

MC BILLING ACADEMY

Student Workbook

Medical Billing • Claims • Denials • Revenue Cycle Practice

LEARN	PRACTICE	APPLY	REVIEW
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Premium training resource | 2026 Edition

How to Use This Workbook

Complete the exercises after studying the matching topic in the Premium Advanced Medical Billing Guide. Write your reasoning, not just the final answer. The goal is to develop a repeatable billing thought process.

Important: These exercises are educational. Actual payer, coding, documentation, and compliance requirements must be verified against current authoritative sources.

Module 1 — Foundations

1. Define revenue cycle management in your own words.

2. List the steps you believe occur between a patient scheduling an appointment and a zero balance.

3. Explain the difference between a charge, an allowed amount, a payment, and patient responsibility.

4. Why can inaccurate demographic information create downstream billing problems?

Module 2 — Eligibility & Benefits

1. Write five data elements you would verify before a visit.

2. Explain deductible, copayment, coinsurance, and out-of-pocket maximum.

3. A patient has two active plans. What information must be confirmed before deciding which payer receives the claim first?

4. Why should benefit verification be documented?

Module 3 — Coding & Claims

1. Explain the roles of ICD-10-CM, CPT, and HCPCS Level II.

2. What is a modifier intended to communicate?

3. Describe the difference between a rejected claim and a denied claim.

4. List four claim data elements that can trigger front-end edits.

Module 4 — Payments

1. What information would you compare when reviewing an ERA?

2. Explain contractual adjustment versus patient responsibility.

3. A payer issues a zero payment. List four possible reasons you would research.

4. Why should credit balances be reviewed promptly?

Module 5 — Denials

1. Create a root-cause category for each: eligibility, authorization, coding, timely filing, COB.

2. What evidence could support a timely-filing appeal?

3. Explain why simply resubmitting a denied claim can make a problem worse.

4. Write a complete follow-up note template.

Module 6 — Appeals

1. List the information you would gather before drafting an appeal.

2. Why does an appeal deadline matter?

3. What is the role of medical records in some appeals?

4. Describe when escalation may be appropriate.

Module 7 — Compliance

1. Explain PHI in practical billing terms.

2. What does minimum necessary mean in a billing workflow?

3. Explain the difference among fraud, waste, and abuse at a high level.

4. Why is an audit trail valuable?

Module 8 — A/R & Metrics

1. Explain Days in A/R and A/R aging.

2. What can a rising denial rate indicate?

3. How can charge lag affect cash flow?

4. Choose three KPIs and explain what operational problem each could reveal.

Case Study Lab

Case A — Eligibility

Scenario: A claim rejects because the member ID is invalid. The patient provided a new insurance card after the visit.

Assignment: Write the steps you would take from verification through resubmission.

Case B — Authorization

Scenario: A payer denies an imaging service for no authorization, but the practice has an authorization number in the chart.

Assignment: List what you would compare before deciding whether to correct, reconsider, or appeal.

Case C — Underpayment

Scenario: A contracted payer allows less than expected for a service.

Assignment: List the claim, remittance, and contract information you would review.

Case D — Timely Filing

Scenario: A claim denies for timely filing, but the clearinghouse report shows an accepted transmission before the deadline.

Assignment: Identify the evidence you would preserve and the next steps.

Case E — COB

Scenario: The secondary payer denies because it has no primary payer information.

Assignment: Describe the documentation and claim information you would gather.
