

# RCM-Cycle

RCM - Revenue Cycle Management System.

\* The complete medical billing process is involved in RCM cycle.

\* RCM cycle having multiple steps. It starts from patient registration to and it will ends at payment collection.

## RCM Steps:-

1. patient Registration / Appointment Scheduling

2. Encounter.

3. Medical Transcription

4. Medical Coding

5. Demo Entry & charge Entry

6. claim form submission

7. Insurance.

8. Payment posting

9. Denial Management - AR calling

10. Collection.

1. Payment Registration / Appointment Scheduling:

Here the patient will contact to the registration for scheduling doctor appointment by submitting his insurance and personal details like address, Health issue.

2. Encounter :-

In this encounter the doctor will give treatment to the patient. Here ever treatment will be recorded As a voice files.

3. Medical Transcription:

In medical transcription .The voice files will be converted into text files.

4) Medical Coding :-  
Here the medical codes will convert the text  
into required coding format.

5) Promo and charge entry :-  
Here the patient details payment introduced  
and treatment details will be entered into the medical  
billing software.

6) Claim Form Team :-  
In this stage the claim form team will send  
the claim form like CMS 1500 (or) HIC Form (or) UB04 to  
insurance.

7) Insurance :-  
Insurance will verify the claim form and will  
release the payment. For some claim will reject because  
some issues.

8) Payment Posting :-  
Payment posting team will post or sent the  
payment to doctors account by checking EOB.

9) Denial Management :-  
In denial management AR callers will  
work in denied claim and take an appropriate action  
depends on denial reason.

10) Collection :-  
Collection team will collect the pending / balance  
amount from the patient.

11/02/22  
Tuesday

Medical 09

**Designation:** AR Associate (or) AR Analyst.

**Billing:** Billing is the process of issuing invoices and collecting payments from customers.

There are 2 types of billings.

They are:-

- (i) physician Billing
- (ii) Hospital Billing.

"Billing type is physician Billing"

**Speciality:** Radiology

Ex:- X-Ray, Scanning

Range: 70010 - 79999.

**Insurance:** The insurance are mainly important in 2 types.

They are:-

- (i) Federal Insurance (Gvt Insurance)
- (ii) Commercial Insurance (Pvt Insurance).

(i) **Federal Insurance:**-

The federal insurances are divided into different types. They are:-

(i) Medicare:-

- \* The person who are more than 65 years old.
- \* long disability person
- \* Must and should more than 10 years tax payers.
- \* ESRD — End Stage Renal diseases.

(ii) Medicaid:-

- \* poor peoples
- \* pregnant ladies.



### (iii) Tricare:

Eligible for Uniform services  
Ex- military, Airforce, Navy.

1. CHAMPVA - Civilian health & Medical program for veteran affairs for (Retired persons).
2. CHAMPS - Civilian health & Medical program for uniform services (Under worked).

### (2) Commercial Services:

They don't have any Eligibility we want the insurance we only want to buy. This called as private insurance.  
There are different types of insurance. They are:-

- i) BCBS
- ii) Signa
- iii) Aetna
- iv) Wellcare
- v) UHC
- vi) Emblem

\*\*\*  
The claim form name: CMS 1500 or HC Form.

"Centers for medicare and medicaid Services"

In CMS 1500 we have 33 boxes

POS - place of service: Box No :- 24(B)

The place where the service is done is called place of service.

Different types of pos:-(codes).

- |                    |                               |
|--------------------|-------------------------------|
| ⇒ Tele Health - 02 | Emergency Room - 23           |
| ⇒ Office - 11      | Ambulatory Service - 24       |
| ⇒ Home - 12        | Birthing centre - 25          |
| ⇒ Urgent care - 20 | Skilled Nursing facility - 31 |
| ⇒ In patient - 21  | Nursing facility - 32         |
| ⇒ Out patient - 22 | Hospice - 34                  |

Inpatient :- 24 hours is called as Inpatient.

out patient :- It means the patient who stays less than 24 hours is called as Out patient.

### Medicare Parts :

The medicare Parts mainly 4 parts.

They are:-

Part A - It covers Inpatient services

Part B - It covers Outpatient services

Part C - It covers both Inpatient & Out-patient & it gives additional benefits.

Part D - It covers prescription drug plans.

### Billing Terminology :

PCP - Primary Care physician is also known as Referral provider.

The doctor who is visited by the patient first.

The second person → Rendering provider.

The first doctor refers to second doctor.

The process will be called as Referral.

Referral : An approval given by PCP to the patient to consult a other provider.

$$\text{Total Billed Amount} = \text{Allowed Amount} + \text{Contractual Adjustment Amount}$$

$$\text{Allowed Amount} = \text{Paid Amount} + \text{Patient Responsibility.}$$



## Patient Response

PR-1 Deductable:  
A fixed amount paid by patient to  
the doctor before insurance benefits starts.  
Ex: \$1240 smtg..

PR-2 Co-pay:  
A fixed amount paid by patient to doctor,  
for every visit  
(After completion  
start to pay)

PR-3 Co-insurance:  
Co-sharing agreement b/w patient & Insurance company

company → 80% will be pay Insurance company  
→ 20% will be pay patient

There are three insurance companies:

- 1) primary Insurance
- 2) secondary Insurance
- 3) Tertiary Insurance

{ Every person must have the minimum 1 insurance and maximum 3 insurances }

## NATO words:

A as an	- Alpha
B	- Bravo
C	- Charlie
D	- David/Delta
E	- Echo
F	- Frank/Foxrot
G	- Golf/Gray
H	- Henry/Hotel

J - India/Jindog

J - Jack/Juliet

K - Kilo

L - Lima/Larry

M - Mike/Mosby

N - November/Nancy

O - Oscar

P - Papa/Pietro

Q - Queen/Quebec

R - Romeo/Roger

S - Sam/Sierra

T - Tango/Tom

U - Uniform

V - Victor

W - Whiskey/William

X - X-Ray

Y - Yankee

Z - Zulu



~~ABO II value~~  
AOB : Assignment of Benefits [Box No:-13]

An agreement sign by patient for payment directly goes into doctor's account.

Release of Information [Box No:-12]

POJ : An Agreement sign by patient for release of information to process/claim.

medical Advance Beneficiary Notice.

ABN : It is an Agreement signed by patient for some services not covered by Medicare for that instance patient will pay from his own pockets.

COB : Co-ordination of Benefits.

It is a way to find out which insurance is primary if a patient has more than one insurance.

Managed Care Plans:

These are different types mainly 4 types.

They are :-

HMO - Health Maintenance Organization.

PPO - Preferred provider Organization.

EPO - Exclusive provider Organization.

POS - point of service.

4) HMO - Health Maintenance Organization.

The patients those who under HMO.

- (i) PCP permission is required
- (ii) Referral is required
- (iii) Only in network services covered  
..... PCP.



In Network doctor:- The doctor who is contracted with insurance company the doctor is called In network doctor.  
Out of Network doctor:- The doctor who is not contracted with insurance company the doctor is called Out of network doctor.

2) PPO - preferred provider Organization.

\* PCP premium not required

\* Referral not required

\* Both In network & Out of network Services covered.

\* Premium is high.

3) EPO - Exclusive provider Organization.

\* PCP premium not required

\* Referral not required

\* Only In network Services covered.

\* Premium is less.

4) POS - point of Service

\* PCP premium is required

\* Referral is required

\* Both Networks Services covered.

\* Premium is moderate.

13/02/25  
Thursday

⇒ Capitation: A fixed amount paid by the payer

to doctor for certain period upfrontly.

⇒ Offset: If an excess amount paid by insurance company that amount will be adjusted by next claim.

Recovery (or) refund:

If an excess amount paid by the insurance company that amount will taken back from doctor.

If claim paid incompletely by the payer that amount will taken back from the provider.

Global period:

When a Surgery done that should be followed by visit regarding that Surgery that follow up period is called "Global period."

major Surgery - Up to 90 days.

Minor Surgery - 7 days to 10 days.

CPT : Current Procedural Terminology.

It is a 5 digit numeric code.  
It describes the treatment done by doctor to patient procedure.

EM Codes : Evaluation and Management Codes.

99201 - 99499

They will be pay the fees for conversation.  
[When ever the conversation done will bill a claim for EM codes].

It describes the conversation happen b/w PT & doctor.

New Patient:

A New patient is one who visits to take a service for the first time (or) One who has not received any service from the doctor with in past three (2) years.



New patient codes: 99201, 99202, 99203, 99204, 99205.

Establish patient: is one who has received services from a doctor with in the past 3 years.  
Establish pt codes: 99211, 99212, 99213, 99214, 99215.

New patient  
99201 - 15 mints  
99202 - 30 mints  
99203 - 45 mints  
99204 - 60 mints  
99205 - 90 mints

Establish Patient  
99211 - 15 mints  
99215 - 30 mints  
99213 - 45 mints  
99214 - 60 mints  
99215 - 90 mints.

DX codes: - diagnosis codes.

(or)

Icd - 10 code - International classification diseases.

It describes the patient illness, symptoms.

(or)

dx codes used to identify diseases, symptoms.

Ex:- I 25.110

R 15.210 etc..

Cleaning House:

It is a intermediary between billing Office &

Insurance company. cleaning house is responsible for doing some edits in claim and sending clean claim to payer.

Ex:- waystar, geteway, joperie.



Scanned with OKEN Scanner

There are 2 types of clearing house.

- (i) Internal clearing house.
- (ii) External clearing house.

EOB: Explanation Of Benefits.

It is a document created by insurance company

it explains the claim status.

ERA: Electronic Remittance Advice.

ERA is nothing but electronic it will be through

the online.

payment Modes:

There are 3 types of modes.

\* check.

\* VCC - Virtual Credit Card.

\* Electronic pay.

Claim Submission Ways:

\* Electronic Submission

\* Through E-mail

\* Through fax → (Contact Number)

\* Through webportals.

Some Important Observations:

HIPAA: Health Insurance portability & accountability.

These guideline is used to protect the patient health

information

Ex: \* don't misuse the data.

\* Don't fraud.



COBRA : consolidate Omnibus budget Reconciliation Act  
This act is useful for those who lost their jobs  
For upto 6 years and for divorced peoples also.

UB-04 ; Uniform Billing (Hospital Billing)  
(81 fields).

NPI : National provider

Identification

Box 24 (J)

It is a 10 digit numeric format gives to doctors & hospitals (or) facilities.

123 - 456 - 78 - 90.

Tax id : Tax Identification number. Box 25

It is a 9 digit numeric number.

123 - 456 - 789.

July 21<sup>st</sup>  
Today

### SCENARIOS.

1) claim not on file:

- \* Ask to call to Rep and ask what is policy Effective date & term date.
- \* Then check patient policy is active (or) not for the date of service.
- \* If patient policy is active then ask to Rep that mailing address, fax number, payer id, TEL for Resending a claim.
- \* If patient policy is inactive then check patient have Secondary insurance are available or not.
- \* If secondary available then bill to secondary
- \* If secondary is not available then bill to patient

- 2) claim status:  
\* call to Rep and ask that what is claim received date.  
\* Ask to rep what is normal processing days for this claim? (30-40 days).  
\* If still processing days is there then allow some days.  
\* If processing days completed then ask to rep reason for delay.  
\* Ask to rep when can I call you back for claim update.  
\* Take claim number/ Call Rep number?

### 3) claim paid:

- \* call to Rep and ask what is claim process date & paid date.  
\* How much allowed amount & paid amount and patient responsibility.  
\* Ask to rep that what is payment mode.
- =) If claim paid through check:  
(i) Ask to rep what is check number.  
(ii) It is single check (or) bulk check.  
(iii) what is pay to address.  
(iv) what is check encashed date.  
(v) Request EOB through fax for updating the payment.
- =) If claim paid EFT:  
(i) Ask to rep what is EFT ID.  
(ii) Ask to rep it is single EFT (or) bulk EFT.  
(iii) what is EFT cleared date.  
(iv) Request EOB through fax for updating the payment.



- (ii) claim processed to words "capitation". What is processed date?
- \* Call to Rep and ask what is capitation period.
  - \* Then Ask to Rep capitation period then ask
  - \* If date is not lies in capitation period then ask to Rep for reprocess.
  - \* If date of service lies in capitation then Req Rep through fax for update payment

Replies  
Monday

### Detail Management

- 4. No Authorization: [Box No:-23] [CO-197].

- Authorization: which takes an approval from the payer by the provider
- Pre Authorization: - which takes an approval from the payer by the provider before starts the service;

Retro Authorization: - which takes an approval from the payer by the provider after starts the Service.

- (i) check CMS1500 Box23, & software whether the Auth# is available or not.
- (ii) If auth# is available call to Rep & Ask for reprocess.
- (iii) If auth# is not available then check patient place of service.

Note: - If in any Emergency cases there is no need to auth# No.

- (iv) If patient place of service is 23 then its Emergency service so no need pre auth# ask to Rep for Reprocess.



- (v) If any other pos means ask to vrep vleto is possible  
 or not.
- (vi) If Retro Arthrt is not possible then appear with medical records.
- (vii) Take call number Ref. number.
- 2) No Referral : [Co-288] [Box No :- 23]
- check CMS 1500 Box # 23 whether the vrep number is available or not.
  - If referral is available then call to Rep & Ask for ref. no.
  - If referral is not available then check patient plan.
  - If patient belongs to PPO (or) EPO so for no ref vrep then ask to vrep for vleprocess.
  - If patient belongs to HMO (or) POS then ask to vrep that PCP name & PCP contact number.
  - For sending corrected claim Ask to vrep corrected mailing address, fax number & TFL.
  - Take call Number Ref. number.
- 3) TFL : Timely Filing limit [Co-29]
- TFL : Every insurance company will give a certain time period to submit a claim the time period is called as "TFL".
- \* Call to Rep and Ask what is claim received date?
  - \* Ask to vrep what is TFL for this claim.
  - \* Ask to vrep what is TFL then Ask to vrep for if we send a claim with in TFL then Ask to vrep for vleprocess.
  - \* If we send a claim after TFL then check we have any POFL available (proof of timely filing limit).

- \* If POFEL is available then ask to step corrected mailing
- \* For sending corrected claim ask to step corrected mailing
- If address, fax number & TFL not available then adjust the balance.
- \* If POFEL is not available then forward to finance.
- \* Take call number / Ref number.

18/08/25  
Tuesday

#### 4) Inclusive / Bundled : [Co-97] [Box:- 24(D)]

- \* call to Rep and Ask that denied CPT is included with same claim (or) different claim
- \* If Rep said same claim then check CMS 1506 Box 24(D)
- \* If Rep said same claim then check CMS 1506 Box 24(D)  
whether the correct modifier is applied (or) not.
- \* If modifiers is not available then forward a claim to Coding team for providing correct modifier.
- \* For sending corrected claim ask to step C.C mailing address, correct modifier, Fax number, TFL.
- \* If modifier is available then appear with medical records (Appeal TFL, different mailing address).
- \* Take call number / Ref number.

I would like to tell

