery performance by state, identifying regional patterns.

Confidence Analysis

Distribution of assessment confidence levels and correlation with outcomes.

Performance Metrics

Detailed operational statistics:

- Average charges per case
- Average recovery per case
- Processing time metrics
- User productivity

Denial Analysis

Comprehensive denial reporting:

- Denial rates by payer
- Top denial reasons
- Appeal success rates
- Prevention opportunities

10.2 Generating Reports

Step 1: Select Report Type

Navigate to **Reports** and choose report category.

Step 2: Set Parameters

Parameter	Options
Date Range	Custom, Last 7/30/90 days, YTD
Facility	All or specific location
User	All or specific team member
Pathway	All or specific program

Step 3: Generate

Click **Generate Report** to build the report.

Step 4: Export

Download in preferred format:

- PDF (formatted report)
- Excel (raw data)
- CSV (data export)

10.3 Scheduling Reports

Set up automatic report delivery:

1. Click **Schedule** on any report
2. Choose frequency: Daily, Weekly, Monthly
3. Select day/time for delivery
4. Enter recipient email addresses
5. Save schedule

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11. Settings & Configuration

11.1 Integrations

SFTP Configuration

Set up automated file transfers:

1. Navigate to **Settings** > **Integrations** > **SFTP**
2. Enter connection details:
   - Host address
   - Port number
   - Username
   - Password or SSH key
3. Configure transfer schedule
4. Test connection

White-Label Branding

Customize the application appearance:

1. Navigate to **Settings** > **Branding**
2. Upload logo files
3. Set brand colors
4. Customize email templates
5. Preview changes

11.2 User Preferences

Export Settings

Setting	Options
Default Format	Detailed, Summary, Worklist, Executive
Date Format	MM/DD/YYYY, DD/MM/YYYY, YYYY-MM-DD
CSV Delimiter	Comma, Tab, Pipe, Semicolon
Include Headers	Yes/No

Notification Settings

Control email and in-app alerts:

- New assignment notifications
- Deadline reminders
- Report delivery
- System announcements

11.3 API Configuration

For technical administrators:

Setting	Description
Base URL	API endpoint address
Timeout	Request timeout (5-120 seconds)
Connection Status	Current API health

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12. Best Practices

12.1 Daily Workflow

1. **Start with Dashboard**: Review overnight changes and key metrics
2. **Process Work Queue**: Address critical and high-priority items first
3. **Complete Eligibility Screens**: Verify pending eligibility cases
4. **Review Denials**: Check new denials and appeal deadlines
5. **End-of-Day Review**: Ensure no items are overdue

12.2 Maximizing Recovery

- **Complete Data Entry**: More information yields better recommendations
- **Act on Immediate Actions**: Time-sensitive items have deadlines
- **Document Everything**: Notes support appeals and audits
- **Use Batch Import**: Process high volumes efficiently
- **Monitor Analytics**: Identify patterns and improvement opportunities

12.3 Denial Prevention

- **Verify Eligibility First**: Screen before service when possible
- **Check Authorizations**: Ensure prior auth is obtained
- **Submit Clean Claims**: Reduce technical denials
- **Track Patterns**: Address recurring denial reasons
- **Appeal Appropriately**: Not all denials warrant appeals

12.4 Team Collaboration

- **Use Assignments**: Clearly assign work items
- **Add Notes**: Document actions and findings
- **Monitor Queue**: Keep work moving
- **Share Knowledge**: Document successful approaches
- **Review Metrics**: Discuss team performance regularly

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13. Troubleshooting

13.1 Common Issues

Import Errors

Problem: Rows failing during import

Solutions:

- Check date format matches preset
- Verify required fields have values
- Remove special characters from data
- Check for encoding issues (save as UTF-8)

Eligibility Not Calculating

Problem: Screening returns no results

Solutions:

- Verify all required fields are completed
- Check state selection is correct
- Ensure income is entered as annual amount
- Verify date of birth format

Report Not Generating

Problem: Report hangs or times out

Solutions:

- Reduce date range
- Clear browser cache
- Try different export format
- Contact support if persists

Work Queue Items Missing

Problem: Expected items not appearing

Solutions:

- Check filter settings
- Verify queue type selection
- Refresh the page
- Check if items were completed by another user

13.2 Getting Help

In-App Help: Click the help icon (?) on any page for context-sensitive guidance.

Support Contact: Contact your system administrator or support team for technical assistance.

Documentation: Access all user guides from Settings > Help.

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14. Glossary

Term	Definition
Assessment	Analysis of a patient account to identify recovery pathways
CARC	Claim Adjustment Reason Code - standardized denial reason
Confidence Level	System's certainty in a recommendation (High/Medium/Low)

DSH	Disproportionate Share Hospital - federal supplemental payment program
Dual Eligible	Patient qualifying for both Medicare and Medicaid
FPL	Federal Poverty Level - income threshold for program eligibility
MAGI	Modified Adjusted Gross Income - income calculation for Medicaid
Pathway	Recovery route (Medicaid, Medicare, DSH, State Program)
Preset	Saved column mapping configuration for data imports
QMB	Qualified Medicare Beneficiary - Medicaid assistance for Medicare premiums
RARC	Remittance Advice Remark Code - additional denial information
Recovery Rate	Percentage of charges successfully collected
Retroactive Coverage	Insurance coverage applied to past dates of service
SFTP	Secure File Transfer Protocol - encrypted file transfer method
Spend-Down	Amount patient must pay before Medicaid coverage begins
Work Queue	Organized list of tasks requiring action

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