

RCM OPERATIONS MANUAL: New Biller Training System

A Complete 90-Day Onboarding System for Medical Billing Departments

MANAGER QUICK START GUIDE

This manual is a self-directed training system built to reduce manager workload while accelerating new biller competency. It gives trainees a clear path to follow, with structured expectations at each stage of onboarding. Managers can use it to standardize training, track progress, and verify readiness without having to coach every step of the process. The system includes training roadmaps, competency checklists, quizzes, evaluation forms, and shadowing guides designed for practical day-to-day use.

- 1. **Day 1** — Give the new hire this manual and confirm they understand the training process.
- 2. **15-minute review** — Review the Training Roadmap together so expectations are clear from the start.
- 3. **Formal checkpoints** — Schedule the three manager evaluations for **Days 30, 60, and 90**.
- 4. **Independent completion** — Have the trainee work through each phase using the checklists and quizzes before advancing.
- 5. **Go/No-Go gates** — Use the **Go/No-Go gates** to decide whether the trainee is ready to move to the next phase.
- 6. **Manager evaluation** — Complete the Manager Evaluation Forms at each scheduled interval and document any gaps that need follow-up.

July 17

SECTION 1: TRAINING ROADMAP

This 90-day roadmap breaks training into 4 phases with clear milestones and Go/No-Go assessment gates so the manager can verify readiness before advancing. Each phase builds on the last, moving the new biller from foundational knowledge to supervised execution, then independent operations, and finally full competency. Use the deliverables and performance thresholds in each phase to measure progress objectively and reduce coaching time. The trainee must meet each gate before moving forward.

Phase	Timeline	Learning Objectives	Deliverables	Go/No-Go Gate
Phase 1: Foundation	Days 1-14	Understand the RCM workflow; learn practice management system navigation;	Beginner Quiz (80% pass); completed system login credentials; signed	Manager verifies quiz score + system access + compliance training

		master insurance terminology; complete HIPAA compliance training; understand the claim lifecycle.	confidentiality agreement.	certificate.
Phase 2: Supervised Practice	Days 15-45	Perform patient registration with supervision; verify insurance eligibility independently; enter charges with 95% accuracy; submit clean claims under review; shadow denial management.	Intermediate Quiz (85% pass); 25 supervised registrations; 50 verified eligibilities; 100 charge entries reviewed.	Manager reviews error rate on charge entry (must be <5%), spot-checks 10 eligibility verifications, reviews quiz score.
Phase 3: Independent Operations	Days 46-75	Manage full patient registration independently; post payments with zero balance errors; work denials independently; conduct AR follow-up calls; meet productivity benchmarks.	Advanced Quiz (85% pass); 100 independent registrations; 200 payment posts; 25 denial resolutions; AR call log.	Manager reviews: payment posting accuracy (must be 98%+), denial resolution rate, productivity metrics, quiz score.
Phase 4: Full Competency	Days 76-90	Operate at full productivity standards; handle complex cases	90-Day Evaluation Form (Pass rating); consistent	Manager completes final evaluation form, reviews 90-day

		independently; mentor new trainees; participate in team problem- solving.	productivity metrics; zero critical errors for 14 consecutive days.	performance data, makes hire/release decision.
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CRITICAL: Go/No-Go Gate Protocol

Trainees must pass each gate before advancing to the next phase. If a trainee fails a gate, they repeat that phase with additional supervision and targeted coaching on the missed competencies. Document all gate results in the personnel file and retain the related quiz scores, evaluation notes, and corrective action items for reference.

 SECTION 2: COMPETENCY CHECKLISTS

These checklists are binary assessment tools managers can use to confirm whether a trainee can perform each task independently. Mark an item only after the trainee demonstrates consistent, unsupervised accuracy in real workflow conditions. Use the date verified column to document when competency was confirmed.

2.1 Patient Registration Competency

Competency Item	Can Perform Independently	Date Verified
Collect complete demographic information	[]	
Verify patient identity using two identifiers	[]	
Scan insurance cards front and back	[]	
Collect copay at time of service	[]	
Explain patient financial responsibility clearly	[]	
Update guarantor	[]	

information accurately		
Create new patient accounts without errors	☐	
Handle walk-in and scheduled visit protocols correctly	☐	
Document patient communication preferences	☐	
Process patient portal registration	☐	

2.2 Insurance Verification Competency

Competency Item	Can Perform Independently	Date Verified
Access payer portals and verify eligibility in real time	☐	
Identify active versus terminated coverage	☐	
Determine primary versus secondary insurance correctly	☐	
Verify authorization requirements for procedures	☐	
Document deductible and out-of-pocket maximums	☐	
Identify copay versus coinsurance obligations	☐	
Verify referral requirements and obtain when needed	☐	
Check for coordination of benefits	☐	
Document verification	☐	

details in the system		
Communicate coverage limitations to patients professionally	[]	

2.3 Charge Entry Competency

Competency Item	Can Perform Independently	Date Verified
Select correct CPT codes from encounter documentation	[]	
Apply appropriate ICD-10 diagnosis codes	[]	
Link diagnoses to procedures correctly	[]	
Enter modifiers when clinically indicated	[]	
Verify units of service match documentation	[]	
Apply place of service codes accurately	[]	
Enter rendering and referring provider information	[]	
Review charges for medical necessity compliance	[]	
Correct charge entry errors before submission	[]	
Meet productivity standards for charge entry	[]	

2.4 Claim Submission Competency

Competency Item	Can Perform Independently	Date Verified
Scrub claims using clearinghouse edits	☐	
Resolve claim edits before submission	☐	
Submit electronic claims via clearinghouse	☐	
Verify claim acceptance by payer	☐	
Track claim status proactively	☐	
Resubmit rejected claims with corrections	☐	
Submit paper claims when required	☐	
Attach supporting documentation correctly	☐	
Meet claim submission timely filing deadlines	☐	
Maintain claim submission logs	☐	

2.5 Denial Management Competency

Competency Item	Can Perform Independently	Date Verified
Identify denial reason codes accurately	☐	
Research denial root causes	☐	
Determine if a denial is appealable	☐	
Write effective appeal letters	☐	

Submit appeals within payer timeframes	[]	
Track appeal status and follow up	[]	
Correct claim errors and resubmit	[]	
Identify patterns in denials for prevention	[]	
Escalate complex denials appropriately	[]	
Document all denial resolution actions	[]	

2.6 Payment Posting Competency

Competency Item	Can Perform Independently	Date Verified
Post insurance payments accurately	[]	
Post patient payments and apply correctly	[]	
Reconcile EOB line items to charges	[]	
Identify and post contractual adjustments	[]	
Process refunds according to policy	[]	
Handle credit balances appropriately	[]	
Post denials and transfer to AR worklist	[]	
Maintain zero posting errors for 30 days	[]	

2.7 AR Follow-Up Competency

Competency Item	Can Perform Independently	Date Verified
Prioritize AR worklist by aging and dollar value	[]	
Contact payers to check claim status	[]	
Document all follow-up activities with detail	[]	
Resolve claims pending additional information	[]	
Identify and escalate underpayments	[]	
Handle patient billing inquiries professionally	[]	
Set up payment plans per policy	[]	
Send patient statements on schedule	[]	
Work AR to meet aging targets (90+ days)	[]	
Meet daily AR follow-up productivity goals	[]	



SECTION 3: TRAINING QUIZZES

These quizzes test applied knowledge at each phase, not memorization alone. Trainees must meet the minimum passing score before advancing to the next phase, and managers should review missed questions immediately to target remediation.

3.1 BEGINNER QUIZ (Phase 1: Days 1-14)

Passing Score: 8/10 (80%)

1. A patient presents with two insurance cards — one from their employer (Blue Cross) and one from their spouse's employer (Aetna). How do you determine which is primary?

A) Always use the card presented first

B) Apply the birthday rule — the parent whose birthday comes first in the calendar year determines primary coverage

C) Ask the patient which one they prefer

D) Bill both simultaneously as co-primary

- 1. You're entering charges for an office visit. The provider documented a 99214 (detailed visit) but only spent 15 minutes with the patient. The medical record shows limited history and exam. What should you do?**

A) Enter the 99214 as documented

B) Query the provider about the level of service before submitting

C) Downcode to 99213 without asking

D) Add a modifier to explain the discrepancy

- 1. A patient's insurance verification shows their deductible is \$2,000 and \$500 has been met. Today's visit will cost \$300. What is the patient's responsibility today (assuming no copay)?**

A) \$0 - insurance covers everything after deductible is met

B) \$300 - they haven't met their full deductible yet

C) \$500 - the remaining deductible amount

D) \$150 - half of the visit cost

- 1. You receive an EOB with denial code CO-16: "Claim lacks information or has submission/billing error(s)." What is your first step?**

A) Immediately appeal the denial

B) Review the original claim for missing or incorrect information

C) Call the patient to collect payment

D) Write off the balance as uncollectible

- 1. A claim was submitted on March 15 for a service date of March 1. Today is June 20 and you haven't received payment. The payer's timely filing limit is 90 days. What should you do?**

A) Wait another 30 days before following up

B) Immediately contact the payer — you're approaching the timely filing deadline

C) Resubmit the claim as a new claim

D) Bill the patient since the deadline has passed

1. A patient calls asking for details about another patient's visit because they are "the spouse." What is the correct response under HIPAA?

A) Provide the information if they can confirm the patient's date of birth

B) Share the details because spouses are always allowed access

C) Verify the patient's authorization or direct the caller to the patient

D) Give only the diagnosis but not the billing details

1. You are registering a new patient and notice the address on the insurance card does not match the address in the system. What should you do?

A) Ignore it – address mismatches are not important

B) Update the address after verifying the information with the patient and payer rules

C) Enter the insurance card address only

D) Cancel the registration and tell the patient to come back later

1. A plan says the patient has a \$25 copay and 20% coinsurance after deductible. Which statement is correct?

A) Copay and coinsurance are the same thing

B) Copay is a fixed amount; coinsurance is a percentage of the allowed charge

C) Coinsurance is paid before the copay

D) Copay only applies to hospital services

1. You check claim status and the payer portal shows received but not yet in process after 12 business days. What is the best next step?

A) Assume it was denied and bill the patient

B) Follow up with the payer to confirm the claim is moving through the system

C) Resubmit immediately to avoid delay

D) Void the claim and re-enter it with a different date

1. A procedure requires linking the diagnosis of diabetes to the lab order for the A1C test. Why is this important?

A) It helps the claim clear medical necessity edits

B) It changes the patient's deductible amount

C) It prevents the patient from receiving a statement

D) It guarantees payment with no review

ANSWER KEY - Beginner Quiz

1. **B**
2. **B**
3. **B**
4. **B**
5. **B**
6. **C**
7. **B**
8. **B**
9. **B**
10. **A**

3.2 INTERMEDIATE QUIZ (Phase 2: Days 15-45)

Passing Score: 8.5/10 (85%)

1. **You submitted a claim for \$500. The EOB shows: Billed \$500, Allowed \$350, Contractual Adjustment \$150, Deductible \$100, Coinsurance \$50, Paid \$200. What do you post to the patient balance?**

A) \$150 (contractual adjustment + deductible + coinsurance)

B) \$150 (deductible + coinsurance only)

C) \$300 (everything not paid by insurance)

D) \$500 (the full billed amount)

1. **A claim denies with code PR-1: "Deductible amount." The patient insists they met their deductible last month. What is your next step?**

A) Write off the balance to avoid conflict

B) Verify current deductible status with the payer and provide documentation to the patient

C) Resubmit the claim with a different diagnosis

D) Transfer the balance to insurance and re-bill

1. **You're working a claim that's 75 days old with status "pending medical records." The timely filing deadline is 90 days. What should you do?**

A) Wait for the provider to send records

B) Immediately escalate to the provider and expedite records submission

C) Bill the patient for the full amount

D) Close the claim as uncollectible

- 1. A patient has Medicare primary and a commercial secondary. Medicare paid \$80 on a \$200 charge with \$120 contractual adjustment. How do you bill the secondary?**

A) Bill the secondary for the full \$200

B) Bill the secondary for \$120 (the Medicare adjustment)

C) Bill the secondary for \$80 (what Medicare paid)

D) Do not bill secondary - Medicare is final

- 1. You notice a pattern: 15 claims for the same CPT code denied in one week for "medical necessity." What should you do?**

A) Appeal each claim individually

B) Alert the provider and billing manager to investigate documentation or coding patterns

C) Change the diagnosis code on all claims and resubmit

D) Bill all patients directly

- 1. A claim rejects in the clearinghouse because a required modifier is missing. The claim has not reached the payer. What is the correct action?**

A) Wait for the payer to request the modifier

B) Correct the modifier and resubmit through the clearinghouse

C) Send a paper claim instead

D) Post the claim as denied and move on

- 1. A service requires prior authorization, but the authorization number is missing on the claim. The payer denies the claim after processing. What should have happened before submission?**

A) The claim should have been billed with no changes

B) The authorization requirement should have been verified and the number attached before claim submission

C) The claim should have been billed to the patient first

D) The provider should have changed the procedure code

- 1. You post a payment and realize the system applied it to the wrong encounter. What is**

the best correction step?

- A) Leave it if the balance is small**
 - B) Reverse the posting and reapply the payment correctly**
 - C) Transfer the balance to collections**
 - D) Write off the difference as a posting error**
- 1. A patient wants a payment plan for a \$900 balance. Your policy allows payment plans only for balances over \$500 with a signed agreement and first payment due today. What do you do?**
- A) Set up the plan immediately with no documentation**
 - B) Confirm the balance qualifies, obtain the signed agreement, and collect the first payment**
 - C) Waive the balance to keep the patient happy**
 - D) Tell the patient to wait until the next statement**
- 1. The clearinghouse rejects a claim because the subscriber ID is invalid. What is the next best step?**
- A) Resubmit the same claim unchanged**
 - B) Verify the insurance information, correct the subscriber ID, and resubmit**
 - C) Send the claim to the patient directly**
 - D) Hold the claim indefinitely without action**

ANSWER KEY - Intermediate Quiz

- 1. B**
- 2. B**
- 3. B**
- 4. B**
- 5. B**
- 6. B**
- 7. B**
- 8. B**
- 9. B**
- 10. B**



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C) Resubmit the claim as a new claim

D) Bill the patient since the deadline has passed

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C) Enter the insurance card address only

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C) Resubmit immediately to avoid delay

D) Void the claim and re-enter it with a different date

1. **A procedure requires linking the diagnosis of diabetes to the lab order for the A1C test. Why is this important?**

A) It helps the claim clear medical necessity edits

B) It changes the patient's deductible amount

C) It prevents the patient from receiving a statement

D) It guarantees payment with no review

ANSWER KEY - Beginner Quiz

1. **B**
2. **B**
3. **B**
4. **B**
5. **B**
6. **C**
7. **B**
8. **B**
9. **B**
10. **A**

3.2 INTERMEDIATE QUIZ (Phase 2: Days 15-45)

Passing Score: 8.5/10 (85%)

1. **You post an EOB for a \$500 claim. The payer allowed \$360, applied a \$120 contractual adjustment, paid \$180, and shows patient responsibility of \$60 deductible and \$0 coinsurance. What is the correct patient balance?**

A) \$60

B) \$180

C) \$240

D) \$120

1. **A claim denied as not medically necessary under a payer policy. The chart note is weak, and no ABN was obtained for the patient. What is the most appropriate next step?**

A) Bill the patient for the full amount immediately

B) Review the policy and documentation; if ABN was required and not obtained, follow write-off policy rather than patient billing

C) Resubmit with the same documentation and expect payment

D) Change the diagnosis code to force payment

- 1. A procedure is scheduled for June 18. Eligibility verification on June 8 shows the policy becomes active on June 15. What should the biller do?**

A) Confirm coverage will be active on the service date and document the effective date

B) Ignore the effective date because the plan is listed as active

C) Cancel the appointment automatically

D) Bill the claim now so the payer can update the record

- 1. A patient has Medicare primary and commercial secondary. Medicare allowed \$200, paid \$160, and left \$40 patient responsibility. Which statement is correct when billing the secondary?**

A) Send the original charge amount to secondary with no adjustment

B) Post Medicare first, then bill the secondary according to COB rules and contract balance logic

C) Bill the patient because Medicare already paid

D) Write off the full remaining balance without review

- 1. Fifteen claims for the same CPT code denied in one week for missing modifier 25. What is the best operational response?**

A) Appeal each claim individually without changing the workflow

B) Identify the root cause, correct the charge capture process, and rebill corrected claims

C) Wait for the payer to reprocess the claims automatically

D) Stop billing that CPT code altogether

- 1. A payer says a service requires authorization, but the provider only issued a referral. What is the correct interpretation?**

A) A referral and authorization are interchangeable

B) A referral directs a patient to a specialist; authorization is payer approval and may still be required

C) If there is a referral, no other payer approval is ever needed

D) Authorization is only used for emergency services

1. During payment posting, you discover a payment was applied to the wrong patient account and created a false credit balance. What should you do?
 - A) Leave it until month-end reconciliation
 - B) Reverse and repost the payment according to policy, then correct the account notes
 - C) Move the credit to another unrelated balance
 - D) Write off the credit to clear the account
1. Your AR worklist includes claims at 32 days, 68 days, and 118 days. A payer appeal limit expires in 7 days on one of the 68-day claims. Which claim should be handled first?
 - A) The 118-day claim because it is oldest
 - B) The 32-day claim because it is newest
 - C) The claim with the 7-day appeal deadline, then the high-dollar aging claims
 - D) The smallest balance regardless of deadline
1. Before submission, the claim scrubber flags that the diagnosis code does not support medical necessity for the ordered lab. What is the best action?
 - A) Submit anyway and wait for denial
 - B) Correct the diagnosis/procedure linkage or query the provider before submission
 - C) Remove the diagnosis and submit clean
 - D) Change the CPT to a lower-value code without review
1. A patient has primary Aetna and secondary Blue Cross, but the claim was sent to Blue Cross first. Blue Cross denied for COB. What should happen next?
 - A) Leave the denial and bill the patient
 - B) Reverse the incorrect submission, bill Aetna first, then send the claim to Blue Cross after primary adjudication
 - C) Resubmit both carriers at the same time again
 - D) Post the denial as contractual adjustment

ANSWER KEY - Intermediate Quiz

1. **A**
2. **B**
3. **A**
4. **B**

- 5. **B**
 - 6. **B**
 - 7. **C**
 - 8. **B**
 - 9. **B**
 - 10. **B**
-

3.3 ADVANCED QUIZ (Phase 3: Days 46-75)

Passing Score: 8.5/10 (85%)

1. **A patient has primary Medicare, secondary commercial coverage, and tertiary Medicaid. Medicare pays first, the commercial plan pays according to COB, and Medicaid shows a patient balance that appears to exceed its allowed amount. What is the correct billing approach?**
 - A) Bill Medicaid for the full remaining balance and ignore its fee schedule**
 - B) Reconcile each payer sequentially, then apply only the amount allowed by the tertiary payer contract**
 - C) Bill the patient because tertiary coverage always makes the patient responsible**
 - D) Rebill commercial first because tertiary coverage cannot be used after Medicare**
1. **A claim for a bilateral procedure was denied because the modifier was missing. The chart supports both sides, and the payer requires documentation for the procedure-specific appeal. What should the biller include in the appeal package?**
 - A) Only a copy of the denial letter and the original claim**
 - B) Operative note, provider order, relevant diagnosis support, and payer-required modifier justification**
 - C) A patient statement requesting payment reconsideration**
 - D) A corrected claim with no explanation**
1. **Your fee schedule shows the payer should have allowed \$420 on a claim, but the EOB allowed only \$360 and paid \$288. What should you do first?**
 - A) Post the payment and ignore the difference**
 - B) Identify the \$60 underpayment, verify contract terms, and submit a reconsideration or adjustment request if supported**
 - C) Bill the patient for the \$60 difference**

D) Write off the difference automatically as contractual adjustment

- 1. A patient account shows a credit balance after an overpayment. The balance is clearly not owed to the patient, and refund policy requires review before issuing funds. What is the correct sequence?**

A) Refund immediately without review to clear the account

B) Validate the overpayment source, confirm no offsets are due, obtain approval if required, then process the refund and document the transaction

C) Transfer the credit to another unrelated account

D) Leave the credit in place until the next annual audit

- 1. A patient is injured at work and the visit should be billed to workers' compensation. The patient also has group health insurance. What is the correct coordination step?**

A) Bill group health first because it pays faster

B) Follow the employer injury routing and bill workers' compensation first; use group health only if workers' compensation denies or is exhausted under policy

C) Bill both carriers simultaneously and let them decide

D) Bill the patient directly until the case is accepted

- 1. A claim was first submitted on January 5, rejected for missing attachment on January 20, corrected and resubmitted on February 2, then denied again on March 10. The payer's timely filing limit is 90 days from date of service. What is the best action if the service date was January 1?**

A) Stop working it because the original filing date is what matters and the claim is untouchable

B) Use the payer's rules to determine whether the corrected submission preserved timeliness and, if necessary, appeal with proof of original submission and rejection history

C) Bill the patient immediately

D) Refile as a brand-new claim with a later date of service

- 1. A patient agrees to a payment plan for a \$1,200 balance. What should the biller confirm before setting it up?**

A) Only the monthly payment amount

B) Written policy compliance, patient consent, hardship rules if applicable, and clear terms for missed payments or account escalation

C) That the patient can pay in cash only

D) The plan is approved automatically if the patient asks for it

1. **A payer denies a claim for lack of medical necessity. The provider wants to submit more documentation. What is the difference between a reconsideration and an appeal?**

A) They are identical terms with no procedural difference

B) A reconsideration is usually an initial review request with additional documentation; an appeal is a formal dispute under payer-level rules

C) An appeal is used only for patient statements

D) A reconsideration can only be used after the appeal deadline has passed

1. **A surgeon performs a procedure that requires a modifier 50 for bilateral service. Another payer requires separate line items instead. What should the biller do?**

A) Use the same billing method for every payer regardless of policy

B) Follow each payer's billing rule: use the required bilateral reporting method and attach documentation when needed

C) Remove the modifier to avoid denials

D) Bill one side only to reduce risk

1. **An account is aging past 120 days. The payer says the balance is contractual, but the fee schedule shows a larger allowable amount than what was posted. What is the correct policy action?**

A) Write off the full difference without review

B) Compare the EOB, contract, and fee schedule; if the balance reflects a true underpayment, pursue correction instead of writing off improperly

C) Bill the patient because any aged balance is patient responsibility

D) Close the account to prevent more work

ANSWER KEY - Advanced Quiz

1. **B**
2. **B**
3. **B**
4. **B**
5. **B**
6. **B**
7. **B**
8. **B**

- 9. B
- 10. B



SECTION 4: MANAGER EVALUATION FORMS

These structured forms help managers assess a new biller objectively at 30, 60, and 90 days. Use the pass/fail thresholds to decide whether the trainee is ready to advance or needs targeted remediation before moving forward.

4.1 30-DAY EVALUATION FORM

Employee Name: _____ Evaluation Date: _____

Evaluator: _____ Training Phase Completed: Phase 1 & 2 (partial)

Competency Area	Rating (1-5)	Notes	Pass/Fail Threshold
System Navigation & Access			4+
Insurance Terminology Knowledge			4+
Patient Registration Accuracy			3+
Insurance Verification Process			3+
Charge Entry Fundamentals			3+
HIPAA Compliance & Confidentiality			5
Attendance & Punctuality			4+
Receptiveness to Feedback			4+

Rating Scale: 1 = Cannot perform | 2 = Performs with significant errors | 3 = Performs with

minor errors | 4 = Performs independently with rare errors | 5 = Exceeds expectations

OVERALL 30-DAY ASSESSMENT

Pass/Fail Decision: ☐ PASS (advance to Phase 2 continued) ☐ FAIL (repeat Phase 2 with remediation)

Manager Comments: _____

Manager Signature: _____ Date: _____

4.2 60-DAY EVALUATION FORM

Employee Name: _____ Evaluation Date: _____

Evaluator: _____ Training Phase Completed: Phase 2 & 3 (partial)

Competency Area	Rating (1-5)	Notes	Pass/Fail Threshold
Claim Submission Accuracy			4+
Denial Management Skills			3+
Payment Posting Accuracy			4+
AR Follow-Up Effectiveness			3+
Productivity Benchmarks			3+
Problem-Solving & Critical Thinking			4+
Communication with Patients			4+
Communication with Payers			3+

Documentation Quality			4+
Independence Level			4+

Rating Scale: 1 = Cannot perform | 2 = Performs with significant errors | 3 = Performs with minor errors | 4 = Performs independently with rare errors | 5 = Exceeds expectations

OVERALL 60-DAY ASSESSMENT

Pass/Fail Decision: ☐ PASS (advance to Phase 3 continued) ☐ FAIL (repeat Phase 3 with targeted coaching)

Manager Comments: _____

Manager Signature: _____ Date: _____

4.3 90-DAY EVALUATION FORM (FINAL)

Employee Name: _____ Evaluation Date: _____

Evaluator: _____ Training Phase Completed: All 4 Phases

Competency Area	Rating (1-5)	Notes	Pass/Fail Threshold
Full Cycle RCM Competency			4+
Claim Accuracy Rate			4+
Payment Posting Error Rate			5
Denial Resolution Rate			4+
AR Days Performance			4+
Productivity			4+

Standards Met			
Quality Standards Met			4+
Independent Decision-Making			4+
Team Collaboration			4+
Compliance & Ethics			5
Professional Development			4+
Overall Job Readiness			4+

Rating Scale: 1 = Cannot perform | 2 = Performs with significant errors | 3 = Performs with minor errors | 4 = Performs independently with rare errors | 5 = Exceeds expectations

FINAL 90-DAY ASSESSMENT & HIRING DECISION

Decision: ☐ HIRE (full competency achieved) ☐ EXTEND (30-day probation with goals) ☐ RELEASE (competency not achieved)

Manager Comments: _____

Manager Signature: _____ Date: _____

HR Signature: _____ Date: _____

SECTION 5: SHADOWING GUIDES

Shadowing is a critical part of Phase 2 training because it lets the trainee observe experienced billers performing real work in a live environment. The goal is to reduce ramp-up time, reinforce correct workflows, and make the trainee ready for supervised execution sooner.

5.1 SHADOWING GUIDE: Live Claim Submission

Trainee Name: _____ Date: _____

Supervisor: _____ Duration: _____

Observation Objectives

- Observe how the supervisor opens the claim work queue and selects the correct encounter
- Watch how demographic, insurance, and provider details are confirmed before submission
- Note how diagnosis and procedure codes are reviewed for accuracy and medical necessity
- Observe how claim edits are identified and corrected before release
- Watch how modifiers, units, and place of service are checked against documentation
- Note how attachments are added when the payer requires supporting documentation
- Observe how the claim is transmitted through the clearinghouse or payer portal
- Watch how submission confirmation, acceptance, or rejection is recorded for follow-up

Post-Shadowing Knowledge Check

1. What fields were verified before the claim was submitted?
2. Which edits or errors had to be corrected before release?
3. What documentation was attached, and why was it needed?
4. How did the supervisor confirm that the claim was accepted?
5. What is the next step if the clearinghouse rejects the claim?

Supervisor Sign-Off

- ☐ Trainee observed the full claim submission workflow
- ☐ Trainee asked relevant questions during the session
- ☐ Trainee can explain the claim submission sequence
- ☐ Trainee is ready for supervised claim submission practice

Supervisor Signature: _____ Date: _____

Trainee Signature: _____ Date: _____



SECTION 5: SHADOWING GUIDES

5.2 SHADOWING GUIDE: Denial Appeal Process

Trainee Name: _____ Date: _____

Supervisor: _____ Duration: _____

Observation Objectives

- Observe how the supervisor identifies the denial reason code on the EOB
- Watch the research process to determine root cause of the denial
- Note how the supervisor determines if the denial is appealable
- Observe how supporting documentation is gathered for the appeal
- Watch how the appeal letter is written with clear clinical justification
- Note how the appeal is submitted according to payer requirements
- Observe how appeal deadlines are tracked and documented
- Watch how the appeal is logged in the system for follow-up

Post-Shadowing Knowledge Check

1. What was the denial reason code and what did it mean?
2. How did the supervisor determine the denial was appealable?
3. What documentation was included in the appeal package?
4. What is the payer's deadline for submitting this appeal?
5. How is the appeal tracked after submission?

Supervisor Sign-Off

- ☐ Trainee observed the full denial appeal workflow
- ☐ Trainee asked relevant questions during the session
- ☐ Trainee can explain the appeal sequence and documentation requirements
- ☐ Trainee is ready for supervised denial appeal practice

Supervisor Signature: _____ Date: _____

Trainee Signature: _____ Date: _____

5.3 SHADOWING GUIDE: Patient Billing Call

Trainee Name: _____ Date: _____

Supervisor: _____ Duration: _____

Observation Objectives

- Observe how the supervisor greets the patient and verifies identity
- Watch how the account balance is explained clearly and professionally
- Note how insurance processing status is communicated
- Observe how payment options are presented
- Watch how the supervisor handles patient objections or concerns
- Note how payment arrangements are documented in the system
- Observe how the supervisor maintains HIPAA compliance during the call
- Watch how the call is documented with next steps

Post-Shadowing Knowledge Check

1. How did the supervisor verify the patient's identity before discussing the account?
2. What information was provided about the patient's insurance processing?
3. How did the supervisor respond when the patient expressed concern about the balance?
4. What payment options were offered to the patient?
5. How was the call outcome documented?

Supervisor Sign-Off

- ☐ Trainee observed a complete patient billing call
- ☐ Trainee asked relevant questions during the session
- ☐ Trainee can explain the call flow and compliance expectations
- ☐ Trainee is ready for supervised patient billing call practice

Supervisor Signature: _____ Date: _____

Trainee Signature: _____ Date: _____
