MC BILLING ACADEMY

The Complete Practical Medical Billing & Revenue Cycle Handbook

Premium 2026 Edition | Terminology • Workflows • Case Studies • Practice Tools

An original instructional resource for aspiring medical billers, revenue-cycle professionals, and independent practice teams.

Educational reference only. Payer, coding, compliance, and regulatory requirements change; verify authoritative current sources before use.

How to use this handbook

Each chapter has four teaching parts: concepts and vocabulary, a step-by-step workflow, a worked scenario, and a practice lab. The worksheets are designed to be copied for classroom or internal training. No real patient data should be entered into shared examples.

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CHAPTER 01 | Revenue cycle architecture

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

A medical billing operation should track the account from appointment through final resolution, not merely through claim submission.

Vocabulary in context

Patient access: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Encounter: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Charge capture: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Charge entry: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Claim lifecycle: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Accounts receivable: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Patient responsibility: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Guarantor: A term used in revenue cycle architecture. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Revenue cycle architecture: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Revenue cycle architecture: worked scenario

Situation

A practice sees rising accounts receivable despite a stable number of visits.

Research plan

Segment the balance by payer, age, denial status, and patient responsibility before proposing a fix.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Revenue cycle architecture: applied practice lab

Exercise: Define Patient access and Encounter and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Charge capture is inaccurate?

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Exercise: Which source documents would you check for the scenario: A practice sees rising accounts receivable despite a stable number of visits.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 02 | Registration and eligibility

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Eligibility and benefit verification are separate questions. Coverage on a date does not guarantee a specific service will be paid.

Vocabulary in context

Subscriber: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Dependent: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Member identifier: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Group number: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Eligibility: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Benefit verification: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Effective date: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Termination date: A term used in registration and eligibility. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Registration and eligibility: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Registration and eligibility: worked scenario

Situation

The claim rejects because the member identifier belongs to an old plan.

Research plan

Verify the date-of-service coverage, update the source registration record, correct the claim, and confirm acceptance.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Registration and eligibility: applied practice lab

Exercise: Define Subscriber and Dependent and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Member identifier is inaccurate?

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Exercise: Which source documents would you check for the scenario: The claim rejects because the member identifier belongs to an old plan.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 03 | Benefits and patient cost sharing

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Patient estimates should distinguish verified plan facts from assumptions about future adjudication.

Vocabulary in context

Deductible: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Copayment: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Coinsurance: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Allowed amount: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Out-of-pocket maximum: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Network: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Covered service: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Exclusion: A term used in benefits and patient cost sharing. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Benefits and patient cost sharing: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Benefits and patient cost sharing: worked scenario

Situation

A patient has a copayment for the visit and coinsurance for a separate test.

Research plan

Explain each cost-sharing category and avoid presenting an estimate as a final bill.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Benefits and patient cost sharing: applied practice lab

Exercise: Define Deductible and Copayment and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Coinsurance is inaccurate?

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Exercise: Which source documents would you check for the scenario: A patient has a copayment for the visit and coinsurance for a separate test.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 04 | Coordination of benefits

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Payment order is determined by applicable COB rules, not by which insurance card the patient prefers.

Vocabulary in context

Primary payer: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Secondary payer: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Coordination of benefits: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Other coverage: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Primary remittance: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medicare secondary payer: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Payer order: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Cross-over: A term used in coordination of benefits. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Coordination of benefits: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Coordination of benefits: worked scenario

Situation

A secondary insurer denies because no primary processing information was included.

Research plan

Confirm payer order, obtain the primary remittance, and follow secondary submission requirements.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Coordination of benefits: applied practice lab

Exercise: Define Primary payer and Secondary payer and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Coordination of benefits is inaccurate?

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Exercise: Which source documents would you check for the scenario: A secondary insurer denies because no primary processing information was included.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 05 | Authorizations and referrals

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Authorization approval does not itself guarantee payment; the approved service, dates, units, provider, and claim must align.

Vocabulary in context

Prior authorization: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Precertification: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Referral: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Authorized units: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Effective dates: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Rendering provider: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Ordering provider: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medical necessity: A term used in authorizations and referrals. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Authorizations and referrals: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Authorizations and referrals: worked scenario

Situation

An imaging service was authorized for one date but performed later.

Research plan

Compare authorization conditions and request permitted correction or review before appealing.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Authorizations and referrals: applied practice lab

Exercise: Define Prior authorization and Precertification and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Referral is inaccurate?

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Exercise: Which source documents would you check for the scenario: An imaging service was authorized for one date but performed later.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 06 | Diagnosis coding

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Diagnosis coding should be supported by the clinical record and current official coding guidance.

Vocabulary in context

ICD-10-CM: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Diagnosis code: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Code specificity: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Sequencing: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Documentation: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medical necessity: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Excludes note: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Annual update: A term used in diagnosis coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Diagnosis coding: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Diagnosis coding: worked scenario

Situation

A payer questions whether a diagnosis supports a diagnostic test.

Research plan

Review documentation, coverage criteria, and code assignment with qualified coding staff; do not invent a diagnosis.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Diagnosis coding: applied practice lab

Exercise: Define ICD-10-CM and Diagnosis code and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Code specificity is inaccurate?

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Exercise: Which source documents would you check for the scenario: A payer questions whether a diagnosis supports a diagnostic test.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 07 | Procedure coding

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Procedure codes and modifiers communicate what was performed and relevant circumstances, not what amount the practice hopes to collect.

Vocabulary in context

CPT: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

HCPCS Level II: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Procedure code: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Modifier: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Units of service: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

E/M: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Add-on code: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Code descriptor: A term used in procedure coding. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Procedure coding: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Procedure coding: worked scenario

Situation

A billed procedure and modifier combination fails a claim edit.

Research plan

Review the documented service and applicable coding rules before making a correction.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Procedure coding: applied practice lab

Exercise: Define CPT and HCPCS Level II and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Procedure code is inaccurate?

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Exercise: Which source documents would you check for the scenario: A billed procedure and modifier combination fails a claim edit.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 08 | Coding edits and integrity

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Automated edits are prompts for review, not authorization to change documentation or codes without support.

Vocabulary in context

NCCI: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

MUE: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Bundling: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Unbundling: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Upcoding: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Global period: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Procedure-to-procedure edit: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Audit trail: A term used in coding edits and integrity. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Coding edits and integrity: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Coding edits and integrity: worked scenario

Situation

Two procedure lines are flagged as potentially bundled.

Research plan

Review current edit policy and documented distinctness, then use the appropriate supported reporting method.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Coding edits and integrity: applied practice lab

Exercise: Define NCCI and MUE and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Bundling is inaccurate?

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Exercise: Which source documents would you check for the scenario: Two procedure lines are flagged as potentially bundled.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 09 | Professional claims

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Professional claims require accurate provider identities, service locations, dates, codes, and diagnosis links.

Vocabulary in context

CMS-1500: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

837P: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Billing provider: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Rendering provider: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

NPI: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

TIN: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Place of service: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Diagnosis pointer: A term used in professional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Professional claims: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Professional claims: worked scenario

Situation

A payer rejects a professional claim for a missing rendering provider identifier.

Research plan

Validate enrollment and the applicable provider role, correct the field, and resubmit.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Professional claims: applied practice lab

Exercise: Define CMS-1500 and 837P and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Billing provider is inaccurate?

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Exercise: Which source documents would you check for the scenario: A payer rejects a professional claim for a missing rendering provider identifier.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 10 | Institutional claims

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Facility billing uses claim elements and payment methodologies that differ from professional billing.

Vocabulary in context

UB-04: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

837I: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Type of bill: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Revenue code: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Statement period: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Condition code: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Occurrence code: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Patient status: A term used in institutional claims. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Institutional claims: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Institutional claims: worked scenario

Situation

An institutional claim has a bill-type and revenue-code inconsistency.

Research plan

Review the encounter classification and applicable institutional instructions before correcting.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Institutional claims: applied practice lab

Exercise: Define UB-04 and 837I and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Type of bill is inaccurate?

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Exercise: Which source documents would you check for the scenario: An institutional claim has a bill-type and revenue-code inconsistency.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 11 | Electronic transactions

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

A transmitted claim is not necessarily accepted or adjudicated; preserve each stage of the electronic trail.

Vocabulary in context

837: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

835: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

999 acknowledgment: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

277CA: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Clearinghouse: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Claim scrubber: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Batch: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Claim control number: A term used in electronic transactions. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Electronic transactions: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Electronic transactions: worked scenario

Situation

A clearinghouse dashboard says sent but the payer cannot locate the claim.

Research plan

Trace transmission, acknowledgment, payer acceptance, and claim number before duplicating the submission.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Electronic transactions: applied practice lab

Exercise: Define 837 and 835 and explain where each appears in the billing workflow.

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Exercise: What could go wrong if 999 acknowledgment is inaccurate?

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Exercise: Which source documents would you check for the scenario: A clearinghouse dashboard says sent but the payer cannot locate the claim.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 12 | Rejections and corrections

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

A rejection is not the same as an adjudicated denial; choose the correction pathway based on actual claim status.

Vocabulary in context

Rejection: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Denial: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Original claim: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Corrected claim: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Replacement claim: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Void claim: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Resubmission: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Claim frequency: A term used in rejections and corrections. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Rejections and corrections: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Rejections and corrections: worked scenario

Situation

A replacement is sent as a new original claim and then denied as duplicate.

Research plan

Identify the original claim status and use the payer-supported correction method.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Rejections and corrections: applied practice lab

Exercise: Define Rejection and Denial and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Original claim is inaccurate?

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Exercise: Which source documents would you check for the scenario: A replacement is sent as a new original claim and then denied as duplicate.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 13 | Adjudication and remittance

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Read remittance information at claim and line level before posting or billing a patient.

Vocabulary in context

Adjudication: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

EOB: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

ERA: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

CARC: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

RARC: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Adjustment group: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Allowed amount: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Patient responsibility: A term used in adjudication and remittance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Adjudication and remittance: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Adjudication and remittance: worked scenario

Situation

A payer pays zero dollars but assigns part of the amount to deductible.

Research plan

Distinguish valid patient cost share from denied or noncovered charges using remittance and plan rules.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Adjudication and remittance: applied practice lab

Exercise: Define Adjudication and EOB and explain where each appears in the billing workflow.

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Exercise: What could go wrong if ERA is inaccurate?

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Exercise: Which source documents would you check for the scenario: A payer pays zero dollars but assigns part of the amount to deductible.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 14 | Payment posting and reconciliation

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Payment posting should reconcile the remittance with actual deposits and maintain a traceable audit record.

Vocabulary in context

EFT: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

835: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Payment posting: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Contractual adjustment: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Credit balance: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Recoupment: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Offset: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Refund: A term used in payment posting and reconciliation. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Payment posting and reconciliation: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Payment posting and reconciliation: worked scenario

Situation

An EFT amount differs from the total expected payments in the batch.

Research plan

Review offsets, recoupments, split deposits, and unapplied amounts before closing reconciliation.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Payment posting and reconciliation: applied practice lab

Exercise: Define EFT and 835 and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Payment posting is inaccurate?

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Exercise: Which source documents would you check for the scenario: An EFT amount differs from the total expected payments in the batch.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 15 | Denial classification

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Group denials by root cause and financial impact rather than treating each account as an unrelated exception.

Vocabulary in context

Eligibility denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Authorization denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Timely filing denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Duplicate denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medical necessity denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Coding denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

COB denial: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Root cause: A term used in denial classification. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Denial classification: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Denial classification: worked scenario

Situation

The same authorization denial recurs for a specialty clinic.

Research plan

Audit the intake authorization process and assign a preventive action owner.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Denial classification: applied practice lab

Exercise: Define Eligibility denial and Authorization denial and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Timely filing denial is inaccurate?

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Exercise: Which source documents would you check for the scenario: The same authorization denial recurs for a specialty clinic.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 16 | Appeals and reconsiderations

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

The strongest appeal responds to the actual reason for the adverse decision with relevant records and policy.

Vocabulary in context

Appeal: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Reconsideration: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Reopening: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Appeal deadline: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medical records: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Proof of timely filing: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Peer-to-peer: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Escalation: A term used in appeals and reconsiderations. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Appeals and reconsiderations: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Appeals and reconsiderations: worked scenario

Situation

A timely-filing denial arrives despite an earlier dated acceptance report.

Research plan

Check the filing rule, preserve proof of receipt, and pursue the applicable review route before deadline.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Appeals and reconsiderations: applied practice lab

Exercise: Define Appeal and Reconsideration and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Reopening is inaccurate?

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Exercise: Which source documents would you check for the scenario: A timely-filing denial arrives despite an earlier dated acceptance report.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 17 | Medicare billing concepts

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Medicare requirements depend on coverage category, setting, beneficiary status, and applicable contractor guidance.

Vocabulary in context

Part A: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Part B: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Medicare Advantage: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

MAC: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

NCD: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

LCD: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

ABN: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

MSP: A term used in medicare billing concepts. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Medicare billing concepts: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Medicare billing concepts: worked scenario

Situation

A Medicare service is denied under a coverage determination.

Research plan

Identify the program and relevant coverage policy before assessing documentation or appeal rights.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Medicare billing concepts: applied practice lab

Exercise: Define Part A and Part B and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Medicare Advantage is inaccurate?

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Exercise: Which source documents would you check for the scenario: A Medicare service is denied under a coverage determination.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 18 | Medicaid and managed care

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Medicaid eligibility and payment policies vary by state and delivery system.

Vocabulary in context

Medicaid: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Managed care organization: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

State plan: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Provider enrollment: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Prior authorization: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Encounter data: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Covered benefit: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Dual eligible: A term used in medicaid and managed care. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Medicaid and managed care: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Medicaid and managed care: worked scenario

Situation

A Medicaid managed care claim denies for provider enrollment status.

Research plan

Verify plan participation, state program enrollment, dates, and submission requirements.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Medicaid and managed care: applied practice lab

Exercise: Define Medicaid and Managed care organization and explain where each appears in the billing workflow.

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Exercise: What could go wrong if State plan is inaccurate?

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Exercise: Which source documents would you check for the scenario: A Medicaid managed care claim denies for provider enrollment status.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 19 | Privacy and compliance

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

A reliable billing workflow protects information, preserves truthful documentation, and escalates suspected improper billing.

Vocabulary in context

HIPAA: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

PHI: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Minimum necessary: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Business associate: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Audit: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

False Claims Act: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Fraud: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Abuse: A term used in privacy and compliance. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Privacy and compliance: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Privacy and compliance: worked scenario

Situation

An employee sends account details to an unverified email recipient.

Research plan

Follow incident-response procedures and approved secure communication practices.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Privacy and compliance: applied practice lab

Exercise: Define HIPAA and PHI and explain where each appears in the billing workflow.

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Exercise: What could go wrong if Minimum necessary is inaccurate?

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Exercise: Which source documents would you check for the scenario: An employee sends account details to an unverified email recipient.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 20 | Revenue cycle analytics

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Metrics must have stable definitions, denominators, and periods before comparisons are meaningful.

Vocabulary in context

Days in A/R: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

A/R aging: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Clean claim rate: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Denial rate: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Net collection rate: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Charge lag: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Payment lag: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

First-pass resolution: A term used in revenue cycle analytics. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Revenue cycle analytics: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Revenue cycle analytics: worked scenario

Situation

Days in A/R rise even though total charges remain stable.

Research plan

Break down aging by payer, denial reason, claim status, and collection responsibility.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Revenue cycle analytics: applied practice lab

Exercise: Define Days in A/R and A/R aging and explain where each appears in the billing workflow.

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_____

_____

Exercise: What could go wrong if Clean claim rate is inaccurate?

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_____

Exercise: Which source documents would you check for the scenario: Days in A/R rise even though total charges remain stable.

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Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 21 | Contract and reimbursement analysis

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Payment variance review begins with the actual contract and methodology rather than billed charges.

Vocabulary in context

Fee schedule: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Contractual rate: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Underpayment: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Fee-for-service: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Capitation: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

DRG: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

APC: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

RVU: A term used in contract and reimbursement analysis. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Contract and reimbursement analysis: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Contract and reimbursement analysis: worked scenario

Situation

A practice flags a capitated encounter as underpaid using a fee-for-service estimate.

Research plan

Identify the contract model and carve-outs before deciding whether a variance exists.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Contract and reimbursement analysis: applied practice lab

Exercise: Define Fee schedule and Contractual rate and explain where each appears in the billing workflow.

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_____

_____

Exercise: What could go wrong if Underpayment is inaccurate?

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Exercise: Which source documents would you check for the scenario: A practice flags a capitated encounter as underpaid using a fee-for-service estimate.

_____

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_____

Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 22 | Patient billing and resolution

Learning goals

Explain the vocabulary in plain language, connect each concept to an actual claim, recognize when further verification is needed, and document a defensible next action.

Operating principle

Patient balances should reflect accurate adjudication and applicable consumer protection and organizational policies.

Vocabulary in context

Patient statement: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Self-pay: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Financial assistance: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Payment plan: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Good faith estimate: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Credit balance: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Refund: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Collection policy: A term used in patient billing and resolution. In daily practice, identify its exact meaning in the applicable record, payer instructions, contract, or current coding guidance, then confirm how it changes claim handling.

Practical distinction

An account can be technically complete yet not payable. Separate data accuracy, clinical documentation, benefit coverage, contract terms, and payer adjudication. These are related but distinct checks.

Patient billing and resolution: a six-step operating workflow

1. Gather

Identify the patient, account, service date, payer, provider and transaction history.

2. Confirm

Compare entered data with primary source records and applicable payer requirements.

3. Diagnose

Classify the issue: registration, benefit, coding, documentation, authorization, submission, or adjudication.

4. Choose action

Use the permitted correction, resubmission, records request, reconsideration, appeal, or escalation process.

5. Document

Record evidence, action, confirmation number, owner and next follow-up date.

6. Prevent

Assign a root-cause category and consider upstream workflow improvement.

Quality-control checkpoint

Do not change codes, dates, service units, payment allocations, or patient responsibility simply to obtain payment. Corrections must be supported by the record and applicable rules.

Patient billing and resolution: worked scenario

Situation

A patient receives a statement while a secondary claim remains pending.

Research plan

Verify payer processing and account status before deciding whether the patient balance is due.

Sample internal account note

Date: [date] | Account: [reference] | Issue: [specific status and payer explanation] | Verified: [sources checked] | Action: [what was submitted or requested] | Confirmation: [reference number] | Next review: [date]

Common pitfalls

Resubmitting before confirming status can create duplicates. Using an unsupported code change can create compliance risk. Failing to document the payer interaction can slow later appeals.

Team discussion

Who owns the first correction? What evidence is needed? Which deadline applies? How can this failure be prevented?

Patient billing and resolution: applied practice lab

Exercise: Define Patient statement and Self-pay and explain where each appears in the billing workflow.

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_____

_____

Exercise: What could go wrong if Financial assistance is inaccurate?

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Exercise: Which source documents would you check for the scenario: A patient receives a statement while a secondary claim remains pending.

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_____

Exercise: Outline a compliant action plan and include a follow-up date.

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Exercise: Name one operational KPI or quality control that could identify this problem earlier.

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Self-check: ■ Needs review ■ Developing ■ Ready to apply with supervision

CHAPTER 23 | Cross-functional workflow toolkit

Registration verification

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Date of service: _____

Patient name / ID: _____

Subscriber / member ID: _____

Payer: _____

Coverage dates: _____

Verification reference: _____

Staff initials: _____

Reviewer notes

_____

_____

_____

_____

_____

Claim tracking

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Account / claim #: _____

Payer claim number: _____

Submission date: _____

Acceptance evidence: _____

Current status: _____

CARC / RARC: _____

Next action: _____

Owner: _____

Reviewer notes

_____

_____

_____

_____

_____

Denial investigation

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Denial type: _____

Financial impact: _____

Payer explanation: _____

Contract / policy checked: _____

Documentation needed: _____

Resolution pathway: _____

Appeal deadline: _____

Reviewer notes

_____

_____

_____

_____

_____

Appeal preparation

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Decision date: _____

Appeal deadline: _____

Supporting records: _____

Payer policy: _____

Requested outcome: _____

Submission channel: _____

Proof of receipt: _____

Reviewer notes

_____

_____

_____

_____

_____

Payment variance

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Expected contractual amount: _____

Actual allowed amount: _____

Actual paid amount: _____

Adjustments: _____

Units / modifiers: _____

Contract reference: _____

Follow-up: _____

Reviewer notes

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Patient balance validation

Use this reproducible checklist as a training form. Do not include protected patient data in unsecured copies.

Primary adjudication: _____

Secondary adjudication: _____

Valid patient cost share: _____

Payments received: _____

Adjustments: _____

Refund or credit: _____

Statement release: _____

Reviewer notes

_____

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CHAPTER 24 | Final practice examination

Question 01. In revenue cycle architecture, explain the first two checks you would make for this scenario: A practice sees rising accounts receivable despite a stable number of visits.

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Question 02. Define Patient access and describe why the term matters in a claim.

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Question 03. In registration and eligibility, explain the first two checks you would make for this scenario: The claim rejects because the member identifier belongs to an old plan.

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Question 04. Define Subscriber and describe why the term matters in a claim.

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Question 05. In benefits and patient cost sharing, explain the first two checks you would make for this scenario: A patient has a copayment for the visit and coinsurance for a separate test.

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Question 06. Define Deductible and describe why the term matters in a claim.

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Question 07. In coordination of benefits, explain the first two checks you would make for this scenario: A secondary insurer denies because no primary processing information was included.

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Question 08. Define Primary payer and describe why the term matters in a claim.

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Question 09. In authorizations and referrals, explain the first two checks you would make for this scenario: An imaging service was authorized for one date but performed later.

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Question 10. Define Prior authorization and describe why the term matters in a claim.

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Question 11. In diagnosis coding, explain the first two checks you would make for this scenario: A payer questions whether a diagnosis supports a diagnostic test.

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Question 12. Define ICD-10-CM and describe why the term matters in a claim.

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Question 13. In procedure coding, explain the first two checks you would make for this scenario: A billed procedure and modifier combination fails a claim edit.

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Question 14. Define CPT and describe why the term matters in a claim.

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Question 15. In coding edits and integrity, explain the first two checks you would make for this scenario: Two procedure lines are flagged as potentially bundled.

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Question 16. Define NCCI and describe why the term matters in a claim.

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Question 17. In professional claims, explain the first two checks you would make for this scenario: A payer rejects a professional claim for a missing rendering provider identifier.

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Question 18. Define CMS-1500 and describe why the term matters in a claim.

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Question 19. In institutional claims, explain the first two checks you would make for this scenario: An institutional claim has a bill-type and revenue-code inconsistency.

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Question 20. Define UB-04 and describe why the term matters in a claim.

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Question 21. In electronic transactions, explain the first two checks you would make for this scenario: A clearinghouse dashboard says sent but the payer cannot locate the claim.

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Question 22. Define 837 and describe why the term matters in a claim.

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Question 23. In rejections and corrections, explain the first two checks you would make for this scenario: A replacement is sent as a new original claim and then denied as duplicate.

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Question 24. Define Rejection and describe why the term matters in a claim.

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Question 25. In adjudication and remittance, explain the first two checks you would make for this scenario: A payer pays zero dollars but assigns part of the amount to deductible.

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Question 26. Define Adjudication and describe why the term matters in a claim.

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Question 27. In payment posting and reconciliation, explain the first two checks you would make for this scenario: An EFT amount differs from the total expected payments in the batch.

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Question 28. Define EFT and describe why the term matters in a claim.

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Question 29. In denial classification, explain the first two checks you would make for this scenario: The same authorization denial recurs for a specialty clinic.

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Question 30. Define Eligibility denial and describe why the term matters in a claim.

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Question 31. In appeals and reconsiderations, explain the first two checks you would make for this scenario: A timely-filing denial arrives despite an earlier dated acceptance report.

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Question 32. Define Appeal and describe why the term matters in a claim.

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Question 33. In medicare billing concepts, explain the first two checks you would make for this scenario: A Medicare service is denied under a coverage determination.

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Question 34. Define Part A and describe why the term matters in a claim.

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Question 35. In medicaid and managed care, explain the first two checks you would make for this scenario: A Medicaid managed care claim denies for provider enrollment status.

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Question 36. Define Medicaid and describe why the term matters in a claim.

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Question 37. In privacy and compliance, explain the first two checks you would make for this scenario: An employee sends account details to an unverified email recipient.

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Question 38. Define HIPAA and describe why the term matters in a claim.

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Question 39. In revenue cycle analytics, explain the first two checks you would make for this scenario: Days in A/R rise even though total charges remain stable.

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Question 40. Define Days in A/R and describe why the term matters in a claim.

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Question 41. In contract and reimbursement analysis, explain the first two checks you would make for this scenario: A practice flags a capitated encounter as underpaid using a fee-for-service estimate.

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Question 42. Define Fee schedule and describe why the term matters in a claim.

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Question 43. In patient billing and resolution, explain the first two checks you would make for this scenario: A patient receives a statement while a secondary claim remains pending.

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Question 44. Define Patient statement and describe why the term matters in a claim.

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Model response guide

Award up to 4 points for each response: correct concept (1), relevant source verification (1), compliant next action (1), and documentation or prevention (1). Model responses below are examples, not the only acceptable wording.

01. Segment the balance by payer, age, denial status, and patient responsibility before proposing a fix.

02. A medical billing operation should track the account from appointment through final resolution, not merely through claim submission.

03. Verify the date-of-service coverage, update the source registration record, correct the claim, and confirm acceptance.

04. Eligibility and benefit verification are separate questions. Coverage on a date does not guarantee a specific service will be paid.

05. Explain each cost-sharing category and avoid presenting an estimate as a final bill.

06. Patient estimates should distinguish verified plan facts from assumptions about future adjudication.

07. Confirm payer order, obtain the primary remittance, and follow secondary submission requirements.

08. Payment order is determined by applicable COB rules, not by which insurance card the patient prefers.

09. Compare authorization conditions and request permitted correction or review before appealing.

10. Authorization approval does not itself guarantee payment; the approved service, dates, units, provider, and claim must align.

11. Review documentation, coverage criteria, and code assignment with qualified coding staff; do not invent a diagnosis.

12. Diagnosis coding should be supported by the clinical record and current official coding guidance.

13. Review the documented service and applicable coding rules before making a correction.

14. Procedure codes and modifiers communicate what was performed and relevant circumstances, not what amount the practice hopes to collect.

15. Review current edit policy and documented distinctness, then use the appropriate supported reporting method.

16. Automated edits are prompts for review, not authorization to change documentation or codes without support.

17. Validate enrollment and the applicable provider role, correct the field, and resubmit.

18. Professional claims require accurate provider identities, service locations, dates, codes, and diagnosis links.

19. Review the encounter classification and applicable institutional instructions before correcting.

20. Facility billing uses claim elements and payment methodologies that differ from professional billing.

21. Trace transmission, acknowledgment, payer acceptance, and claim number before duplicating the submission.

22. A transmitted claim is not necessarily accepted or adjudicated; preserve each stage of the electronic trail.

23. Identify the original claim status and use the payer-supported correction method.

24. A rejection is not the same as an adjudicated denial; choose the correction pathway based on actual claim status.

25. Distinguish valid patient cost share from denied or noncovered charges using remittance and plan rules.

26. Read remittance information at claim and line level before posting or billing a patient.

27. Review offsets, recoupments, split deposits, and unapplied amounts before closing reconciliation.

28. Payment posting should reconcile the remittance with actual deposits and maintain a traceable audit record.

29. Audit the intake authorization process and assign a preventive action owner.

30. Group denials by root cause and financial impact rather than treating each account as an unrelated exception.

31. Check the filing rule, preserve proof of receipt, and pursue the applicable review route before deadline.

32. The strongest appeal responds to the actual reason for the adverse decision with relevant records and policy.

33. Identify the program and relevant coverage policy before assessing documentation or appeal rights.

34. Medicare requirements depend on coverage category, setting, beneficiary status, and applicable contractor guidance.

35. Verify plan participation, state program enrollment, dates, and submission requirements.

36. Medicaid eligibility and payment policies vary by state and delivery system.

37. Follow incident-response procedures and approved secure communication practices.

38. A reliable billing workflow protects information, preserves truthful documentation, and escalates suspected improper billing.

39. Break down aging by payer, denial reason, claim status, and collection responsibility.

40. Metrics must have stable definitions, denominators, and periods before comparisons are meaningful.

41. Identify the contract model and carve-outs before deciding whether a variance exists.

42. Payment variance review begins with the actual contract and methodology rather than billed charges.

43. Verify payer processing and account status before deciding whether the patient balance is due.

44. Patient balances should reflect accurate adjudication and applicable consumer protection and organizational policies.

CHAPTER 25 | 30-day learning and implementation plan

Day 01: Review Revenue cycle architecture. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 02: Review Revenue cycle architecture. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 03: Review Registration and eligibility. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 04: Review Benefits and patient cost sharing. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 05: Review Benefits and patient cost sharing. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 06: Review Coordination of benefits. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 07: Review Authorizations and referrals. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 08: Review Diagnosis coding. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 09: Review Diagnosis coding. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 10: Review Procedure coding. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 11: Review Coding edits and integrity. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 12: Review Professional claims. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 13: Review Professional claims. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 14: Review Institutional claims. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 15: Review Electronic transactions. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 16: Review Rejections and corrections. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 17: Review Rejections and corrections. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 18: Review Adjudication and remittance. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 19: Review Payment posting and reconciliation. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 20: Review Payment posting and reconciliation. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 21: Review Denial classification. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 22: Review Appeals and reconsiderations. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 23: Review Medicare billing concepts. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 24: Review Medicare billing concepts. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 25: Review Medicaid and managed care. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 26: Review Privacy and compliance. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 27: Review Revenue cycle analytics. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 28: Review Revenue cycle analytics. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 29: Review Contract and reimbursement analysis. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Day 30: Review Patient billing and resolution. Define three terms, complete a scenario, document a sample account note, and identify one authoritative source. ■

Official source checklist

• CMS Medicare manuals, coverage determinations, fee schedules and claims guidance: cms.gov

• HHS OCR privacy and security guidance: hhs.gov/hipaa

• HHS OIG compliance guidance: oig.hhs.gov

• Official ICD-10-CM annual code and guideline releases from CDC/CMS

• AMA CPT resources and licensing: ama-assn.org

• X12 transaction standard information: x12.org

• State Medicaid program manuals and applicable managed-care payer policies

• Current contracts, payer provider manuals, remittance files and claim acceptance reports

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