AAPC

RCMS

Revenue Cycle Management Specialist (RCMS)®

STUDY GUIDE

2025

2025

Official Study Guide

Revenue Cycle Management Specialist (RCMS)®

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Regarding HCPCS Level II

HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2025 code set for HCPCS Level II was unavailable when published.

Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real-world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Introduction

A Revenue Cycle Management Specialist holds a mid-level position that is responsible for understanding the healthcare revenue process life cycle. The role consists of analyzing and improving current processes, while evaluating the need for new process implementation. The processes include having a global understanding from patient access, authorization through the administrative process of clinical documentation improvement, coding, billing, operations, and back-end processes.

Revenue Cycle Management Specialists must have strong communication skills, understand how to research newly published and/or changing regulations and guidelines, and be able to create synergy by integrating departmental processes to improve the financial stability of the facility or office.

By earning the RCMS™ credential, you can show employers you are equipped with all the needed skills and knowledge required to be successful in this role. An RCMS is a member of AAPC who has passed an examination that evaluates mastery of revenue cycle management in facilities and for provider services to government and private payers. Once certified, an RCMS must obtain a total of 36 continuing education units (CEUs) over the course of two years.

The responsibilities of an RCMS regarding the healthcare revenue cycle may include:

1. Accurately apply and justify coding and billing conventions to ensure proper claims processing and reimbursement.
2. Demonstrate a comprehensive understanding of compliance guidelines, laws, and regulations across the revenue cycle workflow to ensure adherence to industry standards.
3. Understand and apply best practices in reimbursement and collections to support effective revenue cycle management.
4. Manage new charge establishment and ongoing maintenance of CPT®, HCPCS, and ICD-10-PCS pricing, fee schedules, cost centers, revenue codes, strategic pricing, and code updates for both hospital/facility and professional charges.
5. Demonstrate knowledge of health record requirements and utilize resources such as Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) to ensure accurate claim submissions.
6. Interpret and analyze case data for denied claims, identifying root causes and implementing corrective actions to improve approval rates.
7. Apply knowledge of minimum data specifications for claims, enrollment data, coding, admission and discharge data, and specialty reference codes to ensure compliance and accuracy in reporting.
8. Analyze, review, and optimize payer contracts and policies to maximize reimbursement and financial performance.
9. Demonstrate a clear understanding of patient access processes and demographic data management to support clean claim submission and ensure quality patient care.
10. Use reports and analytics to monitor patient success, social determinants of health (SDoH), utilization, follow-up care, quality reporting, readmissions, and population health trends.
11. Identify and address underlying causes of denials, implement automated denial tracking and resolution systems, and train staff on common denial reasons to improve reimbursement outcomes.
12. Understand the impact of clean claim submissions on quality improvement initiatives and overall revenue cycle performance.
13. Implement and monitor scheduling activities to improve patient care coordination, operational workflows, and resource utilization.
14. Lead the CDM team in utilizing system work queue functionality to contribute to clean claims, maintain internal controls, and ensure compliance with charging regulations.

RCMS Examination Format

The RCMS examination is a 4-hour timed test. The test is open book, allowing for use of CPT®, ICD-10-CM, HCPCS Level II, and ICD-10-PCS code books. The test has 135 questions. The exam is designed to assess your understanding of healthcare revenue cycle management for both facilities and provider organizations. Below is a breakdown of the exam topics and the estimated number of questions per section:

- Compliance – 11 questions
- Operations – 19 questions

Examples of Reports

A/R Aging Report—Simple

Days in A/R	(0–30)	(31–60)	(61–90)	(91–120)	(121–150)	(151+)	Balance
Amount	$111,687.96	$14,161.61	$9,913.69	$7,156.70	$8,569.00	$21,025.00	$172,513.96
	64.74%	8.21%	5.75%	4.15%	4.97%	12.19%	100.00%

(This report can also be broken out by payer, by provider, or by patient responsibility to monitor the aging by each of these categories.)

A/R Aging Report—Categorized by Payer Type

Month	0-30	31-60	61-90	91-120	<121	Total	
Patient	$8,083	$17,437	$17,763	$3,876	$62,724	**$109,883**	**10%**
	7%	16%	16%	4%	57%		
Medicaid	$93,548	$74,181	$64,132	$25,660	$58,170	**$315,691**	**29%**
	30%	23%	20%	8%	18%		
Commercial	$143,842	$206,513	$95,567	$58,388	$173,321	**$677,631**	**61%**
	21%	30%	14%	9%	26%		
Total	$245,473	$298,131	$177,462	$87,924	$294,215	**$1,103,205**	**100%**
Total	22%	27%	16%	8%	27%		
Benchmark	62%	15%	8%	5%	10%		

A/R By Service Date

Overall aging by month

Month-End	Balance	0 - 30	31 - 60	61 - 90	91 - 120	121 - 150	151 - 180	181+	> 360	> 90 %
11/30/20X0	$ 6,729,989	$ 2,748,658	$ 1,558,697	$ 851,354	$ 640,962	$ 440,587	$ 333,801	$ 155,929	$ 445	23.35%
12/31/20X0	$ 7,590,268	$ 2,711,144	$ 1,653,632	$ 1,207,802	$ 659,402	$ 506,452	$ 389,179	$ 462,655	$ 6,120	26.58%
1/31/20X1	$ 8,586,823	$ 2,881,490	$ 1,443,804	$ 1,292,225	$ 1,126,482	$ 570,852	$ 459,341	$ 812,629	$ 13,829	34.58%
2/28/20X1	$ 9,260,096	$ 2,882,698	$ 1,670,169	$ 1,094,471	$ 1,102,472	$ 862,558	$ 519,785	$ 1,127,942	$ 22,622	39.01%
3/31/20X1	$ 9,386,722	$ 3,101,643	$ 1,580,126	$ 1,019,417	$ 778,412	$ 827,980	$ 715,773	$ 1,363,371	$ 20,224	39.48%
4/30/20X1	$ 9,339,111	$ 2,966,403	$ 1,558,579	$ 1,060,203	$ 838,593	$ 620,951	$ 621,107	$ 1,658,209	$ 15,066	33.39%
5/31/20X1	$ 8,910,357	$ 3,039,098	$ 1,237,226	$ 883,712	$ 798,927	$ 652,467	$ 370,914	$ 1,928,013	$ 88,045	42.09%
6/30/20X1	$ 8,547,413	$ 3,034,294	$ 1,207,022	$ 740,015	$ 651,496	$ 600,687	$ 494,917	$ 1,818,982	$ 168,535	41.72%
7/31/20X1	$ 8,181,391	$ 2,670,692	$ 1,301,581	$ 734,939	$ 536,039	$ 502,362	$ 498,811	$ 1,936,966	$ 293,440	42.46%
8/31/20X1	$ 8,111,027	$ 2,965,522	$ 1,021,637	$ 633,753	$ 527,362	$ 442,848	$ 382,092	$ 2,137,813	$ 425,079	43.03%
9/30/20X1	$ 8,368,552	$ 3,290,015	$ 1,164,294	$ 601,945	$ 426,518	$ 416,090	$ 340,448	$ 2,129,242	$ 515,325	39.58%
10/31/20X1	$ 8,556,802	$ 2,970,195	$ 1,500,048	$ 727,387	$ 446,709	$ 332,096	$ 352,459	$ 2,227,909	$ 687,509	39.26%
11/30/20X1	$ 8,936,037	$ 3,075,183	$ 1,396,604	$ 961,117	$ 564,839	$ 353,952	$ 303,088	$ 2,281,254	$ 765,551	39.20%
12/31/20X1	$ 9,309,187	$ 3,207,254	$ 1,457,264	$ 811,676	$ 756,138	$ 435,534	$ 311,868	$ 2,329,452	$ 826,197	41.17%
	$ 11,264,131	$ 4,588,749	$ 1,734,422	$ 913,263	$ 590,029	$ 688,060	$ 336,078	$ 2,413,531	$ 979,833	35.76%
Current month %		**34.5%**	**15.7%**	**8.7%**	**8.1%**	**4.7%**	**3.4%**	**25.0%**		
Prev month %		**34.4%**	**15.6%**	**10.8%**	**6.3%**	**4.0%**	**3.4%**	**25.5%**		

Selfpay Aging by Month

	Total Claims	Total Balance	0 - 30 Balance	31 - 60 Balance	61 - 90 Balance	91 - 120 Balance	121 - 150 Balance	151 - 180 Balance	181 +Balance	> 90 %
11/30/20X0	7688	$ 601,188	$ 242,240	$ 141,612	$ 129,445	$ 91,485	$ 29,130	$ 14,909	$ (47,634)	14.62%
12/31/20X0	10032	$ 830,687	$ 395,194	$ 159,038	$ 110,556	$ 99,474	$ 43,657	$ 18,753	$ 4,015	19.97%
1/31/20X1	10847	$ 900,592	$ 345,417	$ 246,613	$ 120,362	$ 87,842	$ 52,502	$ 24,335	$ 23,521	20.90%
2/28/20X1	12630	$ 1,035,657	$ 369,759	$ 240,924	$ 183,529	$ 90,504	$ 57,631	$ 41,948	$ 51,363	23.31%
3/31/20X1	14155	$ 1,024,255	$ 403,684	$ 145,731	$ 176,137	$ 133,066	$ 45,937	$ 51,034	$ 68,667	29.16%
4/30/20X1	16423	$ 1,327,873	$ 556,716	$ 248,366	$ 168,031	$ 148,398	$ 87,950	$ 33,895	$ 84,518	26.72%
5/31/20X1	19348	$ 1,431,416	$ 578,616	$ 307,893	$ 187,823	$ 123,439	$ 84,863	$ 71,023	$ 77,760	24.95%
6/30/20X1	21072	$ 1,537,206	$ 658,094	$ 346,972	$ 236,663	$ 145,506	$ 30,947	$ 48,010	$ 71,015	19.22%
7/31/20X1	21628	$ 1,574,694	$ 483,356	$ 437,692	$ 266,680	$ 200,847	$ 79,801	$ 17,315	$ 89,005	24.57%
8/31/20X1	22531	$ 1,726,320	$ 627,400	$ 332,335	$ 332,849	$ 202,125	$ 134,661	$ 52,062	$ 44,888	25.12%
9/30/20X1	24071	$ 1,877,516	$ 615,968	$ 408,901	$ 262,474	$ 278,664	$ 111,735	$ 105,734	$ 94,041	31.43%
10/31/20X1	25407	$ 2,052,633	$ 576,566	$ 414,993	$ 335,409	$ 232,561	$ 183,373	$ 101,911	$ 207,820	35.35%
11/30/20X1	26296	$ 2,025,696	$ 500,156	$ 327,881	$ 318,773	$ 256,951	$ 172,043	$ 167,400	$ 282,492	43.39%
12/31/20X1	27287	$ 2,015,828	$ 453,534	$ 269,937	$ 268,654	$ 260,850	$ 172,802	$ 172,421	$ 417,630	50.78%
1/31/20X2	26486	$ 1,998,615	$ 518,387	$ 248,586	$ 211,186	$ 201,342	$ 167,765	$ 141,370	$ 509,980	51.06%

ICD-10-PCS Code Set

As an RCMS™, you need to be aware of the foundation of ICD-10-PCS codes and how these codes impact patient accounts and the overall revenue cycle. This curriculum is not comprehensive but provides a basic understanding of ICD-10-PCS codes and some of the common errors when reporting services with these codes.

The International Classification of Diseases, 10th Revision, Procedure Coding System or (ICD-10-PCS) is the United States version of the World Health Organization's (WHO) ICD-10 code system. ICD-10-PCS procedure codes have been adopted under the Health Insurance Portability and Accountability Act (HIPAA) to report procedural and medical services delivered to patients who are designated as inpatient or being treated in a hospital setting. The ICD-10-PCS code set was originally developed and released for use in 1998.

The ICD-10-PCS code system is maintained and updated by the Centers for Medicare & Medicaid Services (CMS). This code system is updated annually. The ICD-10-PCS code set provides a structure, a capacity, and the flexibility for healthcare systems to capture data in each unique code. This coding system uses specific clinical detail to provide quality data capture, allowing efficient tracking of procedures. This tracking accounts for various quality of care issues and a more proficient way of reporting services for reimbursement.

Let's review how the ICD-10-PCS system is constructed to meet current and future medical coding needs.

ICD-10-PCS Tells the "What" of Inpatient Care

ICD-10-PCS tell the "what" in story of patient care. The code set explains:

- What body system and part is being treated? For example, Achilles tendon of the muscular system, ear cochlea, etc.
- What is the root operation? For example, control, release, removal, transfer, alteration, etc.
- What device was left in the body? For example, pacemaker, artificial joint, etc.
- What approach was used for a surgery or procedure? For example, open approach with percutaneous endoscopic assistance; external approach (e.g., closed fracture, resection of tonsils); or percutaneous procedure via device.

Structure, Tables, and Organization

All codes in ICD-10-PCS are seven characters. Each code is built through a consistent structure. The process of constructing a PCS code builds a code through each character used. Individual letters and numbers, called values, are selected in sequence to comprise the seven-character code. A common error can be reporting codes with less than seven characters, which would be an invalid code and will cause a claim to be denied or rejected.

Characters

All codes in ICD-10-PCS are seven characters long. Each character in the seven-character code represents an aspect of the procedure, as shown in the following diagram of characters from the main section of ICD-10-PCS, called medical and surgical.

1	2	3	4	5	6	7
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

An ICD-10-PCS code is best understood as the result of a process rather than as an assigned number. The coding process consists of assigning values from among the valid choices for that part of the system, following the rules governing constructing codes. It is logical and systematic in its coding approach.

Values

One of 34 possible values can be assigned to each axis of classification in the 7th character code: the numbers 0–9 and the alphabet (except I and O, because they are easily confused with the numbers 1 and 0). A finished code looks like the example below.

02103D4 *Bypass Coronary Artery, One Artery from Coronary Vein with Intraluminal Device, Percutaneous Approach*

Choosing a specific value for each of the seven characters derives this code. Based on details about the procedure performed, values for each character specifying the section, body system, root operation, body part, approach, device, and qualifier are assigned.

Because the definition of each character is a function of its actual physical position in the code, the same value placed in a different position in the code means something totally different. The value 0 in the first character means something different than 0 in the second character, or 0 in the third character, and so on.

ICD-10-PCS System Organization

ICD-10-PCS is composed of 17 sections, represented by the numbers 0–9 and the letters of the alphabet (except I and O because they are easily confused with the numbers 1 and 0). The broad procedure categories contained in these sections range from surgical procedures to substance abuse treatment and new technology. The complete ICD-10-PCS is presented

CPT® codes have an alphanumeric structure, with a "T" in the last position. Category III codes can be reported alone, without an additional Category I code.

In the guidelines for Category III codes, the code book states, "If a Category III code is available, this code must be reported instead of a Category I unlisted code." This is an important instruction for the reporting of Category III codes. A Category I unlisted code does not provide adequate information about the procedure or service performed. For example:

0673T *Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance*
(Do not report 0673T in conjunction with 76940, 76942, 77013, 77002)

Notice in this example, 0673T also has a parenthetical note listing codes that cannot be reported. The codes listed in the parenthetical note represent imaging and guidance services. Review the code description and you will see that imaging and guidance is included with the code. As we noted earlier, these notes provide information to code accurately.

Category III CPT® codes are updated twice a year, on Jan. 1 and July 1, and are implemented six months later. The updates are published on AMA's website at https://www.ama-assn.org/practice-management/cpt/category-iii-codes.

CPT® Conventions and Iconography

An established set of conventions and symbols are used throughout the CPT® code book. CPT® conventions and iconography include indentations, code symbols, also referred to as iconology, and parenthetical instructions. These conventions and symbols communicate information in a clear and easily recognizable format.

; Semicolon and Indented Procedures—The use of the semicolon was developed so CPT® did not have to list full descriptions for every code in the publication. A CPT® procedure or service code that contains a semicolon is divided into two parts: the description before the semicolon and the description after the semicolon.

(a) The words before the semi-colon are considered the "standalone" code or the common procedure in the code descriptor.

(b) The indented descriptor is dependent on the preceding common "standalone" procedure code.

(c) It is not necessary to report the main code (e.g., 20100) when reporting the indented codes (e.g., 20101, 20102 or 2103).

EXAMPLE

20100 Exploration of penetrating wound (separate procedure); neck

20101 chest

20102 abdomen/flank/back

20103 extremity

The full descriptor for CPT® code 20101, 20102 and 20103 includes the portion before the semicolon in 20100 to make the full description of the codes as follows:

20101 Exploration of penetrating wound (separate procedure); chest

20102 Exploration of penetrating wound (separate procedure); abdomen/flank/back

20103 Exploration of penetrating wound (separate procedure); extremity

One or more symbols may be attached to specific CPT® codes to designate information relevant to that code. These symbols include the following:

- New procedure or service: this symbol appears for only one year after a code is added to the CPT® code set.

EXAMPLE

- **15011** Harvest of skin for skin cell suspension autograft; first 25 sq cm or less

▲ Designates code descriptors that have been altered. Appendix B shows what has been altered in the description of the CPT® code.

EXAMPLE

The code as listed in the numeric section of the CPT® code book:

▲ **92132** Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral

The code as listed in Appendix B indicating the specific changes made to the code:

▲ **92132** ~~Scanning c~~Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral

Chapter 2

1. When coding for a fracture, where in the ICD-10-CM code book should you first look to determine if a 7th character is required?
   A. The Tabular List under the main fracture code category.
   B. The Alphabetic Index under "Fracture".
   C. The Neoplasm Table in the Index.
   D. The Table of Drugs and Chemicals.

2. In ICD-10-CM coding, what is the purpose of the "Excludes1" note, and where can it be found in the book?
   A. It means the listed conditions cannot be coded together and is found in the Tabular List.
   B. It means both conditions must be coded together and is found in the Alphabetic Index.
   C. It means the second condition should be coded first and is found in the Neoplasm Table.
   D. It means the listed condition is optional to code and is found in the Table of Drugs and Chemicals.

3. Where should a coder always start when looking up an ICD-10-CM diagnosis code?
   A. The Tabular List
   B. The Alphabetic Index
   C. The Neoplasm Table
   D. The Table of Drugs and Chemicals

4. In the ICD-10-PCS code book, which section of the Medical and Surgical root operations is used for a procedure that takes out some or all of a body part?
   A. Bypass and Replacement
   B. Dilation and Fragmentation
   C. Reposition and Repair
   D. Resection and Excision

5. In ICD-10-PCS, which character position represents the Approach used to perform the procedure?
   A. Second character
   B. Third character
   C. Fifth character
   D. Seventh character

6. Which section of the CPT® code book contains the guidelines that must be reviewed before selecting a code for a procedure?
   A. Appendices
   B. Introduction
   C. Guidelines at the beginning of each section
   D. Index

Chapter 3

Medical Necessity

Health insurance companies only cover services they define as medically necessary. Medical necessity is defined differently by different entities.

According to § 1862(a)(1)(A) of the Social Security Act, Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Medicare releases National coverage determinations (NCDs) and the Medicare administrative contractors (MACs) release local coverage determinations (LCDs) to state whether an item or service will be considered medically necessary. The National Correct Coding Initiative (NCCI) is released by the Centers for Medicare & Medicaid Services (CMS) to indicate codes considered to be bundled for procedures and services deemed necessary to accomplish a major procedure. Medically Unlikely Edits (MUEs) are released by CMS to indicate the number of units that can be reported for a service or procedure on the same day.

The objectives for this chapter include:

- Understanding the purpose of the NCCI
- Recognize the modifiers that are applicable with NCCI edits
- Determine how Medicaid utilizes the NCCI edits differently from CMS
- Identify the purpose of NCDs
- Understand LCDs and how they differ from NCDs

National Correct Coding Initiative (NCCI)

NCCI is an automated edit system used to indicate specific CPT® code pairs and whether they can be reported on the same date of service for the same beneficiary by the same provider. CMS implemented the NCCI to promote correct coding methodologies and to control improper assignment of codes resulting in inappropriate reimbursement. NCCI coding policies are based on:

- Analysis of standard medical and surgical practice
- Coding conventions included in CPT®
- Coding guidelines developed by national medical specialty societies through the CPT® Advisory Committee (committee members include representatives of major medical societies)
- Local and national coverage determinations
- A review of current coding practices

The edits are updated quarterly by CMS, and the policy manual is updated annually.

NCCI is used by professional medical coders and billers to determine codes considered by CMS to be bundled for procedures and services deemed necessary to accomplish a major procedure. Bundled procedure codes are not reported separately. The components of a bundled procedure are included in the comprehensive procedure code.

Medicare Administrative Contractors (MACs) are entities (third party payers, insurance companies) that contract with the federal government to adjudicate and process claims in the geographical region for which they have been given jurisdiction. The MAC is responsible for making coverage decision policies and protecting the integrity of the Medicare program. Each MAC and the jurisdiction they are responsible for may have differing policies.

NCCI edits were originally developed to assist MACs in processing Medicare Part B claims. In August 2000, NCCI edits were added to the Outpatient Code Editor (OCE) to assist MACs in processing Part B claims for outpatient hospital services.

The NCCI includes two types of edits:

1. Procedure-to-Procedure (PTP) edits

   PTP edits apply to code pairs that should not be billed together because one service inherently includes the other. In certain situations, an appropriate modifier may be allowed and used.

   Mutually exclusive edits (MEE) are included in the PTP edits. These edits include code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same date of service. For example, two different types of laboratory testing that would produce the same result as one test.

2. Medically Unlikely Edits (MUEs)

   MUEs indicate a maximum number of Units of Service (UOS) allowable under most circumstances for a single CPT® or HCPCS Level II code billed by a provider on a single date of service for a beneficiary.

The NCCI is composed of two provider-type choices of code pair edits and three provider-type choices of MUEs.

2. Assigns an ambulatory payment classification (APC) number for each service covered under Hospital Outpatient Prospective Payment System (OPPS) and return information to be used as input to the PRICER program - a tool used to estimate Medicare prospective payment system (PPS) payments.
3. Assigns an ASC payment group for services on claims from certain Non-OPPS hospitals.

The OCE is used by Medicare MACs in the processing of Medicare outpatient claims.

For example, one edit evaluates the consistency of the sex and the diagnoses on the claim. The OCE flags a claim for a male with a diagnosis of uterine fibroma. Individual MACs determined the action and extent of follow-up that results from an OCE edit.

Function of the OCE

The OCE edits claims data to identify errors, return a series of edit flags, assign an APC number for each service covered under the OPPS, and return information used as input to the CMS PRICER program.

OCE Edits

EXAMPLE

If an 18-year-old female had a diagnosis related to prostate cancer, it would create a conflict between the diagnosis, age, and sex; therefore, the diagnosis edit return data would contain the edit numbers 2 and 3.

The occurrence of an edit can result in one of six different dispositions:

Claim Rejection—There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.

Claim Denial—There are one or more edits present that cause the whole claim to be denied. A claim denial means the provider cannot resubmit the claim but can appeal the claim denial.

Claim Return to Provider (RTP)—There are one or more edits present that cause the whole claim to be returned to the provider. A claim RTP means the provider can resubmit the claim once the problems are corrected.

Claim Suspension—There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not RTP but is not processed for payment until the MAC makes a determination or obtains further information.

Line Item Rejection—There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means the claim can be processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed.

Line Item Denials—There are one or more edits present that cause one or more individual line items to be denied. A line item denial means the claim can be processed for payment with some line items denied for payment. The line item cannot be resubmitted but can be appealed.

A single claim can have one or more edits in all six dispositions. Review the examples from the OCE edit table below (Table 3.9).

Table 3.9 OCE Edit Description Examples

Edit	Description	Action
1	Invalid diagnosis code	RTP
2	Diagnosis and age conflict	RTP
3	Diagnosis and sex conflict	RTP
4	Medicare secondary payer alert (v1.0–v1.1)	Suspend
9	Noncovered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial
10	Service submitted for denial (condition code 21)	Claim denial
11	Service submitted for MAC review (condition code 20)	Suspend
12	Questionable covered service	Suspend
13	Separate payment for service is not provided by Medicare	Line item rejection
20	Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection

The OCE edits are updated quarterly. A complete list of edits can be found at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.

Primary vs. Secondary Insurance

Patients may be covered under more than one health insurance policy. When this happens, determine which insurance is primary and which is secondary. When a patient is the subscriber for their insurance coverage, this insurance payer is considered the patient's primary insurance. If the patient is also covered under another insurance, for instance from a spouse, the spouse's coverage would be the secondary insurance.

General Instructions:

Punctuation:

Names—Commas are used to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Address—Do not use punctuation or other symbols in the address. For example, a 9-digit ZIP code is entered without a hyphen. One of the top 10 reasons electronic claims are rejected is due to an invalid ZIP code.

Dates—Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a; however, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, they must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Item Instructions:

Item 1—Shows the type of health insurance coverage applicable to this claim by checking the appropriate box (for example, if a Medicare claim is being filed, check the Medicare box). Other indicates health insurance including HMOs, commercial insurance (for example, BCBS, UHC, Aetna), automobile accident, liability, or workers' compensation.

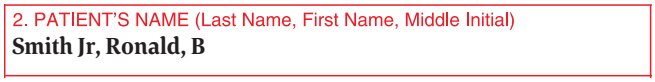
Item 1a—Enter the patient's insurance ID number. This information is found on the patient's insurance card.

For Medicare, enter the Medicare beneficiary identifier (MBI) whether Medicare is the primary or secondary payer. This is a required field. The patient is always the subscriber for Medicare. A common Medicare electronic claim rejection is for an invalid MBI.

For TRICARE, enter the DoD Benefits Number (DBN 11-digit number). This is found on the back of the military ID card and is also known as the Electronic Data Interchange-Personal Identification number (EDI-PI). There is also a 10-digit DoD ID number on the front of the card. This is not the number used to submit claims.

For BCBS, enter the member ID (for example, XYZ123456789, R12345678).

Item 2—Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's insurance card. This is a required field. The name on the insurance card must match identically to the name on the claim form. Confirm the patient's identity by verifying that the name on the insurance card and the name on the patient's photo ID are identical. When a patient has a junior or senior suffix, the last name suffix is entered after the last name and before the first name. Professional suffixes and titles should not be included.



Item 3—Enter the patient's 8-digit birth date (MM|DD|CCYY) and sex. This information is usually provided by the patient when completing new patient paperwork. Compare the information provided by the patient with the patient's photo ID.

Understand the Reason for Denials

Claim denial management and prevention starts with root cause analysis. Managing and preventing denials begins with analyzing the problem. After analyzing, plan to track and trend denials by maintaining the data in spreadsheets or monitoring reports generated in your practice management system or clearinghouse. Manual tracking can be done by creating spreadsheets. Spreadsheets should have the denial reason, date of denial, appeal timelines, amount denied versus amount recovered, payer name, etc.

Data tracking must be done for a minimum of three months to give a baseline for understanding the denials. Tracking should be done for the immediate previous month to give you the data that can be tracked and trended. Review the data based on the payers and reasons.

Example of denials by denial type, count, and associated dollars over one month's time.

April-20XX			
Denial Code/Reason	**Count**	**Percent**	**Amount**
468—DUPLICATE CLAIM	9	9.57%	$1,575.00
487—NO PRECERT OR PRIORAUTH	19	20.21%	$3,325.00

April-20XX			
Denial Code/Reason	**Count**	**Percent**	**Amount**
597—NOT PRIMARY PAYER	15	15.96%	$2,625.00
390—PATIENT NOT INSURED BY PAYER	14	14.89%	$2,450.00
437—FREQUENCY OF SERVICE	7	7.45%	$1,225.00
629—PROVIDER NOT ENROLLED	6	6.38%	$1,050.00
596—SERVICE IS NOT COVERED	7	7.45%	$1,225.00
522—TIME LIMIT FOR FILING EXPIRED	4	4.26%	$700.00
532—NOT AUTH NETWORK/ PRIMARY PROV	7	7.45%	$1,225.00
444—MULTIPLE PROCEDURES ON SAME DOS	4	4.26%	$700.00
OTHER	2	2.13%	$350.00
Total	**94**		**$16,450.00**

In this report, your first step would be to work the accounts with no precertification or no authorization because it has the largest financial impact.

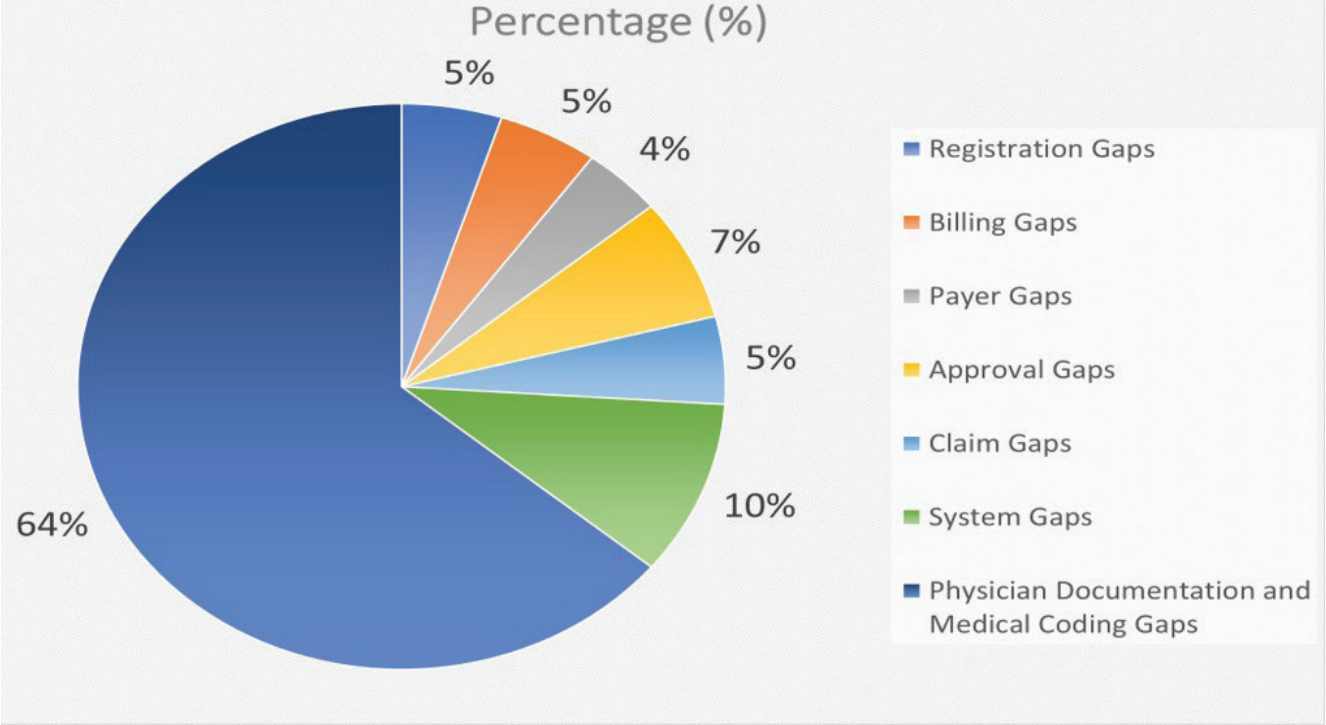
Example of denial percentages by denial type over a year's time.

Denial Types	Jan-YR	Feb-YR	Mar-YR	Apr-YR	May-YR	Jun-YR	Jul-YR	Aug-YR	Sep-YR	Oct-YR	Nov-YR
Non-covered	39.92%	40.39%	46.3%	71%	37.0%	42.4%	53.2%	46.5%	43.2%	39.4%	47.5%
Not eligible	23.71%	29.28%	13.0%	10%	22.1%	20.8%	16.2%	21.2%	19.1%	19.5%	20.0%
Need additional info	12.75%	11.81%	8.9%	5%	13.2%	13.8%	8.9%	8.4%	9.8%	16.5%	13.3%
Included	5.12%	6.69%	8.6%	6%	6.3%	9.2%	10.0%	6.4%	6.7%	12.9%	8.4%
Modifier incomplete	1.34%	4.4%	2.4%	1%	12.0%	1.5%	1.2%	3.5%	1.8%	0.7%	
Invalid PX/DX	1.07%	0.0%	0.0%	0%	0.0%	0.0%	0.0%		0.5%	0.4%	0.5%
Provider not certified	5.93%	1.94%	15.3%	3%	3.0%	0.0%	1.5%	1.7%	0.8%	1.0%	1.0%
No auth or referral	4.46%	1.86%	1.9%	0%	1.4%	2.0%	4.6%	3.9%	1.1%	1.1%	1.7%
Pre-existing	0.0%	1.81%	1.6%	1%	0.9%	1.6%	0.7%	1.1%	1.0%	1.2%	1.3%
Non-Par	1.36%	0.0%	0.0%	0%	0.0%	1.5%	0.0%		0.0%	0.0%	
POS error	4.35%	1.3%	0.0%	0%	2.0%	3.8%	1.2%	1.9%	0.0%	0.0%	0.7%
Untimely	0.0%	0.51%	2.2%	3%	2.0%	3.6%	2.5%	5.4%	16.0%	7.4%	6.2%

In this report, there is consistently a high percentage of non-covered services. The RCMS™ should start looking for systemic errors by monitoring the scheduling and check-in staff to verify proper procedures are being followed.

Find the Root Causes: Breakdown the Reasons for Denials

Breakdown of denials according to their root cause. As the chart below suggests, 64 percent of denials and rejections occur for "physician documentation and medical coding gaps," indicating improvements needed in providers' or facilities' documentation and coding processes.



Let's clarify the denial examples in the pie chart above.

Registration Gaps – These are mostly due to mismatched or incorrect patient demographic information like age, gender, birthdate, etc.

Billing Gaps – These are related to incorrect billing information being entered like wrong code, DOS, or payer; incorrect encounter type; etc.

Payer Gaps – These are payer-related errors, even though contractual terms are met and billed.

Claims Gaps – These are due to nonadherence of basic claims protocols like copay, deductible, and direct billing and basic adjudication rules.

System Gaps – These are related to the practice management system (PMS) providing incorrect insurance filing order, duplicating line items, integration failures, or preapproval missing. All of this depends on the PMS used for the billing process.

Physician Documentation and Medical Coding Gaps – These are caused by insufficient documentation to support the services provided, medical necessity, unbundling of codes, or frequency of ordering.

There are various causes for denials; people, process, technology, and data may be the culprit(s).

People

- Insurance is not recognized
- Front office has minimal focus on RCM
- Collecting payment is considered a back-end task when it should be done on the front-end

Process

- A standard operating procedure (SOP) is not followed
- Workflows are mostly done to manage flow of patients
- A verification process is not in place

Working the Aging Accounts in the A/R Report

The example below is an A/R summary report.

A/R Summary Report

Insurance Type	Patients	Debits	Credits	Balance Due	Current	30 Days	60 Days	90 Days
Self Pay	2	4,750.00	0.00	4,750.00	4,750.00	0.00	0.00	0.00
Medicare	83	100,698.69	82,295.74	18,402.95	6,029.14	66.54	0.00	12,307.27
Medicaid	22	35,880.00	1,000.00	34,880.00	33,140.00	1,740.00	0.00	0.00
Private	40	65,843.00	24,111.00	41,731.88	5,843.86	27,310.00	0.00	8.578.02
Work Comp	3	5,240.00	3,640.00	1,780.00	790.00	0.00	0.00	950.00
PPO/HMO	34	45,140.00	17,102.45	28,037.55	25,803.86	2,233.69	0.00	0.00
Totals	184	257,551.69	128,149.19	129,582.38	76,356.86	31,350.23	0.00	21,835.29

Insurance pending accounts should be worked aggressively, every month. The A/R aging summary should be worked starting with the oldest claims and/or largest balances first. The longer a balance sits in A/R the less likely it will be paid. The oldest claims should be worked before the newer claims because of timely filing requirements. If for some reason, the insurance carrier did not receive the claim, it will need to be resubmitted within the timely filing time frame. It is also important to work the largest balances. There will be a greater return on claims with larger balances.

It is important to know your healthcare organization's internal policies for A/R management. Some offices will set internal policies assigning certain carriers to specific employees. Internal policies will dictate which accounts are worked and in what order.

Claims Tracking

Tracking an insurance claim can allow for quicker response time for correcting and/or resubmitting a claim. Most carriers will process a claim and make payment within 15 days. Claims can be tracked by looking the claim up on the insurance carrier website, making a phone call to the insurance carrier, or utilizing a clearinghouse claims status system. Tracking a claim can sometimes determine the status of the claim faster than waiting for the insurance carrier to respond. Once the status of a claim is determined, the biller can then follow up on the claim. Common claim statuses found when tracking a claim include:

- No record of the claim. If the claim was never received by the insurance carrier, a new claim can be submitted.
- Claim denied. If the claim was denied the denial can be investigated, corrected and resubmitted.
- Claim pending. If the claim is pending for information from the member this will allow the member to be notified, and the provider's office can assist the member with contacting the insurance carrier and giving them the additional information needed.
- Claim paid. The biller may be required to locate the check and ERA to determine if the payment was inadvertently applied to an incorrect account.

The Prompt Payment Act is a federal law that ensures that federal agencies pay their bills within 30 days of receipt and acceptance of material and/or services. When payments are not made in a timely manner interest should be automatically paid.

Key Performance Indicators (KPIs) and Analysis

KPIs at your organization may vary based on your leadership but there are some basic benchmarking metrics that are essential to every revenue cycle. Before you begin, define your timeframe and be consistent. Consistency in your reporting is essential to monitoring the health of your revenue cycle. Typical periods would be three months, six months, or 12 months. For these examples our period will be three months. Let's take a closer look at KPI measures.

1. Days in A/R

The simple explanation of A/R days is the average time that it takes a service to receive payment by the responsible party. Your responsible party may be an insurance company, patient, or, in some cases, a third party. Knowing this average will help quantify the efficiency of your revenue cycle.

How do you calculate the average days in A/R for your organization?

Chapter 9

Quality in Healthcare

Introduction

Quality in a medical clinic protects patients, staff, providers, and the stability of the business. Managers must understand the importance of quality, and how they can marry the intrinsic desire of employees to provide quality care with the requirements to measure, monitor, and report the quality measurements that make an organization successful.

The learning objectives for this chapter include:

- Define Key Concepts
- Explain Quality Assurance and Quality Control in Healthcare
- Analyze the Quality Improvement Process
- Understand Benchmarking and Quality Metrics
- Explore Value-Based Healthcare
- Apply Health Information Technology (HIT) in Quality Improvement
- Discuss Regulatory and Compliance Aspects of Quality Measures
- Evaluate Strategies for Continuous Quality Monitoring

Quality Assurance, Quality Control, and Quality Improvement

Quality Assurance (QA) is an integrated system of management activities involving planning, training, quality control, assessment, data review, reporting, and quality improvement to ensure a process, item, or service is of the type and quality needed and expected by the user. QA is also a management function that deals with setting policy and running an administrative system of controls to ensure the usability of the product (e.g., data).

Quality Control (QC) is a system of technical activities that measures the performance of a process, item, or service against a defined set of criteria or standard. QC is a technical function that includes activities such as calibrations and analyses of a sample of items (claims, lab results, data, etc.) to assess the bias and precision associated with sample results.

Continuous Quality Improvement (CQI) is a strategy of continuous refinement to improve quality. All activities and processes can be defined as individual processes. By making each process or workflow function better, the overall process becomes more efficient. Greater efficiency translates into less waste, more consistent treatment, and potentially greater profits. Quality improvement is not a one-time fix, but an ongoing effort.

QA Is Not Quality Improvement

	Quality Assurance	Quality Improvement
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Focus	Individuals, "bad apples"	Processes and Systems
Responsibility	Few	All

Source: https://targethiv.org/sites/default/files/media/documents/2022-12/CQII_TOT_Day_1_2022.pptx

Examples within a clinic that require QCs:

- Equipment calibration (for example: lab machines, diagnostic imaging, ECG units, etc.).
- Reviewing logs of who accesses different records in an electronic medical record (EMR).
- Regularly testing fire extinguishers within the clinic.
- Verifying accurate temperatures for vaccine refrigerators.

Examples of QAs in an organization include:

- Front desk audits to verify patient demographics are being entered correctly.
- Verifying that policies are up to date and meaningful (for example: billing, clinical intake, registration, etc.).
- Patient satisfaction surveys to verify patient needs are being met.
- Training medical staff on proper use of medical supplies, including needles, casting supplies, topical medications, etc.

Implementing QC and QA efforts will improve patient outcomes, mitigate potential risk of medical liability, and keep staff protected.

37. You have been asked to review the billing accuracy of Testosterone Cypionate injections at your healthcare facility. The Compliance Department has flagged concerns that the medication may be incorrectly billed, leading to potential revenue loss or overbilling. Your task is to run a report analyzing testosterone injections over the last six months and determine if the correct number of units was billed based on the prescribed dosage.

    Drug Ordered: Testosterone Cypionate 100 mg IM

    Drug Supplied: 1000 mg/10 mL multi-dose vial (100 mg per 1 mL)

    HCPCS Code Used: J1071 (Testosterone Cypionate)

    You pull a six-month report and analyze 50 claims for testosterone injections. Here's what you find:

Claim Count	Dose Administered	Units Billed
15 claims	100 mg	100 units
10 claims	200 mg	200 units
10 claims	100 mg	50 units
10 claims	200 mg	400 units
5 claims	100 mg	200 units

    What billing errors do you find?

    A. Underbilling in 10 cases and overbilling in 15 cases

    B. No billing errors found, all claims are correct

    C. Underbilling in 5 cases and overbilling in 10 cases

    D. Overbilling in 5 cases and underbilling in 10 cases

38. You have been asked to review the billing accuracy of Testosterone Cypionate injections at your healthcare facility. The Compliance Department has flagged concerns that the medication may be incorrectly billed, leading to potential revenue loss or overbilling. Your task is to run a report analyzing testosterone injections over the last six months and determine if the correct number of units was billed based on the prescribed dosage.

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10 claims	100 mg	50 units
10 claims	200 mg	400 units
5 claims	100 mg	200 units

    How many total units are overbilled when reviewing the report?

    A. 0 units

    B. 4000 units

    C. 1500 units

    D. 2500 units

CASE 1

ABC Healthcare Organization and all the providers participate with Grand Apple Insurance. There has been an updated policy and a specific posted bulletin for claims resubmitted. ABC Healthcare Organization completed reports for claims at two of their clinics impacted by this update. ABC Healthcare Organization decided their internal process for claims impacted by this update would be a two-phase review process.

The claims at the West Clinic are in phase one of the review process. This means the denied claims were identified and are pending the additional internal review prior to resubmission.

The claims at Brown Clinic are in phase two of the review process. This means the denied claims passed the internal review and are ready for resubmission.

After reviewing the updated reimbursement policy, the resubmission bulletin, and the reports listed below answer these questions.

- Which claim number(s) on the West Clinic denial report are eligible resubmission after review?
- Which claim number(s) on the Brown Clinic resubmission report are eligible for resubmission?
- What box on the 1500 form requires the frequency code and control number for a corrected claim?

Reimbursement policy update: Grand Apple Insurance Computer-Assisted Guidance

Dates of service on or after July 1, XXXX reimbursement policy expanded noncovered services. Policy update does not allow separate reimbursement for computer-assisted guidance. These services are considered essential to the principal surgical and included. CPT® code 20985, 0054T, or 0055T will be denied as a non-covered.

Resubmission bulletin: Grand Apple Insurance Computer-Assisted Guidance

If a claim was denied as noncovered for dates of services on or after July 1, XXXX for CPT® code 20985, 0054T, or 0055T the claim can be resubmitted as a corrected claim. The corrected claim should be filed electronically (EDI), with a frequency code (Replacement/Resubmission of a Prior Claim [7]) and with the payer assigned control reference number of (258972014).

CLAIMS DENIAL REPORT – West Clinic

Claim Number	DOS	SERVICE	AMOUNT	DENIAL REASON
25	7/5/XXXX	0055T	$600.00	Noncovered service
98	10/4/XXXX	20985	$925.00	Noncovered service
51	6/22/XXXX	0054T	$495.00	Noncovered service
87	5/18/XXXX	0054T	$495.00	Noncovered service
48	7/12/XXXX	20985	$925.00	Noncovered service
77	4/9/XXXX	0055T	$600.00	Noncovered service
92	11/12/XXXX	20985	$925.00	Noncovered service
49	8/15/XXXX	0055T	$600.00	Noncovered service
45	1/18/XXXX	20985	$925.00	Noncovered service
12	9/18/XXXX	0054T	$495.00	Noncovered service
62	2/25/XXXX	0055T	$600.00	Noncovered service
32	8/1/XXXX	0055T	$600.00	Noncovered service
57	4/12/XXXX	20985	$925.00	Noncovered service
99	3/9/XXXX	0055T	$600.00	Noncovered service

Chapter 8

1. **Answer:** A. To simplify the administration of health insurance.

   Rationale: The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to improve portability and continuity of health insurance coverage, combat waste, fraud, and abuse in health insurance and healthcare delivery, promote the use of medical savings accounts, improve access to long-term care services and coverage, and simplify the administration of health insurance.

2. **Answer:** C. Healthcare Providers, Health Plans, and Healthcare Clearinghouses.

   Rationale: HIPAA applies directly to three groups referred to as covered entities, including Healthcare Providers, Health Plans, and Healthcare Clearinghouses.

3. **Answer:** B. Overuse of services resulting in unnecessary costs.

   Rationale: In healthcare compliance, 'waste' refers to the overuse of services or other practices that result in unnecessary costs. It is often associated with the misuse of resources, but not necessarily for personal gain.

4. **Answer:** B. Any form of remuneration in return for referrals for services paid by Medicare or Medicaid.

   Rationale: The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration, directly or indirectly, in return for referring an individual for the furnishing of any item or service for which payment may be made in whole or in part under a federal healthcare program.

5. **Answer:** D. Patients

   Rationale: Under HIPAA, covered entities include healthcare providers, health plans, and healthcare clearinghouses. Patients, whose data is protected under HIPAA, are not considered covered entities.

6. Answer: A. To prevent physician conflicts of interest due to their ability to benefit financially from referrals.

   Rationale: The Stark Law, also known as the physician self-referral law, is designed to prevent conflicts of interest by prohibiting physicians from referring patients to medical facilities in which the physician or a member of the physician's immediate family has a financial interest.

7. **Answer:** C. Payments made to physicians for patient referrals.

   Rationale: Safe harbors under the Anti-Kickback Statute are designed to permit conduct otherwise prohibited under the act. Payments made to physicians for patient referrals are not permitted under the safe harbors of the anti-kickback rules as it is the kind of conduct the law was designed to prevent.

8. **Answer:** D. Compliance Officer

   Rationale: Designate a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards. In some practices, the role of compliance officer is fulfilled by the office manager or other administrative staff, such as a coding or billing supervisor. The role of the compliance officer is to develop the compliance plan and monitor its effectiveness.

34. **Answer:** A. CPT® code 99459 has no work RVUs associated with it and therefore Dr. Jones would not get credit for it.

    Rationale: CPT® code 99459 has no wRVU associated with it. It is for the practice expense of the additional expense associated with the pelvic exam.

35. **Answer:** A. Appendix P

    Rationale: Appendix P in the CPT® code book provides a list of codes that can be used for synchronous real-time audio/video visits.

36. **Answer:** C. Based on the documentation, the left ovary and the right ovary both show malignant tumors. The physician needs education on coding to the highest level of specificity.

    Rationale: ICD-10-CM Guidelines state we must code to the highest level of specificity known if the documentation supports it (Section F.3). Also, coding from the header for a procedure is not advised for coding accuracy. The body of the surgical note must be referenced in order to accurately assign all codes. This includes PCS, CPT®, and diagnoses. The physician must receive feedback on coding according to their documentation and what supports it to the highest level of specificity.

37. **Answer:** A. Underbilling in 10 cases and overbilling in 15 cases

    Rationale:

    Underbilling Cases:

    10 claims billed at 50 units instead of 100

    Overbilling Cases:

    10 claims billed at 400 units instead of 200

    5 claims billed at 200 units instead of 100

38. **Answer:** D. 2500 units

    Rationale: Overbilling Cases:

    10 claims billed at 400 units instead of 200 → (10 × 200 units = 2000 units overbilled)

    5 claims billed at 200 units instead of 100 → (5 × 100 units = 500 units overbilled)

    Total overbilled units = 2500

39. **Answer:** A. 500 units

    Rationale:

    Underbilling Cases:

    10 claims billed at 50 units instead of 100 → (10 × 50 units = 500 units underbilled).

    Total underbilled units = 500

40. **Answer:** D. Q4011

    Rationale: The HCPCS code for the fiberglass, short arm cast supplies for a pediatric patient 0-10 years old is Q4012.

41. **Answer:** A. Inpatient ventilator management should be billed with CPT® codes 94002-94005.

    Rationale: Ventilator management on its own, with no other issues addressed, would fall under CPT® codes 94002-94004. If Dr. Jones is treating a critically ill patient, he needs to document why they are critically ill and how he is treating the critical illness. While vent management is bundled into the critical care code, ventilation management without the patient being critically ill has its own codes.

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