MEDICAL BILLING & REVENUE CYCLE MANAGEMENT TRAINING MANUAL

A practical, from-scratch guide to medical billing, coding fundamentals, claims, denials, compliance, and real-world billing scenarios.

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Table of Contents

Chapter 1: Introduction to Medical Billing & the Revenue Cycle 3

Chapter 2: Key Departments & Roles in the Billing Process 5

Chapter 3: Patient Registration, Insurance Verification & Eligibility 7

Chapter 4: Understanding Health Insurance Types 8

Chapter 5: Network Status, Negotiation, Authorization & Sanctions 10

Chapter 6: Core Billing Terminology 11

Chapter 7: Medical Coding Fundamentals 14

Chapter 8: Claims Preparation & Submission 17

Chapter 9: Adjudication, EOB, ERA & Payment Posting 18

Chapter 10: Denial & Rejection Management 19

Chapter 11: Appeals & Corrections 22

Chapter 12: Accounts Receivable (A/R) Management & Key Metrics 23

Chapter 13: Patient Billing & Collections 24

Chapter 14: HIPAA, Compliance & Fraud Prevention 25

Chapter 15: Call Handling Scripts 27

Chapter 16: Glossary of Key Terms 28

Chapter 17: Knowledge Check — Review Questions 31

Chapter 18: Coding & Billing Scenarios — Practice Set 33

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Chapter 1: Introduction to Medical Billing & the Revenue Cycle

What Is Medical Billing?

Medical billing is the process of translating the healthcare services a patient receives into standardized billing codes and submitting them as claims to insurance companies for reimbursement. It is the financial link between the care a provider delivers and the payment that keeps the practice running.

> **Example:** A patient visits a doctor for a fever. The doctor diagnoses a viral infection, orders lab tests, and prescribes medication. All of these services are converted into standardized codes and sent as a claim to the patient's insurance company for payment.

Why It Matters

- Ensures doctors, clinics, and hospitals actually get paid for the care they provide.
- Helps patients understand and manage their share of healthcare costs.
- Creates an accurate record of patient and treatment history.
- Is essential to keeping any healthcare business financially viable.

What Is Revenue Cycle Management (RCM)?

Revenue Cycle Management is the complete, end-to-end financial process a healthcare provider follows to get paid — starting the moment an appointment is scheduled and ending only once every dollar owed has been collected, whether from the insurance company or the patient.

The RCM Lifecycle

1. **Scheduling & Registration** — the patient's appointment is booked and demographic/insurance details are collected.
2. **Insurance Eligibility Verification** — coverage, benefits, and authorization requirements are confirmed before the visit.
3. **Charge Capture** — the services, supplies, and provider documentation from the visit are recorded.
4. **Medical Coding** — the visit is translated into standardized diagnosis and procedure codes.
5. **Claim Submission** — the coded claim is sent electronically (or on paper) to the payer.
6. **Payer Adjudication** — the insurance company reviews the claim and decides what it will pay.
7. **Payment Posting** — the payment received is applied to the patient's account.
8. **Denial Management** — any denied or rejected claims are corrected and resubmitted or appealed.
9. **A/R Follow-Up** — unpaid claims are tracked and pursued until resolved.
10. **Patient Billing & Collections** — any remaining balance is billed to, and collected from, the patient.

A simple way to remember the flow: *Patient Visit → Charge Entry → Coding → Claim Submission → Payment Posting → Denials (if any) → Follow-Up → Paid.*

Why RCM Discipline Matters

- It ensures steady, predictable cash flow for the practice.

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- It minimizes denials and write-offs that quietly erode revenue.
- It directly improves overall practice profitability.

Final Tips to Keep in Mind Throughout This Manual

- Accuracy is everything — small data-entry or coding errors are the single biggest cause of denials.
- Learn payer-specific rules; every insurance company plays by slightly different rules.
- Always verify insurance *before* the visit, not after.
- Use the tools available: clearinghouses, EHR/PM systems, and denial-tracking reports.

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Chapter 2: Key Departments & Roles in the Billing Process

Medical billing is rarely a one-person job. A claim passes through several hands before it becomes a payment, and understanding each role helps every person in the chain do their part well.

Roles & Responsibilities

Patient Registration / Front Desk

Collects patient demographics, verifies insurance, and schedules appointments.

> **Example:** The front desk collects the patient's name, date of birth, insurance ID, and copay amount before the visit even begins.

Charge Entry

Enters the data for medical services and charges rendered, linking the correct diagnosis and procedure codes to each charge.

> **Example:** Visit charge: $120. Diagnosis: J10.1 (Influenza). Procedure: 99213 (established office visit).

Medical Coder

Converts the provider's documentation into standardized CPT, ICD-10, and HCPCS codes. Accuracy here is crucial — miscoding is one of the top causes of denials and compliance risk.

> **Example:** Flu diagnosis: ICD-10 J10.1. Office visit: CPT 99213. Injection administered: HCPCS J3420.

Medical Biller

Handles charge entry, claim submission, denial follow-up, and patient statements — essentially the person who turns coded services into collected revenue.

Claims Submission

Clean claims are sent electronically (or, less commonly, on paper) to the correct insurance payer — Medicare, Medicaid, or a commercial insurer.

> **Example:** A claim for flu-related services is submitted electronically to Blue Cross Blue Shield.

Payment Posting

Posts the payment received from the insurer or patient and adjusts the account according to the allowed amount and any contractual write-off.

> **Example:** Billed: $120. Insurance paid: $90. Patient responsibility (copay/deductible): $30.

Denial Management

Investigates denied or rejected claims, identifies the root cause, corrects it, and resubmits or appeals.

> **Example:** A claim is denied for an invalid diagnosis code, corrected, and resubmitted successfully.

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Accounts Receivable (A/R) / Follow-Up

Follows up on unpaid or delayed claims, contacting payers or patients for status updates before balances age out.

> **Example:** A claim goes unpaid for 45 days, so the biller calls Aetna to escalate the payment.

Payer / Insurer

Reviews (adjudicates) the submitted claim against the patient's coverage and processes payment accordingly.

Credentialing (Supportive Department)

Ensures each provider is properly enrolled and verified with every insurance company the practice bills — a required step before any claim can even be submitted.

> **Example:** Dr. Smith must be fully credentialed with Medicare before he can see and bill for Medicare patients.

The Workflow in Practice

Provider documents the visit → Coder assigns diagnosis and procedure codes → Biller enters charges → Claim is submitted → Payer adjudicates → Payment is posted → Patient is billed for any remaining balance.

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Chapter 3: Patient Registration, Insurance Verification & Eligibility

Registration Essentials

- Collect accurate demographics: full legal name, date of birth, address, and contact information.
- Obtain complete insurance details: plan name, subscriber ID, group number, and effective/termination dates.

Verification Steps

- Call the payer or check their online portal to confirm active coverage.
- Confirm plan benefits: deductible status, copay amount, and coinsurance percentage.
- Confirm whether prior authorization or a referral is required for the planned service.
- Always document the verification results and any reference number provided by the payer.

Eligibility & Verification of Benefits (VOB) Call Checklist

This is the exact set of questions a front-desk or intake team should be prepared to ask on a verification call:

1. Is the patient's coverage active for the date of service?
2. What is the plan type (PPO, HMO, EPO, POS, etc.)?
3. What are the effective and termination dates of the policy?
4. Who is the primary insurance holder?
5. Is the patient the primary policyholder or a dependent?
6. What is the copay for office visits and specialist visits?
7. What is the deductible amount, and how much has already been met?
8. What is the coinsurance percentage?
9. What is the out-of-pocket maximum, and what has accumulated toward it so far?
10. Is prior authorization or a referral required for this specific service?
11. Are there visit limits on this service (e.g., therapy or mental health visits)?
12. Are telehealth services covered under this plan?
13. Is the provider in-network for this patient's specific plan?
14. Are there exclusions or restrictions that apply to the requested service?
15. What is the correct claim mailing address or payer ID for electronic claims?
16. Can I get a reference number for this call?

Tip: Never skip the reference number. If a claim is later denied for eligibility reasons despite a positive verification, that reference number is the practice's proof the check was done.

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Chapter 4: Understanding Health Insurance Types

Government Health Insurance

Government programs help specific groups of people in the U.S. by covering healthcare costs through public funds. There are four main programs: Medicare, Medicaid, TRICARE, and Railroad Medicare.

Medicare

A federal program mainly covering people age 65+, people with certain disabilities, and patients with End-Stage Renal Disease (ESRD) or ALS.

> **Example:** Mrs. Clara, 67, visits a cardiologist. Her services are billed under Medicare Part B. Medicare covers 80%, and she is responsible for the remaining 20% coinsurance.

- **Part A** — hospital stays, nursing facilities, hospice.
- **Part B** — doctor visits, outpatient care, medical supplies.
- **Part C** — Medicare Advantage, offered by private companies.
- **Part D** — prescription drug coverage.

Medicaid

A joint state-and-federal program for low-income individuals and families, children, pregnant women, and the elderly or disabled. Coverage rules vary by state.

> **Example:** A pregnant woman in Texas earning below the poverty level receives prenatal care, an ultrasound, and delivery services fully covered by Texas Medicaid.

Feature	Medicare	Medicaid
Eligibility	65+ or disabled	Income-based (varies by state)
Funding	Federal	Federal & State
Administration	National	State-specific (rules vary)
Covers Long-Term Care	Limited	Yes (extensive for eligible persons)
Prescription Drugs	Part D (optional)	Often included
Premiums	Yes, for Part B/D	Often free or minimal
Focus	Age / disability	Financial need

TRICARE

A health insurance program for active-duty military, retirees, and their families, managed by the Department of Defense, with plans such as TRICARE Prime and TRICARE for Life (which acts as secondary to Medicare).

Railroad Medicare

Covers retired railroad workers and is administered nationwide by Palmetto GBA. Claims must be submitted separately from traditional Medicare.

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Managed Care Plans

Managed care is a system for delivering healthcare that manages cost, utilization, and quality through provider networks, pre-authorization requirements, and a focus on preventive care.

Plan	PCP / Referral	Out-of-Network	Notes
HMO	Required	Not covered	Lowest cost, most restrictive. Example: Kaiser Permanente.
PPO	Not required	Covered (higher cost)	Most flexible, highest premiums. Example: BCBS PPO.
EPO	Not required	Not covered (except emergencies)	Lower premium than PPO, limited network. Example: Oscar EPO.
POS	Required	Covered with referral	Hybrid of HMO and PPO. Example: Cigna POS.

Medicaid Replacement Plans (Medicaid Managed Care Organizations)

State-approved private plans that administer Medicaid benefits and often add extras like dental, vision, transportation, and over-the-counter item allowances.

> **Example:** Aetna Better Health, United Healthcare Community Plan, and Molina Healthcare are common examples of Medicaid MCOs.

Supplemental Insurance Plans

Cover costs not included in a patient's main insurance, such as remaining deductibles or coinsurance. Common types include Medigap, critical illness, and hospital indemnity plans. Note: supplemental plans are not used in combination with Medicaid.

Workers' Compensation Plans

Employer-paid insurance covering work-related injuries and illnesses, including medical care, wage replacement, and disability benefits, at no cost to the employee.

Real-Life Scenarios

- **John (HMO)** — needs a PCP referral before seeing a specialist.
- **Lisa (PPO)** — travels frequently and prefers the flexibility of out-of-network coverage.
- **Ahmed (Medicaid MCO)** — receives added dental and transportation benefits.
- **Martha (Supplemental)** — uses a Medigap plan to cover her Medicare coinsurance.
- **Jake (Workers' Comp)** — fully covered for a work-injury surgery and rehabilitation.

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Chapter 5: Network Status, Negotiation, Authorization & Sanctions

In-Network (INN) vs. Out-of-Network (OON) Providers

In-Network providers have a signed contract with the payer and accept its fee schedule.

> **Example:** Dr. Smith is in-network with BCBS. The patient pays a lower, predictable cost through copay/deductible.

Out-of-Network providers have no contract with the insurer, and patients typically face higher costs.

> **Example:** Dr. Patel is out-of-network with UHC and charges $400. The insurer pays only $150, leaving the patient responsible for a $250 balance, plus a higher OON deductible.

Negotiation & Single Case Agreements

When no in-network specialist is available, a practice can negotiate directly with the insurer for a higher payment rate rather than being paid (or denied) at standard out-of-network rates.

> **Example:** Dr. Lee, an out-of-network orthopedic surgeon, treats a patient after an emergency. Her office negotiates a Single Case Agreement (SCA) with the insurer to be paid 80% of allowed charges instead of standard OON rates.

A **Single Case Agreement (SCA)** is a temporary, one-time contract covering one patient and one service, used specifically when no in-network provider is available.

Provider Sanctions

Disciplinary actions taken against a provider, which can include payment suspension, exclusion from a network, or being reported to the OIG or a state licensing board.

> **Example:** A provider found engaging in fraudulent billing is excluded from the Medicare program.

Authorization Types

Type	When It Applies
Prior Authorization	Required before the service is performed (e.g., an MRI).
Retrospective Authorization	Requested after emergency care has already been provided.
Concurrent Review	Ongoing authorization required during a hospital stay.
No Authorization Needed	Applies to routine visits, e.g., a PCP annual checkup, or true emergencies.

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Chapter 6: Core Billing Terminology

This chapter defines the everyday terms every biller needs to speak fluently, with a real-world example for each.

Copay

A fixed, upfront amount a patient pays for a covered service, usually at time of service. Copays do not count toward the deductible, but they do count toward the out-of-pocket maximum.

> **Example:** $25 for a PCP visit, $50 for a specialist visit.

Deductible

The amount a patient must pay out of pocket before insurance begins covering costs.

> **Example:** A $1,500 deductible must be met before insurance starts paying its share.

Coinsurance

After the deductible is met, the percentage of costs the patient continues to pay. (Contrast: a copay is a flat fee; coinsurance is a percentage.)

> **Example:** 20% coinsurance on a $1,000 bill = $200 patient responsibility.

Allowed Amount

The maximum amount an insurer will reimburse for a given service — this defines both the payment and the patient's remaining balance.

> **Example:** Provider billed $200; payer allowed $120; paid $100; patient copay $20.

Out-of-Pocket Maximum

The most a patient will pay in a plan year (combining copays, deductibles, and coinsurance) before the insurer covers 100% of remaining costs.

> **Example:** After reaching a $6,000 maximum, the insurer covers all further covered expenses.

Recoupment

When an insurer reclaims an overpayment, typically by withholding it from a future claim payment.

> **Example:** A $500 overpayment is recovered by the payer from a future claim.

Refund

When a provider proactively returns an overpayment to the payer or patient, as opposed to having it enforced via recoupment.

> **Example:** A patient paid $100 out of pocket, but insurance later covered the full cost, so the practice issues a refund.

W-9 Form

Provides a provider's tax ID and legal business name to insurers for claim processing, enrollment, or payment reporting.

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No-Show Fee

A fee charged for missing an appointment without adequate notice; policies must be clearly disclosed to patients in advance.

> **Example:** A $75 fee for a cancellation made less than 24 hours before the appointment.

Coordination of Benefits (COB)

The process that determines which insurance is primary and which is secondary when a patient has more than one policy, preventing overpayment and duplicate billing.

> **Example:** A patient's primary insurance is Aetna and secondary is Molina Healthcare.

Advance Beneficiary Notice (ABN)

A Medicare-required notice given to a patient before a potentially uncovered service, informing them they may be responsible for the full cost.

> **Example:** A patient signs an ABN in advance for a non-medically-necessary therapy service.

Referring Provider vs. Ordering Provider

A referring provider sends the patient to another provider; an ordering provider requests equipment or a specific service.

> **Example:** A PCP refers a patient to a cardiologist (referring); a physician orders a wheelchair (ordering).

MUE Edits

Medically Unlikely Edits limit the number of units of a service that can be billed for one patient on one day, preventing overbilling and unintentional errors.

> **Example:** Only one unit of a specific lab test is allowed to be billed per day.

NCCI Edits

National Correct Coding Initiative edits prevent unbundled or improper coding combinations, protecting coding integrity.

> **Example:** Billing separately for an incision that is part of a larger surgery is denied under NCCI.

Assignment of Benefits (AOB)

A patient's authorization allowing the insurer to pay the provider directly rather than reimbursing the patient, resulting in faster provider payment.

> **Example:** A signed AOB routes payment directly to the hospital, not the patient.

Local Coverage Determination (LCD)

A decision by a Medicare Administrative Contractor (MAC) on whether a specific service is covered at the local level, and under what coding/documentation conditions.

> **Example:** An LCD may state a lab test is covered only when linked to a specific diagnosis code.

Enrollment

The process by which a provider registers with Medicare, Medicaid, or a private payer to be authorized to bill and receive payment.

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Example: A new physician submits CMS-855I to enroll in Medicare.

Appeal / Redetermination / Reconsideration

An appeal is a formal request to review a denial. A redetermination is the first level of appeal specifically for Medicare claims; a reconsideration is the second-level appeal used for non-Medicare payers.

EFT / ERA / Check / Virtual Card

The four common payment methods: EFT (direct deposit), ERA (a digital breakdown of the payment), paper Check (slower), and Virtual Card (a one-time-use credit card number, which may carry processing fees).

Inpatient vs. Outpatient

Inpatient care means the patient is formally admitted with a physician order for at least one overnight stay. Outpatient care is received without formal admission, including ER visits, clinic visits, and same-day surgery.

Payer ID

A unique identifier assigned to each insurance payer used for routing electronic claims correctly through a clearinghouse.

Example: United Healthcare may use a payer ID such as 87726 — always verify with the clearinghouse, since IDs can vary by product line.

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Chapter 7: Medical Coding Fundamentals

CPT — Current Procedural Terminology

CPT codes are five-digit numeric codes developed by the American Medical Association (AMA) to describe medical, surgical, and diagnostic services.

CPT Range	Category
00100–01999	Anesthesia
10021–69990	Surgery
70010–79999	Radiology
80047–89398	Pathology & Laboratory
90281–99607	Medicine
99091–99499	Evaluation & Management (E/M)

ICD-10-CM — Diagnosis Codes

ICD (International Classification of Diseases) codes report diagnoses and conditions to payers. ICD-10-CM is the current U.S. clinical modification.

- E11.9 — Type 2 diabetes mellitus without complications
- J10.1 — Influenza with other respiratory manifestations
- F32.1 — Major depressive disorder, moderate
- Z00.00 — Encounter for general adult medical exam without abnormal findings

HCPCS — Healthcare Common Procedure Coding System

HCPCS includes Level I (which is simply CPT) and Level II codes, which cover supplies, equipment, and non-physician services such as ambulance transport or durable medical equipment (DME).

Example: A0428 — Ambulance service, basic life support, non-emergency transport. E0100 — Crutches.

Place of Service (POS) Codes

The POS code tells the payer where the service was rendered, which directly affects how the claim is priced and adjudicated.

Code	Place of Service
11	Office
12	Home
20	Urgent Care Facility

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Code	Place of Service
21	Inpatient Hospital
22	Outpatient Hospital — On Campus
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
02	Telehealth — Provided Other than in Patient's Home

Modifiers with Real Scenarios

A modifier adjusts the description of a service without changing its core meaning — it tells the payer *how* or *where* a service was performed differently than usual.

Modifier	Description	Example Scenario
25	Significant, separately identifiable E/M service, same physician, same day	Patient comes in for a rash but also needs evaluation for a migraine.
59	Distinct procedural service	Same-day wound repair and lesion excision at different sites.
26	Professional component	Billing for reading an X-ray only (not the technical part).
TC	Technical component	Billing for X-ray machine usage only.
76	Repeat procedure, same physician	Repeat EKG on the same day due to chest pain.
77	Repeat procedure, different physician	A different provider repeats the X-ray.
91	Repeat lab test	Lab test repeated to verify an abnormal result.
LT	Left side of body	Cataract surgery on the left eye.
RT	Right side of body	Removal of a mole on the right arm.
50	Bilateral procedure	Bilateral knee injections.
24	Unrelated E/M during post-op period	Post-op patient seen for an unrelated cough.
57	Decision for surgery	An E/M visit leads directly to same-day surgery scheduling.
58	Staged / related procedure in post-op period	A planned second-look surgery.
78	Return to OR for a complication	Post-op bleeding requires an unplanned return to surgery.

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Modifier	Description	Example Scenario
79	Unrelated procedure during post-op period	A post-op hip surgery patient needs an unrelated mole removed.
XE	Separate encounter	Lab tests performed at separate visits.
XP	Separate practitioner	Same service performed by a different provider.
XS	Separate structure	A different organ system treated in the same session.
XU	Unusual, non-overlapping service	Same lab test performed on different samples.
GA	Waiver of liability on file	Used alongside an ABN for a non-covered Medicare service.

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Chapter 8: Claims Preparation & Submission

Charge Entry & Fee Schedules

Every code is entered into the practice's PM/EHR system, and the appropriate fee schedule is applied — either a contracted rate with a specific payer or a UCR (usual, customary, and reasonable) rate.

Claim Forms

- **CMS-1500** — used for physician and other professional services.
- **UB-04** — used for facility and hospital services.

Electronic vs. Paper Submission

Most claims today are submitted electronically through a clearinghouse using the HIPAA-standard 837 transaction format, which validates and routes the claim to the correct payer far faster than paper submission.

What Makes a “Clean Claim”

A clean claim is one that is accepted and processed by the payer without any additional information or correction needed. Before submitting, always double-check:

- Patient demographics match the insurance card exactly (name, DOB, gender).
- The correct, active subscriber/member ID and group number are on the claim.
- Diagnosis (ICD-10) and procedure (CPT/HCPCS) codes are valid and support each other.
- The rendering and billing provider NPIs are correct and properly credentialed with the payer.
- The correct Place of Service code is used for where the service was actually rendered.
- Any required modifiers, referring/ordering provider information, or prior authorization number are included.

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Chapter 9: Adjudication, EOB, ERA & Payment Posting

The Adjudication Process

Once a claim reaches the payer, it goes through adjudication: the payer checks the patient's eligibility on the date of service, confirms the service is within benefit limits, and applies its coding rules before deciding what to pay.

Explanation of Benefits (EOB) & Electronic Remittance Advice (ERA)

An EOB (or its electronic equivalent, the ERA) shows exactly how a claim was processed: the amount paid, any adjustments or write-offs applied, and what the patient still owes.

Payment Posting

The payment poster matches the EOB/ERA line-by-line to the original claim, posts the insurer's payment, and records any contractual adjustment or write-off.

Worked Example

A visit is billed at $250. The EOB shows the insurance paid $180.

Line Item	Amount
Billed Amount	$250.00
Insurance Payment	$180.00
Patient Balance (Billed – Paid)	$70.00

The $70 difference is then reviewed: part may be a contractual write-off (if the provider is in-network) and part may be genuine patient responsibility (copay, deductible, or coinsurance), depending on what the EOB specifies.

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Chapter 10: Denial & Rejection Management

Denials and rejections are not the same thing, and knowing the difference determines how quickly — and successfully — a claim gets paid.

	Rejection	Denial
When it happens	Before the claim is accepted into the payer's system	After the claim is accepted and adjudicated
Typical cause	Data/formatting errors (wrong payer ID, invalid ID format)	Coverage, medical necessity, or authorization issues
Fix	Correct and resubmit as a new claim	Correct and resubmit, or file a formal appeal

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Common Claim Denials & Resolutions

Denial Code / Reason	Description	Resolution Steps
CO-16: Missing Information	Required information is missing from the claim.	Review the claim for missing fields (DX, modifiers, NPI, etc.), correct, and resubmit.
CO-18: Duplicate Claim	Claim is a duplicate of one already processed.	Check claim status and avoid multiple submissions; use the appeal process if it's actually a corrected claim.
CO-50: Medical Necessity Denied	Service was not deemed medically necessary by the payer.	Submit an appeal with supporting documentation (chart notes, peer-reviewed studies).
CO-96: Non-Covered Charges	Service is not covered by the payer's policy.	Check the payer coverage policy; educate the patient, bill secondary insurance, or obtain an ABN in advance.
CO-109: Claim Not Covered by This Payer	Claim was sent to the wrong payer, or that payer isn't responsible.	Verify insurance and coordination of benefits; rebill to the correct payer.
CO-197: Precertification/Authorization Missing	Authorization was required but not obtained.	Contact the payer to retro-authorize if allowed, or appeal with clinical justification.
CO-204: Service Not Covered Under Patient's Plan	The patient's specific plan does not cover the service.	Confirm coverage with the payer or patient; offer cash-pay options if needed.
CO-208: NPI Missing or Invalid	Provider NPI not recognized or omitted.	Verify and correct the NPI in the system; update credentialing if necessary.
CO-B7: Provider Not Eligible	Rendering provider not authorized for the billed service.	Check provider enrollment status, correct the provider on the claim, or appeal.
PR-1: Deductible Not Met	Patient responsibility due to an unmet deductible.	Bill the patient, or submit the claim to secondary insurance if one exists.
CO-22: Coordination of Benefits (COB) Issue	Other insurance is listed, but COB information is missing or wrong.	Obtain COB details from the patient/insurer, correct the claim, and resubmit.
CO-23: Payment Adjusted — Payer Secondary	Payer is actually secondary, but was billed as primary.	Verify payer order and submit to the primary payer first.
CO-45: Charges Exceed Fee Schedule	Billed amount exceeds the contracted allowed amount.	Adjust the write-off per the contract; collect the remaining patient balance if applicable.
CO-11: Diagnosis Inconsistent with Procedure	ICD-10 code does not medically justify the billed CPT.	Verify coding accuracy, update the diagnosis or procedure code, and resubmit with corrected codes.
CO-151: Payment Adjusted — Submission Error	Payer identified a provider billing error.	Review the EOB and payer policy, correct the error, and resubmit or appeal with an explanation.

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Common Claim Rejections & Resolutions

Rejection Reason	Description	Resolution
Invalid/Missing Patient Demographics	Patient name, DOB, or gender doesn't match payer records.	Verify against the insurance card; correct and resubmit.
Invalid/Missing Subscriber ID	Incorrect or missing insurance member ID.	Confirm the ID with the patient or payer portal; update and resubmit.
Insurance Not Active on Date of Service	Coverage terminated or not yet effective.	Contact the patient or check the eligibility portal; update insurance or hold for new coverage.
Provider Not Enrolled/Credentialed with Payer	NPI not on file or linked to the correct tax ID/group.	Verify enrollment status; complete or submit credentialing if missing.
Invalid/Missing Diagnosis or CPT Code	Code is not valid for the date of service or is in an invalid format.	Verify code validity per current coding guidelines and payer edits.
Mismatched Payer ID	Incorrect payer ID used in electronic submission.	Check the payer list or clearinghouse directory; correct and resubmit.
Improper Place of Service (POS)	POS code not appropriate for the CPT code or telehealth service.	Match the CPT-to-POS mapping; use POS 02 or 10 for telehealth when required.
Missing Referring/Ordering Provider	A required field (for labs, imaging, DME) was left blank.	Add a valid referring/ordering provider NPI and resubmit.
Duplicate Claim	Resubmission of the same claim without any correction.	If it's a true duplicate, do not resubmit; otherwise use the correct resubmission/frequency indicator.
Invalid Patient-Provider Relationship Code	Incorrect relationship of the patient to the insured.	Confirm whether the patient is self, spouse, or child; correct and resubmit.

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Chapter 11: Appeals & Corrections

Understanding the Appeal Ladder

- **Appeal** — a formal request asking the payer to review a denial decision.
- **Redetermination** — the first level of appeal specifically for Medicare claims.
- **Reconsideration** — the second level of appeal, typically used for non-Medicare payers.

Appeal Timelines

Appeal windows typically run 30–60 days from the date of denial, though this varies by payer — always confirm the exact deadline stated on the denial notice or EOB.

What Goes Into a Strong Appeal Letter

1. Patient and claim details (name, DOB, member ID, date of service, claim number).
2. The specific denial reason being appealed, quoted directly from the EOB or denial notice.
3. A clear, factual explanation of why the service should be covered or the denial reversed.
4. Supporting documentation: relevant chart notes, the prior authorization number (if one exists), test results, or peer-reviewed clinical guidelines.
5. A specific, direct request — e.g., “We request the claim be reprocessed and paid at the contracted rate.”
6. Contact information and the appeal filing deadline being met.

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Chapter 12: Accounts Receivable (A/R) Management & Key Metrics

A/R Aging Buckets

Unpaid claims are typically tracked in aging buckets so nothing falls through the cracks:

- 0–30 days — normal, still within expected processing time.
- 31–60 days — needs a first follow-up call or portal check.
- 61–90+ days — needs escalation; risk of missing timely filing/appeal windows increases.

Key Performance Indicators (KPIs)

- **Denial Rate** — the percentage of claims denied on first submission.
- **Days in A/R** — the average number of days it takes to collect on a claim.
- **Clean Claim Rate** — the percentage of claims accepted and paid without any correction needed.

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Chapter 13: Patient Billing & Collections

Patient Statements

A clear statement should show the date of service, a plain-language description of the service, what insurance paid, and exactly what the patient owes and why.

Payment Options

- Offer installment/payment plans for larger balances.
- Provide an online payment portal for convenience.

Collections Best Practices

- Follow up on schedule: at 30, 60, and 90 days past due.
- Document every outreach attempt — call, letter, email — with the date and outcome.
- Always communicate clearly and respectfully; a confused or frustrated patient is far less likely to pay promptly.

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Chapter 14: HIPAA, Compliance & Fraud Prevention

HIPAA — the Health Insurance Portability and Accountability Act (1996) — exists to protect the privacy, security, and confidentiality of patients' health information.

What Is PHI (Protected Health Information)?

PHI includes any health information that can identify an individual, such as:

- Name, address, phone number, or email
- Social Security number
- Medical record number
- Health plan details
- Lab results or mental health information
- Full-face photographs

Key HIPAA Rules

Rule	Description	Applies To
Privacy Rule	Regulates use and disclosure of Protected Health Information (PHI).	All covered entities (providers, payers, clearinghouses)
Security Rule	Requires administrative, physical, and technical safeguards for electronic PHI (ePHI).	Applies to electronic records only
Breach Notification Rule	Requires notification to patients, HHS, and sometimes media, in the event of a data breach.	All covered entities and business associates
Enforcement Rule	Describes investigation, penalties, and procedures for HIPAA violations.	Enforced by the OCR (Office for Civil Rights)
Omnibus Rule	Updates HIPAA to include HITECH Act provisions, expanding liability to business associates.	Vendors, subcontractors, etc.

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Common HIPAA Violations

Violation	Example
Unauthorized Access	A staff member accesses a friend's chart without a work-related need.
Lost/Stolen Devices	An unencrypted laptop containing PHI is stolen from a car.
Improper Disposal	Throwing paper medical records in a regular trash bin.
Sharing Info Without Consent	Discussing patient information in a public area, like an elevator or hallway.
Lack of Safeguards	Not using password protection or automatic screen-lock timeouts.
Social Media Posts	Posting patient stories or photos without written consent.
Wrong Recipient	Sending lab results to the wrong patient's email address.
Failure to Obtain Consent	Disclosing PHI to a third party without proper authorization.

Preventing HIPAA Violations — Best Practices

- Always lock your screen and log off when leaving your workstation.
- Use secure, encrypted communication — never text or email PHI without encryption.
- Complete annual HIPAA training without exception.
- Never share passwords or access a record out of personal curiosity.
- Shred all printed PHI before disposal.
- Limit PHI disclosure strictly to the minimum necessary for the task at hand.

Fraud & Abuse Awareness

Beyond privacy, billers must also guard against fraud and abuse risks:

- **Upcoding** — billing for a more expensive service than was actually performed.
- **Unbundling** — billing separately for services that should be billed together under one code.
- **OIG Audits** — the Office of Inspector General actively audits providers for billing fraud and abuse.
- **No Surprises Act** — a federal law (effective 2022) that protects patients from surprise out-of-network bills, particularly for emergency services.

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Chapter 15: Call Handling Scripts

Strong phone skills save hours of rework. These scripts can be adapted for training new hires or used as a quick-reference cheat sheet on live calls.

Script 1: Claim Status & Denial Inquiry Call

Opening the call:

- “Hello, this is [Your Name] calling from [Provider/Facility Name], NPI number [XXXXXXXXXX].”
- “I'm calling to check the status of a claim / follow up on a denial. May I proceed with the patient information?”
- Provide: Patient Name, Date of Birth, Member ID, Date of Service, Billed Amount, CPT code(s), and Rendering Provider.

Core questions to ask:

- “Can you please confirm the status of this claim? Was it received?”
- “Is it in process, paid, or denied?”
- If denied: “Can you provide the denial code and description, the exact denial reason, and the date of denial?”
- “Is this claim eligible for resubmission or appeal, and what steps are needed to correct it?”
- “Is documentation required, such as medical records or a corrected claim?”
- “What is the fax, email, or mailing address for submission, and what is the appeal or resubmission deadline?”
- “Can you confirm the payer ID for electronic resubmission, or the mailing address for a paper claim?”

Closing the call: “Thank you for your help today — could I have the call reference number for our records? Have a great day!”

Script 2: Eligibility & Verification of Benefits (VOB) Call

Use the full checklist in Chapter 3 (Eligibility & VOB Call Checklist) for this call — always confirm active coverage, plan type, deductible/coinsurance status, authorization requirements, and close by requesting a reference number.

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Chapter 16: Glossary of Key Terms

Term	Definition
ABN (Advance Beneficiary Notice)	Informs a Medicare patient in advance of a service that may not be covered.
Accounts Receivable (A/R)	Outstanding payments owed by payers and/or patients.
Adjudication	The payer's process of reviewing and deciding how to pay a claim.
Allowed Amount	The maximum amount a payer will reimburse for a covered service.
AOB (Assignment of Benefits)	The patient's authorization allowing the insurer to pay the provider directly.
Authorization / Prior Authorization	Insurer approval required before (or sometimes after) a service is rendered.
Capitation	A fixed, prepaid amount paid to a provider per patient, per month, regardless of services used.
Claim	A formal request for payment submitted to an insurance payer.
Clean Claim	A claim accepted and processed without needing any correction.
Clearinghouse	An intermediary that validates, formats, and routes electronic claims to payers.
COB (Coordination of Benefits)	The process of determining the order of payment when a patient has multiple insurance policies.
Coinsurance	The percentage of costs a patient pays after meeting the deductible.
Copay	A fixed fee a patient pays per visit or service.
CPT® (Current Procedural Terminology)	Codes describing medical procedures and services.
Deductible	The amount a patient pays before insurance coverage begins.
Denial	A claim that was processed but rejected for payment for a specific reason (e.g., missing authorization).
Dual Eligible	A patient who qualifies for both Medicare and Medicaid.
EFT (Electronic Funds Transfer)	Direct deposit of a claim payment.
EHR (Electronic Health Record)	The digital patient chart used for both clinical care and billing/coding.
EOB (Explanation of Benefits)	The payer's written breakdown of how a claim was processed and paid.
EPO (Exclusive Provider Organization)	A plan requiring in-network care with no out-of-network coverage except emergencies.
ERA (Electronic Remittance Advice)	The digital, automatable version of an EOB.
Fee-for-Service (FFS)	A payment model where providers are paid per individual service rendered.

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Term	Definition
HCPCS	The Healthcare Common Procedure Coding System, covering supplies, equipment, and non-physician services.
HMO (Health Maintenance Organization)	A plan requiring a PCP and referrals, with no out-of-network coverage.
ICD-10-CM	The current diagnosis coding system used in U.S. healthcare billing.
KPI (Key Performance Indicator)	A measurable metric such as denial rate or days in A/R.
Medicaid	State-and-federal health insurance for low-income individuals and families.
Medicare	Federal health insurance, primarily for people 65+ or with certain disabilities.
Modifier	A code appended to a CPT/HCPCS code to clarify how or where a service was performed.
MUE (Medically Unlikely Edit)	A limit on the number of units of a service billable for one patient in one day.
NCCI Edit	A rule preventing improper or unbundled coding combinations.
No Surprises Act	A federal law protecting patients from surprise out-of-network bills, especially for emergencies.
Non-PAR Provider	A provider not contracted with a given insurer; not obligated to write off balances.
NPI (National Provider Identifier)	A unique identification number assigned to healthcare providers.
OIG (Office of Inspector General)	The federal body that monitors and investigates healthcare fraud.
Out-of-Pocket Maximum	The annual cap on a patient's total cost-sharing responsibility.
PAR Provider (Participating)	A provider contracted with an insurer, agreeing to accept its fee schedule.
Payer ID	A unique identifier for an insurance payer, used to route electronic claims correctly.
PHI (Protected Health Information)	Any individually identifiable health information protected under HIPAA.
POS (Place of Service)	A code indicating the location where a healthcare service was rendered.
POS (Point of Service) Plan	A hybrid HMO/PPO plan requiring a PCP but allowing limited out-of-network use.
PPO (Preferred Provider Organization)	A plan covering both in- and out-of-network care, with more flexibility.
RARC (Remittance Advice Remark Code)	A payer note explaining a specific adjustment or denial on an ERA.
RCM (Revenue Cycle Management)	The complete, end-to-end financial workflow from scheduling to final collection.
Referral	A PCP's authorization allowing a patient to see a specialist.
Timely Filing Limit	The payer-set deadline (often 90–180 days) by which a claim must be submitted.

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Term	Definition
TRICARE	Health insurance for active-duty military, retirees, and their families.
UB-04	The standard claim form used for facility and hospital billing.
Upcoding	Billing for a more expensive service than what was actually performed — a form of fraud.
Write-off	The contractual difference between the billed amount and the allowed amount, which the provider cannot collect.

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Chapter 17: Knowledge Check — Review Questions

Use these questions to test your understanding after studying each chapter. They cover definitions, workflow, coding, claims, and compliance — the same core areas a new hire is typically tested on.

Insurance & Patient Basics

1. What is medical billing, in your own words?
2. Define copay, deductible, and coinsurance, and explain how they differ from one another.
3. What is a referral, and why is one sometimes required?
4. What is prior authorization, and how does it differ from a referral?
5. What is an insurance eligibility check, and what should be verified during one?
6. What is Coordination of Benefits (COB), and why does it matter when a patient has two insurance plans?
7. What is the difference between primary and secondary insurance?

Providers, Identifiers & Coding

1. What is an NPI? What is the difference between a billing NPI and a rendering NPI?
2. What is a provider Tax ID/TIN, and why is it required on claims?
3. What is a taxonomy code, and what does it help identify?
4. What is a CPT code? What is a diagnosis (ICD-10) code? How do the two differ?
5. What is a modifier? Give two real examples of when one would be used.
6. What is Place of Service (POS), and why does using the correct one matter?
7. What is a revenue code, and where is it typically used?

Claims & Submission

1. What is a medical claim? What is claim submission?
2. What is a CMS-1500 claim form used for? What is a UB-04 used for?
3. What is a “clean claim,” and what should be checked before submitting one?
4. What is a claim rejection? Give three common causes.
5. What is a claim denial? Give three common causes.
6. What is the key difference between a rejection and a denial?
7. What is a Timely Filing Limit, and why must submission dates be closely monitored?

EOB, ERA & Payment Posting

1. What is an EOB, and what key information does it contain?
2. What is an ERA, and what advantage does it have over a manual/paper EOB?
3. What is the difference between the Billed Amount and the Allowed Amount?
4. What is Patient Responsibility, and how is it calculated?

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5 What is a write-off, and how does it differ from a refund?

6 What is payment posting, and what should be verified before posting an insurance payment?

7 What is the difference between an insurance balance and a patient balance?

AR, Denials, Appeals & Collections

1 What is Accounts Receivable (A/R)? Name at least four common A/R follow-up activities.

2 A claim has been pending with an insurer for 45 days — what steps should you take?

3 What is a resubmission, and when would you resubmit rather than appeal?

4 What is an appeal, and what documentation is typically included with one?

5 What is the difference between a redetermination and a reconsideration?

6 What are the recommended cadences for patient collection follow-up calls?

Compliance & Ethics

1 What does HIPAA stand for, and what is its overall purpose?

2 What is PHI, and name at least four examples of it.

3 What is upcoding, and why is it considered fraud?

4 What is the No Surprises Act, and who does it protect?

5 Name three best practices for preventing a HIPAA violation in daily work.

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Chapter 18: Coding & Billing Scenarios — Practice Set

Work through each scenario and decide on the correct action *before* reading the answer. These mirror the real situations a biller or coder encounters daily.

Scenario 1: Modifier 25 — Same-Day Separate E/M

Situation: A patient comes in for a scheduled rash check, but during the visit also asks the provider to evaluate a new, unrelated migraine.

Question: How should the visit be coded so both the rash-related service and the migraine evaluation are properly reimbursed?

Correct Approach: Bill the appropriate E/M code with modifier 25 appended, since a significant, separately identifiable evaluation and management service was performed by the same physician on the same day, in addition to the originally scheduled service.

Scenario 2: Modifier 59 vs. XS — Distinct Procedures, Different Sites

Situation: A surgeon performs a wound repair and, in the same session, excises an unrelated lesion at a different anatomical site.

Question: Both procedures are on the same date — how should the second procedure be flagged so it isn't bundled or denied?

Correct Approach: Append modifier 59 (or the more specific X{EPSU} modifier — here, XS for “separate structure”) to the lesion excision to indicate it is a distinct procedural service performed on a different structure than the wound repair, preventing an NCCI bundling denial.

Scenario 3: Modifier 50 — Bilateral Procedure

Situation: A patient receives knee injections in both the left and right knee during the same visit.

Question: How is this billed correctly, rather than as two identical, unmodified line items?

Correct Approach: Bill the injection CPT code once with modifier 50 appended to indicate a bilateral procedure (some payers instead want two lines with modifiers LT and RT — always confirm the specific payer's preferred billing method before submitting).

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Scenario 4: Modifier 78 — Unplanned Return to the OR

Situation: A patient develops post-operative bleeding a few days after surgery and must return to the operating room to control it.

Question: How should the second procedure be coded, given it falls within the original surgery's global period?

Correct Approach: Append modifier 78 to the second procedure code, since it represents an unplanned return to the operating room by the same physician for a complication of the original surgery, during the post-operative period.

Scenario 5: CO-16 Denial — Missing Information

Situation: A claim is denied with reason code CO-16, and the remark indicates a missing modifier on one of the procedure codes.

Question: What is the correct next step?

Correct Approach: Pull the original documentation, identify and add the missing modifier, verify no other required field is missing (NPI, diagnosis pointer, etc.), and resubmit the corrected claim promptly — this is a correctable error, not something requiring a formal appeal.

Scenario 6: CO-50 Denial — Medical Necessity

Situation: A claim for an MRI is denied as CO-50 (“not deemed medically necessary”), even though the provider felt it was clearly warranted.

Question: What should the biller do before giving up on the claim?

Correct Approach: File a formal appeal, attaching supporting clinical documentation — the physician's chart notes, relevant history, and any peer-reviewed clinical guideline that supports medical necessity for this specific diagnosis and procedure combination.

Scenario 7: CO-109 Denial — Wrong Payer / COB Issue

Situation: A claim is denied as CO-109 (“claim not covered by this payer”), but the practice's records show the patient has two active insurance policies.

Question: What is likely happening, and how should it be resolved?

Correct Approach: This usually means the claim was sent to the wrong payer, or the coordination of benefits (COB) order was incorrect — the biller should confirm which insurance is actually primary versus secondary, correct the claim, and resubmit it to the correct payer first.

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Scenario 8: CO-197 Denial — Missing Prior Authorization

Situation: A claim for an elective procedure is denied as CO-197 because no prior authorization is on file, though the front desk believed one had been obtained.

Question: How should this be worked?

Correct Approach: First check internally for any authorization number that may not have made it onto the claim. If none exists, contact the payer to ask whether a retroactive authorization is possible; if not, file an appeal with clinical justification for why the service was necessary.

Scenario 9: Claim Rejection — Mismatched Payer ID

Situation: A claim is rejected by the clearinghouse before it ever reaches the payer, citing an invalid or mismatched payer ID.

Question: Is this a denial requiring an appeal, or something else?

Correct Approach: This is a rejection, not a denial — the claim was never actually adjudicated. Look up the correct payer ID in the clearinghouse's payer directory (IDs can vary by product line), correct it, and resubmit as a new claim rather than filing an appeal.

Scenario 10: Eligibility Verification — Terminated Coverage Discovered Pre-Visit

Situation: While verifying benefits two days before a scheduled appointment, the front desk discovers the patient's insurance policy actually terminated two months ago.

Question: What should happen before the appointment takes place?

Correct Approach: Contact the patient immediately to inform them of the lapse and ask whether they have new coverage to provide; if not, discuss self-pay options or rescheduling once active coverage is confirmed — never proceed with billing to a policy already known to be inactive.

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Scenario 11: EOB Math — Calculating Patient Responsibility

Situation: An EOB shows: Billed Amount $500, Allowed Amount $300, Insurance Payment $240, Patient Copay $30, Patient Coinsurance $30.

Question: What is the contractual write-off/adjustment, and what is the total amount that should appear on the patient's statement?

Correct Approach: The contractual write-off is the Billed Amount minus the Allowed Amount: $500 – $300 = $200 (this amount is never billed to the patient). The patient's total responsibility is the copay plus coinsurance: $30 + $30 = $60. Before sending that $60 statement, verify the deductible status and that no secondary insurance should be billed first.

Scenario 12: Payment Posting — Simple Balance Calculation

Situation: A visit is billed at $250. The EOB shows the insurance paid $180 with no separate adjustment listed.

Question: What is the patient's balance, and what should the poster verify before sending the statement?

Correct Approach: $250 – $180 = a $70 patient balance. Before billing the patient, the poster should confirm whether part of that $70 is a contractual write-off (if the provider is in-network with that payer) versus genuine patient responsibility, since posting it incorrectly could result in over-billing the patient.

Scenario 13: A/R Follow-Up — Claim Pending 45 Days

Situation: A claim has shown no movement in the clearinghouse or payer portal for 45 days.

Question: What steps should an A/R specialist take?

Correct Approach: Check the payer portal or clearinghouse for a status update first; if nothing is available, call the payer directly using the claim inquiry script, get a specific reason for the delay and a reference number, and document the outcome with a clear follow-up date so the claim doesn't go untouched again.

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Scenario 14: Denial Rate KPI — Building an Action Plan

Situation: A monthly report shows the practice's overall claim denial rate has climbed to 18%, well above the healthy benchmark of 10% or lower.

Question: What should the billing team do to bring that number down?

Correct Approach: Break the denials down by reason code to find the top 2–3 causes (commonly missing authorization, eligibility issues, or coding errors), address the root cause at its source (e.g., add an eligibility check earlier in the workflow, retrain coders on a specific code set), and track the denial rate weekly until it trends back toward the target.

Scenario 15: HIPAA Red Flag — Spotting a Violation

Situation: A staff member is overheard discussing a patient's diagnosis with a coworker in the office hallway, within earshot of other patients in the waiting area.

Question: Is this a HIPAA violation, and what should happen next?

Correct Approach: Yes — this is an unauthorized disclosure of PHI (sharing information without consent, in a public area). It should be reported per the practice's compliance policy, the staff member should be retrained on minimum-necessary disclosure, and clinical discussions should always be moved to a private space.

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