

MC BILLING ACADEMY

The Complete Advanced Medical Billing & Revenue Cycle Handbook

Professional Terminology • Claim Workflows • Denial Prevention •
Appeals • Compliance • Practice Exercises

2026 Premium Educational Edition | MC Billing

A structured reference and training e-book for medical billers, administrative teams, students and practice owners.

About This Handbook

This handbook combines advanced medical billing terminology with practical workflows, case studies, self-assessments and reusable worksheets. It is designed for self-study, onboarding and internal team discussion. The case studies are fictional and do not contain patient data.

Important: This is educational material, not legal, coding, medical or reimbursement advice. Verify current payer policies, contracts, official code-set guidance, CMS and HHS rules, and state requirements before using any procedure on a real claim.

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Chapter 01 | Revenue Cycle Foundations

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for revenue cycle foundations.

Core operating principle

Registration inaccuracies can propagate into eligibility errors, claim edits, payer denials, and incorrect patient statements.

Terminology desk reference

Patient registration. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Charge capture. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Accounts receivable. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Clean claim. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Claim lifecycle. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Guarantor. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Date of service. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Patient responsibility. A key concept within revenue cycle foundations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Revenue Cycle Foundations | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Revenue Cycle Foundations | Case Study

Situation

A patient is registered with an outdated surname and member number. The clearinghouse rejects the claim before payer adjudication.

Recommended analytical approach

Verify the source registration record; update demographics and member identifiers; check coverage for the date of service; regenerate and transmit the claim; save the acceptance report.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Revenue Cycle Foundations | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Patient registration and Charge capture.

2. Describe how an error involving Accounts receivable might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 02 | Insurance Eligibility and Benefits

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for insurance eligibility and benefits.

Core operating principle

Active coverage alone does not establish that a specific service is covered or that authorization requirements are satisfied.

Terminology desk reference

Subscriber. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Dependent. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Member ID. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Group number. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Eligibility. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Deductible. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Copayment. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Coinsurance. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Out-of-pocket maximum. A key concept within insurance eligibility and benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Insurance Eligibility and Benefits | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Insurance Eligibility and Benefits | Case Study

Situation

A patient has active insurance but the visit is subject to a specialist copayment and a deductible for ancillary testing.

Recommended analytical approach

Verify benefits by service category and network, record the source and date of verification, and communicate estimates as estimates rather than guaranteed liability.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Insurance Eligibility and Benefits | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Subscriber and Dependent.

2. Describe how an error involving Member ID might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ☐ Need more practice ☐ Developing ☐ Confident

Chapter 03 | Coordination of Benefits

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for coordination of benefits.

Core operating principle

Incorrect payer order may delay both claims and distort the patient balance.

Terminology desk reference

Primary payer. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Secondary payer. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

COB. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medicare Secondary Payer. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Other insurance. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Primary EOB. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Payer order. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Dependent coverage. A key concept within coordination of benefits. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Coordination of Benefits | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Coordination of Benefits | Case Study

Situation

A patient presents two policies; the second payer requests primary adjudication information.

Recommended analytical approach

Determine payer order under applicable rules, update the account, submit to the primary payer, and send secondary information with primary processing details.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Coordination of Benefits | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Primary payer and Secondary payer.

2. Describe how an error involving COB might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 04 | Authorizations and Referrals

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for authorizations and referrals.

Core operating principle

An authorization number is not a guarantee of payment; service, dates, units, provider and policy criteria must still align.

Terminology desk reference

Prior authorization. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Referral. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Precertification. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Authorized units. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Effective dates. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Service match. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Ordering provider. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medical necessity. A key concept within authorizations and referrals. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Authorizations and Referrals | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Authorizations and Referrals | Case Study

Situation

An imaging claim denies even though the office has an authorization number.

Recommended analytical approach

Compare the approved service and units against the performed service and claim; identify whether correction, reconsideration, or appeal is allowed.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Authorizations and Referrals | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Prior authorization and Referral.

2. Describe how an error involving Precertification might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 05 | Diagnosis and Procedure Coding

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for diagnosis and procedure coding.

Core operating principle

Codes must reflect documented services and applicable coding rules; never change a code merely to force payment.

Terminology desk reference

ICD-10-CM. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

CPT. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

HCPCS Level II. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Diagnosis code. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Procedure code. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Modifier. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Code descriptor. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Units of service. A key concept within diagnosis and procedure coding. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Diagnosis and Procedure Coding | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Diagnosis and Procedure Coding | Case Study

Situation

A procedure line is denied because its diagnosis linkage does not support the service under payer edits.

Recommended analytical approach

Review clinical documentation, code selection, diagnosis pointers and current policy with qualified coding personnel before correction.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Diagnosis and Procedure Coding | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: ICD-10-CM and CPT.

2. Describe how an error involving HCPCS Level II might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 06 | Coding Edits and Documentation

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for coding edits and documentation.

Core operating principle

Coding edits are screening mechanisms, not substitutes for documentation review or authoritative coding guidance.

Terminology desk reference

NCCI. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

MUE. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Bundling. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Unbundling. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Upcoding. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Global surgical package. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Add-on code. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medical necessity. A key concept within coding edits and documentation. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Coding Edits and Documentation | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Coding Edits and Documentation | Case Study

Situation

Two procedure codes trigger a code-pair edit and the practice believes distinct services were performed.

Recommended analytical approach

Confirm documentation, current edit rules and modifier eligibility before deciding whether a modifier or coding change is appropriate.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Coding Edits and Documentation | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: NCCI and MUE.

2. Describe how an error involving Bundling might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 07 | Professional Claims

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for professional claims.

Core operating principle

Professional claims rely on accurate provider roles, locations and diagnosis-to-service relationships.

Terminology desk reference

CMS-1500. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

837P. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Billing provider. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Rendering provider. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

NPI. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Taxpayer ID. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Place of service. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Diagnosis pointer. A key concept within professional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Professional Claims | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Professional Claims | Case Study

Situation

A professional claim rejects because a rendering-provider identifier is missing.

Recommended analytical approach

Confirm provider identity and enrollment requirements; correct the relevant claim element and resubmit after validation.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Professional Claims | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: CMS-1500 and 837P.

2. Describe how an error involving Billing provider might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 08 | Institutional Claims

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for institutional claims.

Core operating principle

Institutional claims have distinct field and classification requirements that should not be treated as professional-claim equivalents.

Terminology desk reference

UB-04. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

837I. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Type of bill. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Revenue code. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Statement dates. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Condition code. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Occurrence code. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Patient status. A key concept within institutional claims. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Institutional Claims | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Institutional Claims | Case Study

Situation

A facility claim fails an edit because the bill type and revenue code combination is inconsistent.

Recommended analytical approach

Compare the account and service record with current institutional billing guidance and payer-specific edits before resubmission.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Institutional Claims | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: UB-04 and 837I.

2. Describe how an error involving Type of bill might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 09 | Clearinghouses and Claim Status

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for clearinghouses and claim status.

Core operating principle

Transmission, acceptance and adjudication are separate milestones; a successful upload does not prove payer acceptance.

Terminology desk reference

Clearinghouse. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Claim scrubber. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Batch. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

999 acknowledgment. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

277CA. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Claim rejection. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Corrected claim. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Claim control number. A key concept within clearinghouses and claim status. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Clearinghouses and Claim Status | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Clearinghouses and Claim Status | Case Study

Situation

The billing system says 'sent,' but the payer cannot locate the claim.

Recommended analytical approach

Trace the outbound file, acknowledgments, clearinghouse reports and payer acceptance record before submitting again.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Clearinghouses and Claim Status | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Clearinghouse and Claim scrubber.

2. Describe how an error involving Batch might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 10 | Adjudication and Payment Posting

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for adjudication and payment posting.

Core operating principle

Post payer payments and adjustments to the correct claim and line, then reconcile the deposit with remittance records.

Terminology desk reference

Adjudication. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Allowed amount. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Billed charge. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Contractual adjustment. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

ERA. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

835. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

EFT. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Recoupment. A key concept within adjudication and payment posting. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Adjudication and Payment Posting | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Adjudication and Payment Posting | Case Study

Situation

An ERA includes a payment, patient cost share and a contractual adjustment.

Recommended analytical approach

Match claim and service line, confirm adjustment groups and amounts, post consistently, and reconcile EFT totals.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Adjudication and Payment Posting | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Adjudication and Allowed amount.

2. Describe how an error involving Billed charge might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 11 | Denials and Rejections

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for denials and rejections.

Core operating principle

The first task is to distinguish a rejection from an adjudicated denial and read the actual payer explanation.

Terminology desk reference

CARC. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

RARC. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Eligibility denial. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Timely filing. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Duplicate claim. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Noncovered service. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Authorization denial. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Root cause. A key concept within denials and rejections. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Denials and Rejections | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Denials and Rejections | Case Study

Situation

A claim is marked 'duplicate' after staff transmitted a second original claim.

Recommended analytical approach

Find the status of the first claim, compare claim identifiers, and use the payer's corrected-claim or follow-up pathway.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Denials and Rejections | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: CARC and RARC.

2. Describe how an error involving Eligibility denial might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 12 | Appeals and Reconsiderations

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for appeals and reconsiderations.

Core operating principle

Appeal rights and timelines vary; a strong appeal connects the specific adverse decision to evidence and policy.

Terminology desk reference

Appeal. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Reconsideration. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Reopening. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Appeal deadline. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medical records. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Proof of timely filing. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Escalation. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Peer-to-peer review. A key concept within appeals and reconsiderations. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Appeals and Reconsiderations | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Appeals and Reconsiderations | Case Study

Situation

A payer denies for timely filing despite a dated clearinghouse acceptance report.

Recommended analytical approach

Check the contract deadline and submission history, preserve dated evidence, and request the appropriate review within the applicable window.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Appeals and Reconsiderations | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Appeal and Reconsideration.

2. Describe how an error involving Reopening might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 13 | Medicare and Medicaid

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for medicare and medicaid.

Core operating principle

Government program coverage and payment rules depend on program, setting, contractor and beneficiary circumstances.

Terminology desk reference

Medicare Part A. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medicare Part B. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medicare Advantage. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Medicaid. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

MAC. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

NCD. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

LCD. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

ABN. A key concept within medicare and medicaid. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Medicare and Medicaid | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Medicare and Medicaid | Case Study

Situation

A Medicare service is denied under a coverage policy that staff did not check before billing.

Recommended analytical approach

Review the applicable program, national/local coverage guidance and documentation; do not assume commercial payer rules apply.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Medicare and Medicaid | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Medicare Part A and Medicare Part B.

2. Describe how an error involving Medicare Advantage might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 14 | Compliance and Privacy

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for compliance and privacy.

Core operating principle

Privacy safeguards, truthful billing and defensible documentation should be built into routine workflows.

Terminology desk reference

HIPAA. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

PHI. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Minimum necessary. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Business associate. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

False Claims Act. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

OIG. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Audit trail. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Compliance program. A key concept within compliance and privacy. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Compliance and Privacy | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Compliance and Privacy | Case Study

Situation

A staff member emails patient billing details to an unverified outside address.

Recommended analytical approach

Stop inappropriate disclosure, follow the organization's incident-response procedure, and use approved secure communication channels.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Compliance and Privacy | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: HIPAA and PHI.

2. Describe how an error involving Minimum necessary might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 15 | Accounts Receivable and Analytics

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for accounts receivable and analytics.

Core operating principle

Define KPI denominators and measurement periods consistently before comparing trends.

Terminology desk reference

A/R aging. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Days in A/R. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Denial rate. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Clean claim rate. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Charge lag. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Net collection rate. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Underpayment. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Credit balance. A key concept within accounts receivable and analytics. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Accounts Receivable and Analytics | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Accounts Receivable and Analytics | Case Study

Situation

A practice's older receivables rise while its denial rate appears unchanged.

Recommended analytical approach

Segment balances by payer, age, denial category and responsibility; validate KPI definitions and prioritize collectible work.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Accounts Receivable and Analytics | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: A/R aging and Days in A/R.

2. Describe how an error involving Denial rate might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 16 | Advanced Reimbursement Models

Learning outcomes

After this chapter, the learner should be able to define the core terms, identify their role in the claim lifecycle, explain common failure points, and document an appropriate next action for advanced reimbursement models.

Core operating principle

Reimbursement models create different incentives and require different contract and performance data.

Terminology desk reference

Fee-for-service. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Capitation. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

DRG. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

MS-DRG. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

APC. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

RVU. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

RBRVS. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Value-based care. A key concept within advanced reimbursement models. For operational use, locate the applicable source record, verify its meaning in the payer or code-set context, and document how it affects the claim.

Practice checkpoint

Identify the source of truth for each term, the staff role responsible for validating it, and the downstream consequence of an error.

Advanced Reimbursement Models | Workflow

1. Intake

Gather patient, provider, payer, date, service and account identifiers relevant to this topic.

2. Verification

Compare the account data against primary source documents and applicable payer requirements.

3. Classification

Determine whether the issue is a data defect, missing documentation, coverage question, coding concern or payer processing decision.

4. Resolution path

Choose the permitted correction, submission, follow-up, reconsideration, appeal or escalation route.

5. Documentation

Record what was checked, the evidence used, the action taken, and the next follow-up date.

6. Prevention

Classify the root cause and improve the upstream workflow to reduce recurrence.

Control point: Before changing a billed code, financial balance, or claim status, confirm that the change is supported by documentation and applicable rules.

Advanced Reimbursement Models | Case Study

Situation

A practice compares an encounter payment to a fee-for-service expectation under a capitated contract.

Recommended analytical approach

Identify the governing payment arrangement, covered services, carve-outs and reporting requirements before labeling the claim underpaid.

What to document

- Account or claim identifier and date of service
- Payer, contact channel, claim status and reference number
- Relevant documentation, policy or contractual reference
- Chosen action, submission confirmation and follow-up date

Discussion questions

Which source record should be checked first?

What could go wrong if staff immediately resubmit without investigating?

What evidence would justify the chosen action?

Which upstream process could prevent this problem?

Advanced Reimbursement Models | Knowledge Check & Notes

1. Explain the practical difference between any two terms from this chapter: Fee-for-service and Capitation.

2. Describe how an error involving DRG might affect downstream billing.

3. List the records you would examine before correcting a live claim.

4. Describe the difference between fixing an individual account and preventing a recurring root cause.

5. Write a concise payer follow-up note documenting the issue, research, action and next step.

Self-assessment: ■ Need more practice ■ Developing ■ Confident

Chapter 17 | Claim Processing Toolkit

Claim Follow-Up Log

Date: _____

Account / claim #: _____

Payer: _____

Date of service: _____

Current status: _____

CARC / RARC: _____

Research: _____

Action taken: _____

Reference #: _____

Next follow-up: _____

Denial Root-Cause Tracker

Denial category: _____

Payer: _____

Claim count: _____

Dollar impact: _____

Root cause: _____

Preventive owner: _____

Corrective action: _____

Review date: _____

Appeal Preparation Checklist

Claim ID: _____

Adverse determination: _____

Deadline: _____

Policy / contract basis: _____

Clinical support: _____

Submission method: _____

Confirmation: _____

Follow-up: _____

Payment Variance Review

Payer: _____

Contract reference: _____

Service / units: _____

Billed: _____

Allowed: _____

Paid: _____

Adjustment codes: _____

Variance explanation: _____

Chapter 18 | Scenario Workshop

Scenario 1: Revenue Cycle Foundations

A patient is registered with an outdated surname and member number. The clearinghouse rejects the claim before payer adjudication.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Verify the source registration record; update demographics and member identifiers; check coverage for the date of service; regenerate and transmit the claim; save the acceptance report.

Scenario 2: Insurance Eligibility and Benefits

A patient has active insurance but the visit is subject to a specialist copayment and a deductible for ancillary testing.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Verify benefits by service category and network, record the source and date of verification, and communicate estimates as estimates rather than guaranteed liability.

Scenario 3: Coordination of Benefits

A patient presents two policies; the second payer requests primary adjudication information.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Determine payer order under applicable rules, update the account, submit to the primary payer, and send secondary information with primary processing details.

Scenario 4: Authorizations and Referrals

An imaging claim denies even though the office has an authorization number.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Compare the approved service and units against the performed service and claim; identify whether correction, reconsideration, or appeal is allowed.

Scenario 5: Diagnosis and Procedure Coding

A procedure line is denied because its diagnosis linkage does not support the service under payer edits.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Review clinical documentation, code selection, diagnosis pointers and current policy with qualified coding personnel before correction.

Scenario 6: Coding Edits and Documentation

Two procedure codes trigger a code-pair edit and the practice believes distinct services were performed.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Confirm documentation, current edit rules and modifier eligibility before deciding whether a modifier or coding change is appropriate.

Scenario 7: Professional Claims

A professional claim rejects because a rendering-provider identifier is missing.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Confirm provider identity and enrollment requirements; correct the relevant claim element and resubmit after validation.

Scenario 8: Institutional Claims

A facility claim fails an edit because the bill type and revenue code combination is inconsistent.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Compare the account and service record with current institutional billing guidance and payer-specific edits before resubmission.

Scenario 9: Clearinghouses and Claim Status

The billing system says 'sent,' but the payer cannot locate the claim.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Trace the outbound file, acknowledgments, clearinghouse reports and payer acceptance record before submitting again.

Scenario 10: Adjudication and Payment Posting

An ERA includes a payment, patient cost share and a contractual adjustment.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Match claim and service line, confirm adjustment groups and amounts, post consistently, and reconcile EFT totals.

Scenario 11: Denials and Rejections

A claim is marked 'duplicate' after staff transmitted a second original claim.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Find the status of the first claim, compare claim identifiers, and use the payer's corrected-claim or follow-up pathway.

Scenario 12: Appeals and Reconsiderations

A payer denies for timely filing despite a dated clearinghouse acceptance report.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Check the contract deadline and submission history, preserve dated evidence, and request the appropriate review within the applicable window.

Scenario 13: Medicare and Medicaid

A Medicare service is denied under a coverage policy that staff did not check before billing.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Review the applicable program, national/local coverage guidance and documentation; do not assume commercial payer rules apply.

Scenario 14: Compliance and Privacy

A staff member emails patient billing details to an unverified outside address.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Stop inappropriate disclosure, follow the organization's incident-response procedure, and use approved secure communication channels.

Scenario 15: Accounts Receivable and Analytics

A practice's older receivables rise while its denial rate appears unchanged.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Segment balances by payer, age, denial category and responsibility; validate KPI definitions and prioritize collectible work.

Scenario 16: Advanced Reimbursement Models

A practice compares an encounter payment to a fee-for-service expectation under a capitated contract.

Task: Write your initial verification, likely resolution route, documentation plan and prevention recommendation.

Model response: Identify the governing payment arrangement, covered services, carve-outs and reporting requirements before labeling the claim underpaid.

Chapter 19 | Final Knowledge Assessment

01. Name two terms used in revenue cycle foundations and explain their billing relevance.

02. What is the recommended first investigation when this occurs: A patient is registered with an outdated surname and member number. The clearinghouse rejects the claim before payer adjudication.

03. Name two terms used in insurance eligibility and benefits and explain their billing relevance.

04. What is the recommended first investigation when this occurs: A patient has active insurance but the visit is subject to a specialist copayment and a deductible for ancillary testing.

05. Name two terms used in coordination of benefits and explain their billing relevance.

06. What is the recommended first investigation when this occurs: A patient presents two policies; the second payer requests primary adjudication information.

07. Name two terms used in authorizations and referrals and explain their billing relevance.

08. What is the recommended first investigation when this occurs: An imaging claim denies even though the office has an authorization number.

09. Name two terms used in diagnosis and procedure coding and explain their billing relevance.

10. What is the recommended first investigation when this occurs: A procedure line is denied because its diagnosis linkage does not support the service under payer edits.

11. Name two terms used in coding edits and documentation and explain their billing relevance.

12. What is the recommended first investigation when this occurs: Two procedure codes trigger a code-pair edit and the practice believes distinct services were performed.

13. Name two terms used in professional claims and explain their billing relevance.

14. What is the recommended first investigation when this occurs: A professional claim rejects because a rendering-provider identifier is missing.

15. Name two terms used in institutional claims and explain their billing relevance.

16. What is the recommended first investigation when this occurs: A facility claim fails an edit because the bill type and revenue code combination is inconsistent.

17. Name two terms used in clearinghouses and claim status and explain their billing relevance.

18. What is the recommended first investigation when this occurs: The billing system says 'sent,' but the payer cannot locate the claim.

19. Name two terms used in adjudication and payment posting and explain their billing relevance.

20. What is the recommended first investigation when this occurs: An ERA includes a payment, patient cost share and a contractual adjustment.

21. Name two terms used in denials and rejections and explain their billing relevance.

22. What is the recommended first investigation when this occurs: A claim is marked 'duplicate' after staff transmitted a second original claim.

23. Name two terms used in appeals and reconsiderations and explain their billing relevance.

24. What is the recommended first investigation when this occurs: A payer denies for timely filing despite a dated clearinghouse acceptance report.

25. Name two terms used in medicare and medicaid and explain their billing relevance.

26. What is the recommended first investigation when this occurs: A Medicare service is denied under a coverage policy that staff did not check before billing.

27. Name two terms used in compliance and privacy and explain their billing relevance.

28. What is the recommended first investigation when this occurs: A staff member emails patient billing details to an unverified outside address.

29. Name two terms used in accounts receivable and analytics and explain their billing relevance.

30. What is the recommended first investigation when this occurs: A practice's older receivables rise while its denial rate appears unchanged.

31. Name two terms used in advanced reimbursement models and explain their billing relevance.

32. What is the recommended first investigation when this occurs: A practice compares an encounter payment to a fee-for-service expectation under a capitated contract.

Assessment Answer Guide

Open-response questions are scored for accuracy, documentation, appropriate workflow selection and recognition of applicable payer or regulatory rules. Suggested rubric: 4 points complete; 3 mostly correct; 2 partial; 1 minimal; 0 incorrect.

- 01.** Strong responses define terms such as Patient registration and Charge capture and connect them to claim processing.
- 02.** Verify the source registration record; update demographics and member identifiers; check coverage for the date of service; regenerate and transmit the claim; save the acceptance report.
- 03.** Strong responses define terms such as Subscriber and Dependent and connect them to claim processing.
- 04.** Verify benefits by service category and network, record the source and date of verification, and communicate estimates as estimates rather than guaranteed liability.
- 05.** Strong responses define terms such as Primary payer and Secondary payer and connect them to claim processing.
- 06.** Determine payer order under applicable rules, update the account, submit to the primary payer, and send secondary information with primary processing details.
- 07.** Strong responses define terms such as Prior authorization and Referral and connect them to claim processing.
- 08.** Compare the approved service and units against the performed service and claim; identify whether correction, reconsideration, or appeal is allowed.
- 09.** Strong responses define terms such as ICD-10-CM and CPT and connect them to claim processing.
- 10.** Review clinical documentation, code selection, diagnosis pointers and current policy with qualified coding personnel before correction.
- 11.** Strong responses define terms such as NCCI and MUE and connect them to claim processing.
- 12.** Confirm documentation, current edit rules and modifier eligibility before deciding whether a modifier or coding change is appropriate.

- 13.** Strong responses define terms such as CMS-1500 and 837P and connect them to claim processing.
- 14.** Confirm provider identity and enrollment requirements; correct the relevant claim element and resubmit after validation.
- 15.** Strong responses define terms such as UB-04 and 837I and connect them to claim processing.
- 16.** Compare the account and service record with current institutional billing guidance and payer-specific edits before resubmission.
- 17.** Strong responses define terms such as Clearinghouse and Claim scrubber and connect them to claim processing.
- 18.** Trace the outbound file, acknowledgments, clearinghouse reports and payer acceptance record before submitting again.
- 19.** Strong responses define terms such as Adjudication and Allowed amount and connect them to claim processing.
- 20.** Match claim and service line, confirm adjustment groups and amounts, post consistently, and reconcile EFT totals.
- 21.** Strong responses define terms such as CARC and RARC and connect them to claim processing.
- 22.** Find the status of the first claim, compare claim identifiers, and use the payer's corrected-claim or follow-up pathway.
- 23.** Strong responses define terms such as Appeal and Reconsideration and connect them to claim processing.
- 24.** Check the contract deadline and submission history, preserve dated evidence, and request the appropriate review within the applicable window.

- 25.** Strong responses define terms such as Medicare Part A and Medicare Part B and connect them to claim processing.
- 26.** Review the applicable program, national/local coverage guidance and documentation; do not assume commercial payer rules apply.
- 27.** Strong responses define terms such as HIPAA and PHI and connect them to claim processing.
- 28.** Stop inappropriate disclosure, follow the organization's incident-response procedure, and use approved secure communication channels.
- 29.** Strong responses define terms such as A/R aging and Days in A/R and connect them to claim processing.
- 30.** Segment balances by payer, age, denial category and responsibility; validate KPI definitions and prioritize collectible work.
- 31.** Strong responses define terms such as Fee-for-service and Capitation and connect them to claim processing.
- 32.** Identify the governing payment arrangement, covered services, carve-outs and reporting requirements before labeling the claim underpaid.

Chapter 20 | 30-Day Study Roadmap

Day 01: Study Revenue Cycle Foundations. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 02: Study Revenue Cycle Foundations. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 03: Study Insurance Eligibility and Benefits. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 04: Study Insurance Eligibility and Benefits. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 05: Study Coordination of Benefits. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 06: Study Coordination of Benefits. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 07: Study Authorizations and Referrals. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 08: Study Authorizations and Referrals. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 09: Study Diagnosis and Procedure Coding. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 10: Study Diagnosis and Procedure Coding. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 11: Study Coding Edits and Documentation. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 12: Study Coding Edits and Documentation. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 13: Study Professional Claims. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 14: Study Professional Claims. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 15: Study Institutional Claims. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 16: Study Institutional Claims. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 17: Study Clearinghouses and Claim Status. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 18: Study Clearinghouses and Claim Status. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 19: Study Adjudication and Payment Posting. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 20: Study Adjudication and Payment Posting. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 21: Study Denials and Rejections. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 22: Study Denials and Rejections. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 23: Study Appeals and Reconsiderations. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 24: Study Appeals and Reconsiderations. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 25: Study Medicare and Medicaid. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 26: Study Medicare and Medicaid. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 27: Study Compliance and Privacy. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 28: Study Compliance and Privacy. Read the definitions, complete one case study, and write a follow-up note. ■
Complete

Day 29: Study Accounts Receivable and Analytics. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Day 30: Study Accounts Receivable and Analytics. Read the definitions, complete one case study, and write a follow-up note. ■ Complete

Further Study and Official Resources

- CMS: Medicare claims processing manuals, coverage determinations and payment guidance ([cms.gov](https://www.cms.gov)).
- HHS OCR: HIPAA privacy and security guidance ([hhs.gov/hipaa](https://www.hhs.gov/hipaa)).
- HHS OIG: compliance program guidance and enforcement resources (oig.hhs.gov).
- CDC / CMS: official ICD-10-CM guidance and annual updates.
- AMA: current CPT resources and licensing information (ama-assn.org).
- X12: transaction standards and implementation resources (x12.org).
- Your payer contracts, provider manuals, remittance documents and official policy portals.

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