AAPC

RCMS

Revenue Cycle Management Specialist (RCMS)®

STUDY GUIDE

2026

Reviewers:

Katherine Abel, CPC, CPB, CPMA, CPPM, CDEI, AAPC Approved Instructor, AAPC Fellow
Geanetta Johnson Agbona, CPC, CRC, AAPC Approved Instructor
Annette Telafor Backer, CPC, CPB, CDEO, CPCO, CPMA, CPPM, CRC, AAPC Approved Instructor
Sunayana Bansal, CPC, CPB, CPMA, AAPC Approved Instructor
Nicole Benjamin, CPC, CEDC, AAPC Approved Instructor
Carman Carlton, COC, CPCO, CPMA, AAPC Approved Instructor
Yvonne D Dailey, CPC, CPB, AAPC Approved Instructor
Janice Gollihur-Davidson, CPC, CPMA, AAPC Approved Instructor
Heather Greene, MBA, RHIA, CDEI, CIC, RCMS, CDIP, CPC, CPMA, CDEO, CRC, AAPC Approved Instructor
Cindy Hagle, CPC, CPMA, CRC
Christine Hall, CPC, CPB, CRC, CPMA, CDEO, CEMC, AAPC Approved Instructor
Michelle Harris, CPC, CPB, CRC, AAPC Approved Instructor
Leesa Israel, CPC, CPPM, CEMC, CUC, AAPC Approved Instructor
Janis Arleen Klawitter, CPC, CPB, AAPC Approved Instructor
Sheryl Krey, CPC, CPB, AAPC Approved Instructor
Mickie Kumer, CPCO, CPC, CPB, COC, CRC, CPMA, CDEO, CEMC, AAPC Approved Instructor
Craig Laursen, CPC, AAPC Approved Instructor
Marissa Mclure, CPC, CPB, CPMA, CEMC
Venessa Moldovan, CPC, CPB, CPMA, CPPM, AAPC Approved Instructor
Leah Newton, CPC, CPB
Angela Paine, CPC, COC, CPCO, CPB, CPMA, CPPM, CRC, AAPC Approved Instructor, CEMC, CRHC
John Piaskowski, CCVTC, CPC, CGSC, CGIC, CCC, CRC, CPMA, CIRCC, COSC, CUC, AAPC Approved Instructor
Becki Poff, CPC, CDEO, CPB, CMA, CCC, CCVTC, CEDC, CEMC, CFPC, CGIC, CHONC, COSC, CPCD, AAPC Approved Instructor
Rebecca Poff, CPC, CPMA, CCVTC, CEDC, CEMC, CFPC, CGIC, CHONC, COSC, CPCD, AAPC Approved Instructor
Amber Price, CPC, CPB, CPMA
Jean Pryor, CPC, CPCO, CPB, CRC, CPMA, CIMC, AAPC Approved Instructor
Mia Y Reddick, COC, CPC, CPB, CPMA, AAPC Approved Instructor
Brett Rosenberg, CPC, COC, AAPC Approved Instructor
Kara Silvers, CPC, CPB, AAPC Approved Instructor
Priya Singhal, CPC, CIC, CRC, AAPC Approved Instructor
Kathleen M. Skolnick, COC, CPC, CPCO, CPB, CPMA, CPPM, CEMC, CRC, CDEO, CCC, CEDC, CIRCC, COBGC, AAPC Approved Instructor
Joan Snodgrass, CPC, CPB, CRC, AAPC Approved Instructor
Jacqueline J Stack, BSHA, CPC, CPB, CPMA, AAPC Approved Instructor, CEMC, CFPC, CIMC, COPC, CPEDC
Brenda Stevens, CPC, CPB, COC, CRC, CPMA, CDEO, AAPC Approved Instructor
Jamie Taylor, CPB
Lynda Wetter, CPC, CPB, CPMA, CPPM, CEMC, CGSC
Angela Wubben, CPC, CPB

Contents

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

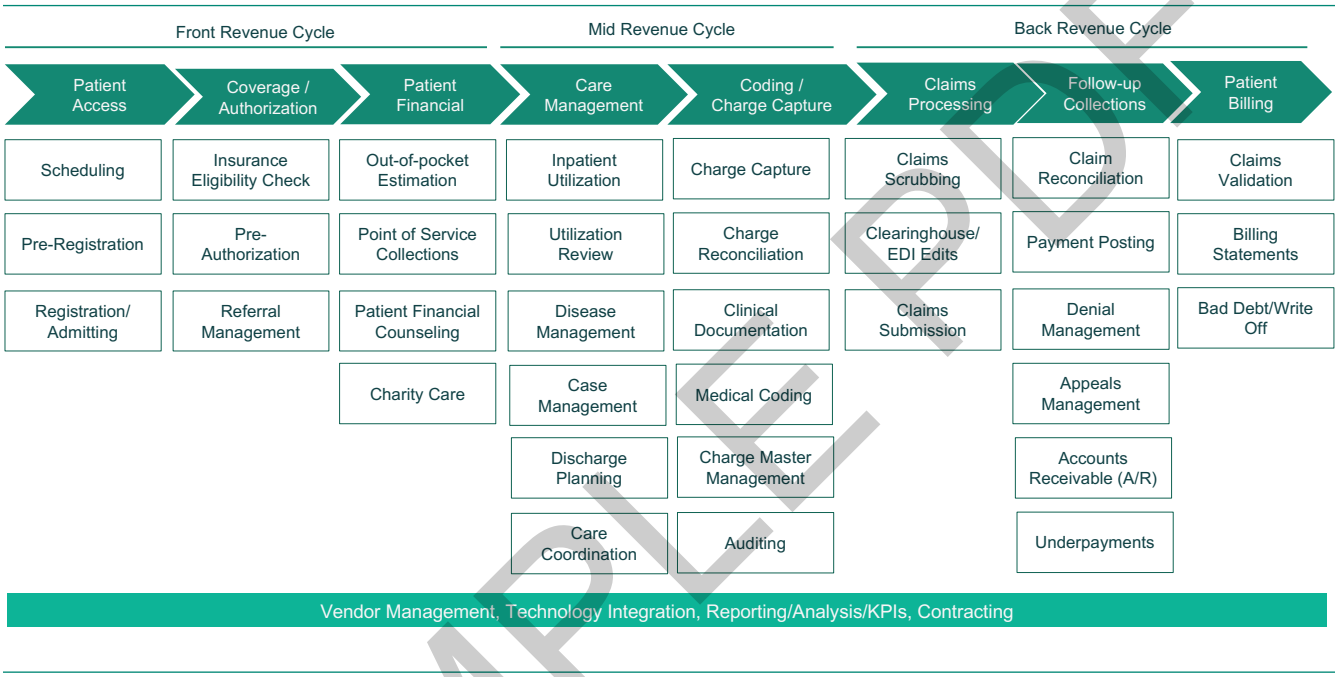
The RCMS examination is a 4-hour timed test. The test is open book, allowing for use of CPT®, ICD-10-CM, HCPCS Level II, and ICD-10-PCS code books. The test has 135 questions. The exam is designed to assess your understanding of healthcare revenue cycle management for both facilities and provider organizations.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

- Compliance – 11 questions
- Operations – 19 questions

Steps of a Successful Revenue Cycle Begins on the Front End

RCM reflects the life cycle of a patient's healthcare encounter—from initial registration to final payment—and ensures that the organization is compensated for the services provided. Here is the complete RCM showing the front, middle, and back end of the cycle:

Revenue Cycle Overview: Front, Mid, and Back End



Front-End RCM Tasks

When there is the first contact with a patient, the goal is to create a rapport with the patient, including familiarizing them with the organization's processes, educating them on clinical and billing policies, insurance coverage, and their responsibility to pay. Tasks that are done at the beginning of the revenue cycle include:

1. Patient scheduling and registration
2. Insurance verification
3. Patient copay, deductible, and coinsurance collection

Middle RCM Tasks

Tasks that are done during the middle of the revenue cycle, or mid-RCM include:

- Clinical documentation of the visit
- Medical billing and coding
- Charge entry

Back-End RCM Tasks

The back-end tasks of healthcare RCM focus on ensuring that the claims submitted to insurance companies are properly processed, payments are accurately posted, and any issues with possible denied or delayed claims are resolved.

- Claims submission
- Payment processing and posting
- Denial management
- Accounts receivable (A/R) follow-up and appeal
- Patient statements
- Reconciliation

Chapter 2

Introduction to Medical Coding

As a Revenue Cycle Management Specialist (RCMS)®, you'll be analyzing and managing the entire process of gathering accurate patient demographic information, billing, claims submission, accounts receivable follow-up, and generating patient statements is referred to as revenue cycle management. In this chapter, we'll focus on the importance of medical coding in the revenue cycle and how it affects the billing process.

Understand that the primary responsibility of a medical coder or clinical documentation specialist is to review clinical documentation, ensuring the appropriate ICD-10-CM, ICD-10-PCS, CPT®, and HCPCS Level II classification codes are assigned to all billable services performed. Medical billers are responsible for creating claims based on the codes provided, submitting claims to the insurance company, and following up on the claims to make sure the organization receives the highest and most appropriate reimbursement possible. It's imperative that coders and billers understand the difference in submission and processing guidelines between respective insurance companies (i.e., commercial payers vs. government payers). Coding and billing departments should be adequately cross trained. A biller cannot effectively work denials without knowledge of coding guidelines. Coders should be aware of the carrier's contracts and carrier-specific guidelines for certain circumstances. A good RCMS™ identifies errors, determines the proper course of action to resolve the mistakes, and educates staff, so errors do not continue.

Code Sets

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 specifies that all electronic data interchange formats be standardized. These standards apply to any health information in electronic form in connection with defined transactions. Healthcare providers use HIPAA-approved code sets to identify the procedures, services, and diagnoses for each patient encounter. There are four standardized coding sets that are used for all claims submitted by medical providers:

- **International Classification of Diseases, Tenth Revision, Clinical Modifications (ICD-10-CM):** ICD-10-CM codes represent the diagnosis or reason a service is performed.
- **International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS):** These codes represent procedures performed at inpatient hospital facilities. These codes are only submitted by facilities. Professional services are not reported with ICD-10-PCS codes.
- **Current Procedural Terminology (CPT®):** CPT® codes represent procedures performed and billed by physicians, non-physician practitioners (NPP), as well as other qualified healthcare professionals. CPT® codes are maintained and updated by the American Medical Association (AMA) annually. They are divided into three categories: Category I, Category II, Category III.
- **Healthcare Common Procedure Coding System (HCPCS) Level II:** These codes are alphanumeric medical codes primarily for non-physician services used to represent healthcare equipment, ambulance services, prosthetic devices, drugs, supplies, and services.

Let's explore these four coding systems to help you understand how accurate physician documentation and proper code assignments will impact a healthcare organization's revenue cycle for the better.

ICD-10-CM Code Set

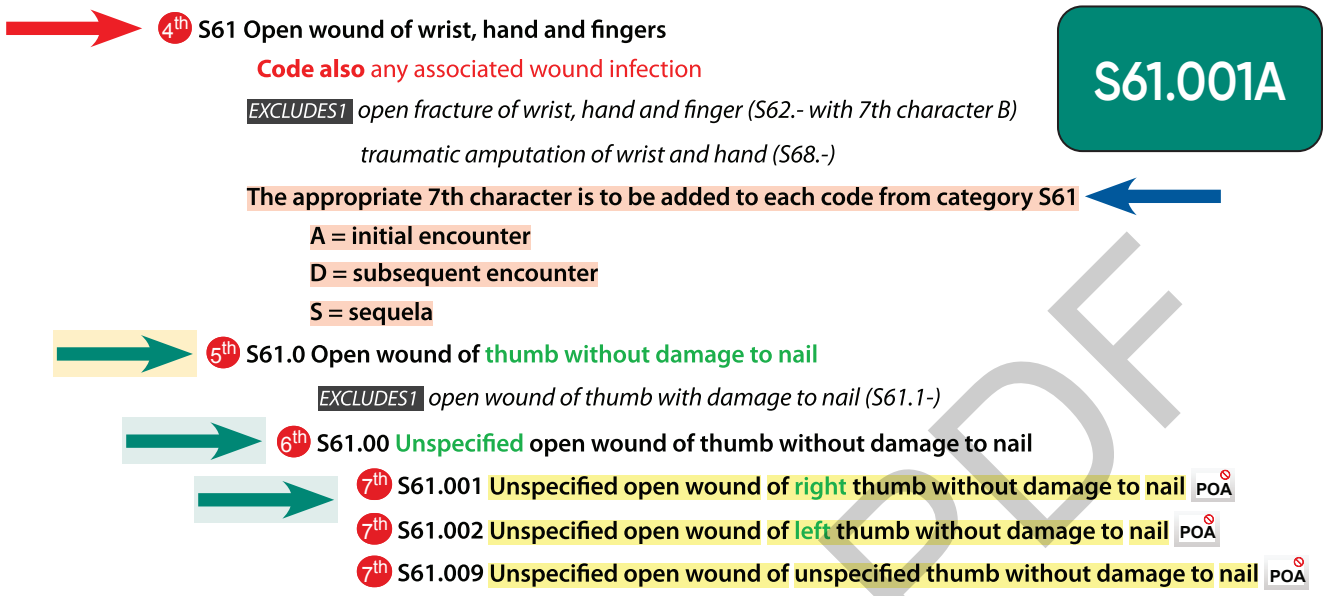
As an RCMS™, you need to know the basics of ICD-10-CM coding and how diagnosis codes impact patient accounts, the overall revenue cycle, and common errors you may come across when invalid codes are reported.

This code system is standardized and used to report disease, injuries, and other conditions for patients. Healthcare providers use ICD-10-CM codes when diagnosing patients. ICD-10-CM classifies patient morbidity and mortality information for statistical purposes. It also provides a basis for indexing health records by diseases and procedures for data storage and retrieval. ICD-10-CM codes are up to seven alpha and numeric characters in length, and update twice per year. These updates occur in April and October.

ICD-10-CM Tells the "Why" of the Patient Encounter

Another way to think about ICD-10-CM codes is that they tell the "why" story for each patient encounter or treatment. The ICD-10-CM codes are not location dependent. They explain why the patient is coming into the office, emergency room, or hospital for admission. Meaning, a patient with a laceration could go to an office for treatment, a patient with a sore throat may show up at an emergency room, or a patient is admitted into the hospital for bladder cancer treatment. These examples are just a starting point to illustrate how diagnoses codes represent the why of a patient encounter.

Let's look at another example:



This is how an ICD-10-CM code would be reported for the first encounter for a patient with an open wound of the right thumb, without damage to the nail. The physician taking care of this patient clearly documents the injury, so the specific code can be reported to the required 7th character.

For this example, the category S61 is for an open would of wrist, hand, and fingers. Notice the red circle preceding the category that indicates a 4th character is required. Move down to the subcategory code of S61.0. This is the 4th character for this code, which defines the thumb without damage to the nail. The 4th character in an ICD-10-CM code further defines the site, etiology, and manifestation or the disease's state or condition.

Proceeding this code is a red circle indicating that a 5th and then 6th character is required. The 5th and 6th character subclassifications represent the most accurate level of specify regarding the patient's condition or diagnosis. Look at the code S61.001. This now defines laterality with the right thumb.

Proceeding the code S61.001 there is a red circle indicating a 7th character is required. The appropriate 7th character that could be added for category S61 are defines as either A – an initial encounter, D – subsequent encounter, or S – sequela. In this example, this is the first time the patient is seeking care for the injury, so the 7th character is A. The correct code to report this injury is S61.001A.

in three parts: The Index, the Tables, and the List of Codes. There is also a list of guidelines and coding conventions in the ICD-10-PCS code book that instructs coders on how to use the PCS code set.

Medical and Surgical Section

The first section, medical and surgical, contains the great majority of procedures typically reported in an inpatient setting. As shown in the previous section discussing ICD-10-PCS code structure, all procedure codes in the medical and surgical section begin with the section value 0.

Example

Character 1 Section	Character 2 Body System	Character 3 Root Operation	Character 4 Body Part	Character 5 Approach	Character 6 Device	Character 7 Qualifier
Medical and Surgical	Tendons	Excision	Lower Arm and Wrist, Right	Open	No Device	No Qualifier
0	**L**	**B**	**5**	**0**	**Z**	**Z**

Sections 1-9 of ICD-10-PCS comprise the medical- and surgical-related sections. These sections include obstetrical procedures, administration of substances, measurement and monitoring of body functions, and extracorporeal therapies, as listed in the table below.

Section value	Description
0	Medical and Surgical
1	Obstetrics
2	Placement
3	Administration
4	Measurement and Monitoring
5	Extracorporeal Assistance and Performance
6	Extracorporeal Therapies
7	Osteopathic
8	Other Procedures
9	Chiropractic

Table 1

In sections 1 and 2, all seven characters define the same aspects of the procedure as in the medical and surgical section.

Codes in sections 3–9 are structured for the most part like their counterparts in the medical and surgical section, with a few exceptions. For example, in sections 5 and 6, the fifth character is defined as duration instead of approach, as in this code for intra-aortic balloon pump (IABP):

G Codes: Procedures/ Professional Services (Temporary)

G codes are temporary codes assigned by CMS. Codes in this section are often used for and preferred by CMS over CPT® codes. Medicare may define G codes to have a slightly different definition than codes for the same or similar services defined by AMA CPT® codes. G codes are under Medicare's jurisdiction.

Some G codes are listed as Merit-based Incentive Payment System (MIPS) codes. MIPS codes are used for reporting performance measures under the Quality Payment Program (QPP). MIPS is the method of reporting quality of care to Medicare. These codes and reporting impact the provider's payment under the Medicare Access and CHIP Reauthorization Act (MACRA).

For example, HCPCS Level II codes G0412-G0415 define fracture care treatment that deals with the pelvis bone and are reported when the procedure is performed unilaterally or bilaterally. The same procedures are listed in CPT® with codes 27215-27218. The CPT® codes reflect the same procedure but are defined as unilateral only.

A common error is reporting services for a CMS patient with the wrong set of codes.

EXAMPLE

When a Medicare patient has a hospital outpatient clinic visit, the facility will report:

G0463 *Hospital outpatient clinic visit for assessment and management of a patient*

REVENUE TIP

When the patient's primary insurance is Medicare, the G codes take precedence over the use of similar CPT® codes for correct billing. Be mindful that many of these codes will have frequency limitations and may require completion of Advanced Beneficiary Notice (ABN). When this is the case, modifier GA should be reported with the correct service code when an ABN is completed and signed.

H Codes: Alcohol and Drug Abuse Treatment Services

H codes are used by state Medicaid agencies mandated by state law to have separate codes for identifying mental health services, including alcohol and drug abuse treatment services, as well as at-risk prenatal care. These services are described as physician or non-physician services, short-term services, or long-term services. If patients are covered by other payers, then CPT® codes would be used to report their services.

A common error when reporting payer-specific codes, like H codes, occurs when these designated codes are reported to the wrong payer. For example, reporting H codes to a commercial insurance plan like Blue Cross Blue Shield (BCBS).

EXAMPLE

Alcohol or drug:

H2018 *Psychosocial rehabilitation services, per diem*

REVENUE TIP

H codes are not billable to Medicare.

J Codes: Drug Administered Other than Oral Method

J codes include injectable as well as inhalation solution drugs. Types of drugs include chemotherapy and immunosuppressive drugs and are usually not self-administered. Each HCPCS Level II code book includes a Table of Drugs, which includes the code, drug name, recommended dosing, and route of administration.

J codes are used to report drugs given subcutaneously, intramuscularly, intrathecally, intravenously, orally, topically, or inhaled. Most J codes come with a specific dosage for a drug. It is important for the quantity of the given drug to be documented and then reported accurately.

For example, code J0561 is reported for penicillin G benzathine, 100,000 units. If an intramuscular injection of 2,400,000 units of penicillin G benzathine was administered to a patient, the drug is reported as J0561 x 24. The 24 represents the number of units given and would be listed on a claim form under the units. This tells the insurance company how much of the drug was given and calculates the line item for that drug.

The dosage of the medication can be listed as milligrams (mg), milliliters (ml), grams (g), and micrograms (mcg) and will be listed with a dosage per unit.

EXAMPLE

J1100 *Injection of dexamethasone sodium phosphate, 1 mg*

J7050 *Infusion of normal saline solution, 250 cc*

Chapter 3

1. Which of the following statements best describes the primary difference between a National Coverage Determination (NCD) and a Local Coverage Determination (LCD)?

   A. NCDs are created by individual Medicare Administrative Contractors (MACs) for their specific jurisdictions, while LCDs apply nationally and must be followed by all MACs.

   B. LCDs provide national coverage guidelines for specific services, whereas NCDs are used only when a service does not have an existing LCD.

   C. NCDs establish nationwide Medicare coverage policies, while LCDs are jurisdiction-specific policies created by MACs to further define coverage in the absence of an NCD.

   D. LCDs override NCDs when both policies exist for the same procedure, allowing for regional flexibility in Medicare coverage decisions.

2. Which of the following is NOT a factor used by the National Correct Coding Initiative (NCCI) in determining coding policies?

   A. Analysis of standard medical and surgical practice.

   B. Guidelines from national medical specialty societies.

   C. Individual physician opinions on bundled procedures.

   D. Local and national coverage determinations.

3. A provider submits a claim for two procedures that are identified as a Procedure-to-Procedure (PTP) edit under the National Correct Coding Initiative (NCCI). Under what circumstance can both procedures be reimbursed?

   A. The provider submits the claim with an appropriate modifier that allows the edit to be bypassed.

   B. The claim is submitted to Medicaid instead of Medicare, as Medicaid does not use NCCI edits.

   C. The procedures are performed on different days but billed together, which automatically overrides the edit.

   D. The provider includes a justification letter with the claim explaining why both procedures were necessary.

4. Which of the following best describes the primary purpose of Medically Unlikely Edits (MUEs)?

   A. To limit the number of units of service that can be reported for a specific CPT® or HCPCS code per patient per day.

   B. To identify procedure-to-procedure code pairs that should not be billed together.

   C. To determine whether a service is considered experimental and therefore ineligible for Medicare reimbursement.

   D. To prevent duplicate claims from being paid when the same service is billed for different patients on the same date of service.

5. Which of the following statements about Medicaid's use of the National Correct Coding Initiative (NCCI) is correct?

   Medicaid must adopt all NCCI edits exactly as implemented by CMS, without modification.
   Medicaid NCCI methodologies include edits for practitioner services, ambulatory surgical centers, outpatient hospitals, and durable medical equipment.
   Medicaid does not use NCCI edits and instead relies solely on state-specific billing guidelines.
   Medicaid providers may appeal NCCI-based denials, but only if they prove medical necessity with documentation from a specialist.

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.

Claim Forms

Introduction

Claim forms are used to report the procedures performed and the reason the procedures were performed to the insurance carrier to obtain payment for those services. There are two claim forms used: the CMS-1500 claim form and the UB-04 claim form. The CMS-1500 claim form is used to report the professional services performed by providers and Ambulatory Surgical Centers (ASCs). The UB-04 claim form is used to report facility services.

The objectives for this chapter include:

- Understand CMS-1500 claim form development and maintenance processes
- Identify types of providers who use the CMS-1500 claim form
- Understand completion of the CMS-1500 claim form
- Apply CMS-1500 claim form fields to electronic submission requirements
- Identify types of providers who use the UB-04 claim form
- Understand completion of the UB-04 claim form
- Apply UB-04 claim form fields to electronic submission requirements

National Uniform Claim Committee

The Health Insurance Portability and Accountability Act (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop, adopt, or modify standards that allow healthcare transactions to be exchanged electronically. Effective Jan. 1, 2012, all HIPAA covered entities are required to send and receive the Accredited Standards Committee ASC X12 Version 5010 for electronic transactions which include:

- Claims (Institutional, Professional and Dental, COB [Professional and Institutional], and NCPDP) (837)
- Claims Status Requests and Responses (276/277)
- Remittance (835)
- Enrollment and Disenrollment in a health plan (834)
- Premium Payment (820)
- Eligibility Requests and Responses (270/271)
- Referral Requests and Responses and Prior Authorizations (278)
- Claims Acknowledgements (277CA)
- Acknowledgement for Healthcare Insurance (999)

As we discuss the paper forms and each of their fields in this chapter, we will also point out pertinent information for the electronic submissions of the claim form. While the term "item" is used for the field on the paper CMS-1500 claim form, electronic fields refer to the term "loop" for the data elements to be sent. For more information on the CMS-1500 claim form see https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN4462429-MLN-WBT-1500/1500/index.html

The specific version for healthcare professionals and suppliers to transmit claims electronically is ANSI ASC X12N 837P. This is translated as:

- ANSI = American National Standards Institute
- ASC = Accredited Standards Committee
- X12N = Insurance section of ASC X12 for the health insurance industry's administrative transactions
- 837 = Standard format for transmitting healthcare claims electronically
- P = Professional version of the 837 electronic format
- Version 5010A1 = Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for healthcare professionals and suppliers.

REVENUE TIP

HIPAA allows filing paper claims when it has been determined that due to limitations in the claims' transaction formats adopted, it would not be possible to submit the claim electronically. Exceptions allowing for paper claims to be filed to Medicare include:

- Roster billing of inoculations covered by Medicare.
- Claims for payment under a Medicare demonstration project that specifies paper submission.
- "Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) claims when there is more than one primary payer
- MSP claims when there is more than one primary payer and more than one allowed amount

More information can be found on these exceptions by accessing the CMS Internet-Only Manuals, Publication 100-04 Medicare Claims Processing Manual, Chapter 24, 90.3- General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims. The link can be located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf.

numeral 1 must be entered. For anesthesia services based on time, the number of minutes must be reported as the units.

Item 24H—This item is used by Medicaid and reports services related to Early & Periodic Screening, Diagnosis, and Treatment (EPSDT). If there is no requirement (for example, state requirements) to report a reason code, enter Y for Yes and N for No. If there is a state requirement, enter the two-character code for the reason. If there is a state requirement, refer to the NUCC Claims Manual for valid codes.

Medicare: Leave blank. Not required.

Item 24I—Enter the qualifier identifying if the number is a non-NPI. The qualifier identifies what type of number is used in 24J.

Medicare: Leave blank. Not required.

Item 24J—Enter the non-NPI number in the shaded area of the field and enter the rendering provider's NPI number in the unshaded portion. A common reason for electronic claims rejection is for an invalid NPI. Verify all NPI numbers are correct when entering them into the practice management system.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I10 B. D2360 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	25	XX				11		99213	25	AB	160 00			NPI	1234567891
2	10	25	XX				11		11402		B	300 00			NPI	1234567891
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE

A provider removes 30 skin tags (11200, 11201 x 2) on a patient at his office on Jan. 1, 20XX.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	XX	01	01	XX	11		11200		A	150 00	1		NPI	123456789
2	01	01	XX	01	01	XX	11		11201		A	100 00	2		NPI	1234567891
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

In this example:

24A - The procedure was performed on Jan. 1, 20XX. Date of service 01 01 XX is entered in 24A.

24B - The procedure was performed at the office. place of service (POS) code 11 is entered in 24B.

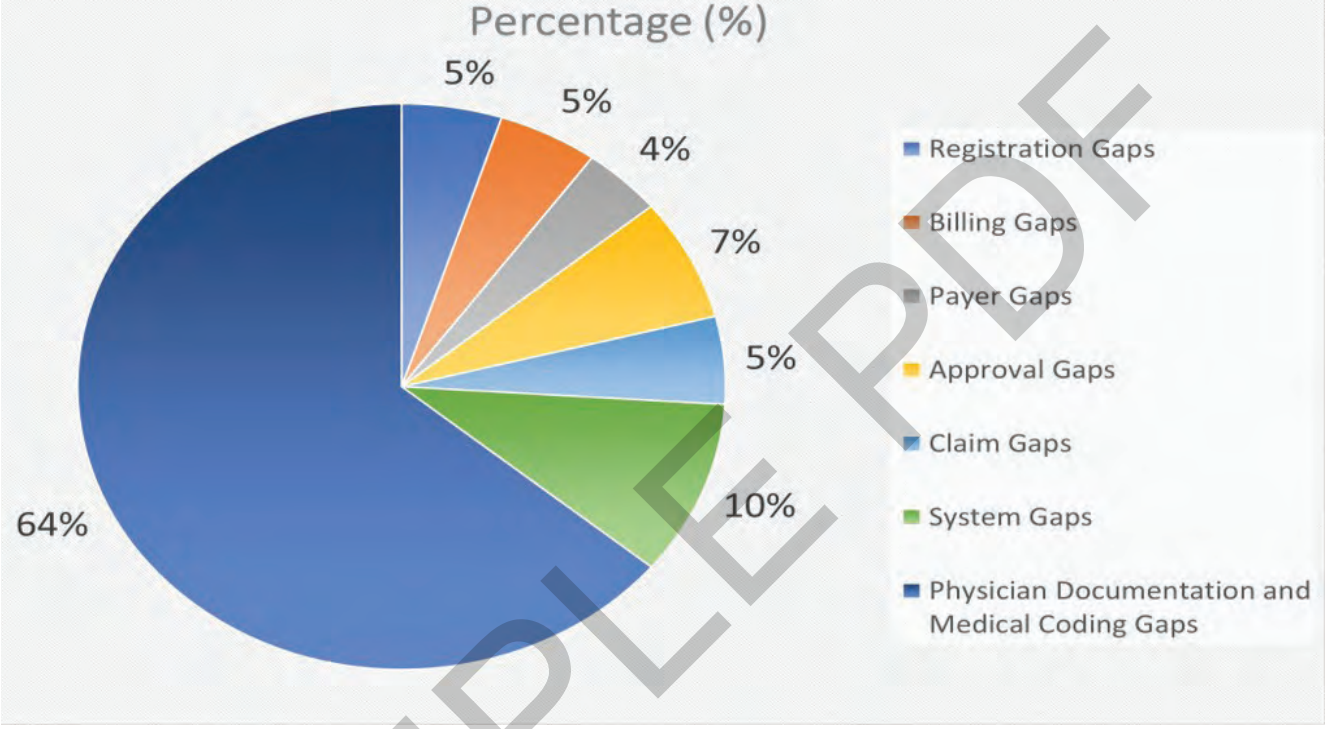
24C - Left blank for most payers.

24D - The procedure codes reported are 11200 and 11201 with no modifiers. Enter 11200 in line 1 and 11201 in line 2 for 24D (procedure 11201 is reported twice, this will be reported by adding 2 units to this line item in 24G).

24E - The diagnosis pointer is A. This refers to the ICD-10-CM code that is entered in Item 21A.

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

Chapter 8

1. What is the purpose of the Health Insurance Portability and Accountability Act (HIPAA)?
   A. To simplify the administration of health insurance.
   B. To increase the cost of healthcare.
   C. To reduce the quality of healthcare.
   D. To limit the transfer of health insurance coverage.

2. Who are the three groups that HIPAA directly applies to?
   A. Insurance companies, hospitals, and patients.
   B. Doctors, nurses, and patients.
   C. Healthcare Providers, Health Plans, and Healthcare Clearinghouses.
   D. Government agencies, healthcare providers, and insurance companies.

3. What does the term 'waste' refer to in the context of healthcare compliance?
   A. Intentional deception for personal gain.
   B. Overuse of services resulting in unnecessary costs.
   C. Misuse of resources for personal benefit.
   D. Practices inconsistent with sound fiscal, business, or medical practices

4. What does the Anti-Kickback Statute prohibit?
   A. Any form of communication between a doctor and a patient.
   B. Any form of remuneration in return for referrals for services paid by Medicare or Medicaid.
   C. Any form of partnership between healthcare providers.
   D. Any form of advertisement for healthcare services.

5. Who is NOT considered a covered entity under the Health Insurance Portability and Accountability Act (HIPAA)?
   A. Doctors
   B. Health Plans
   C. Healthcare Clearinghouses
   D. Patients

6. What is the main focus of the Stark Law?
   A. To prevent physician conflicts of interest due to their ability to benefit financially from referrals.
   B. To ensure that all patients receive the same standard of care.
   C. To regulate the prices of medical equipment.
   D. To provide guidelines for medical research.

CLAIMS RESUBMISSION REPORT – Brown Clinic

Claim Number	DOS	SERVICE	AMOUNT	DENIAL REASON
1	10/12/XXXX	0055T	$600.00	Noncovered service
2	2/12/XXXX	20985	$925.00	Noncovered service
3	7/7/XXXX	0054T	$495.00	Noncovered service
4	9/14/XXXX	0054T	$495.00	Noncovered service
5	3/7/XXXX	20985	$925.00	Noncovered service
6	7/6/XXXX	0055T	$600.00	Noncovered service
7	1/12/XXXX	20985	$925.00	Noncovered service
8	7/14/XXXX	0055T	$600.00	Noncovered service
9	11/9/XXXX	0054T	$495.00	Noncovered service
10	5/12/XXXX	20985	$925.00	Noncovered service
11	9/11/XXXX	20985	$925.00	Noncovered service
12	9/16/XXXX	0055T	$600.00	Noncovered service
13	10/14/XXXX	20985	$925.00	Noncovered service
14	8/1/XXXX	0055T	$600.00	Noncovered service

A. Claim Numbers: 48, 25, 51, 77, 12, 32, 49; Brown Clinic Claim Numbers: 5, 11, 13; Box 11 on 1500 claim form

B. Claim Numbers: 25, 51, 77, 57, 92, 12, 45; Brown Clinic Claim Numbers: 5, 7, 11, 13; Box 22 on 1500 claim form

C. Claim Numbers: 92, 12, 48, 87, 25, 45, 99; Brown Clinic Claim Numbers: 2, 5, 11, 13; Box 23 on 1500 claim form

D. West Clinic Claim Numbers: 51, 87, 77, 45, 62, 57, 99; Brown Clinic Claim Numbers: 2, 5, 7, 10; Box 22 on 1500 claim form

CASE 2

Caring Clinic provides both in-person and Telehealth mental health services to their patients. The state Medicaid fee schedule increased their payment for mental health services for CY 2024. This includes Telehealth services. However, upon review of the fee schedule and comparison of the recent reimbursements, the local practice is questioning if there is a discrepancy. They have reviewed the fee schedule and a recent behavioral health policy in light of their October reimbursements. What should the reimbursement specialist do?

Chapter 9

1. **Answer**: B. To ensure a process, item, or service is of the type and quality needed and expected by the user.

   Rationale: Quality Assurance is an integrated system of management activities that ensures a process, item, or service meets the expected quality and type needed by the user.

2. **Answer:** B. To measure the performance of a process, item, or service against a defined set of criteria or standard.

   Rationale: Quality control is a system of technical activities that measures the performance of a process, item, or service against a defined set of criteria or standard.

3. **Answer:** B. Regularly testing fire extinguishers within the clinic.

   Rationale: Quality control includes activities such as calibrations and analyses of a sample of items to assess the bias and precision associated with sample results. Regularly testing fire extinguishers within the clinic is an example of this.

4. **Answer:** B. To improve patient health while reducing healthcare costs.

   Rationale: The goal of value-based healthcare is to improve patient health while reducing healthcare costs. This is achieved by rewarding providers for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

5. **Answer:** C. Increased complexity in the billing and reimbursement process.

   Rationale: Value-based payment models are often more complex than traditional fee-for-service models. This can make the billing and reimbursement process more difficult to manage.

6. **Answer:** D. Progress notes of all disciplines

   Rationale: The health record content includes identification data and unique identifiers, time and date of service, comprehensive history and physical examination, and progress notes of all disciplines. Progress notes are an important part of the health record as they document the care and treatment provided by various healthcare professionals.

7. **Answer:** A. Quality Payment Program (QPP)

   Rationale: The text states that MACRA replaced PQRS with the Quality Payment Program (QPP).

8. **Answer:** A. Measures that are relevant to a particular clinician's services or care rendered

   Rationale: According to the provided information, "applicable" measures for MIPS-eligible clinicians are defined as measures that are relevant to a particular clinician's services or care rendered.

9. **Answer:** A. Doing the right thing, at the right time, in the right way for the right person or patient population

   Rationale: According to the information provided, quality improvement in healthcare is defined as doing the right thing, at the right time, in the right way for the right person or patient population, resulting in the best possible outcome.

10. **Answer:** B. To determine if the plan is working

    Rationale: The 'Check' phase of the PDCA cycle involves reviewing the original benchmark data to determine if improvements are being made and discussing the successes and potential issues with the current plan.

Practice Examination – Answers and Rationales

1. **Answer:** B. A medical device manufacturer offering a clinic a large volume-based discount on purchases of its products.

   Rationale: The Anti-Kickback Statute prohibits remuneration (financial incentives) that could induce referrals for services paid by federal healthcare programs. Volume-based discounts may be seen as an inducement to purchase more products, potentially violating the statute. However, physician recruitment in underserved areas, proportionate ASC profit distribution, and unbiased educational programs generally fall within safe harbors or legal exceptions.

2. **Answer:** B. A hospital routinely ordering diagnostic tests that are medically unnecessary to increase revenue.

   Rationale: Fraud requires intentional deception, and routinely ordering unnecessary tests to increase revenue meets this definition. The other options involve errors, misinterpretation, or inefficiencies, which would typically be classified as waste or abuse rather than fraud.

3. **Answer:** B. A hospital systemically upcoding inpatient stays to higher-severity MS-DRGs for increased Medicare reimbursement.

   Rationale: Systemic upcoding (assigning a higher-severity MS-DRG for financial gain) is a False Claims Act (FCA) violation and can lead to civil monetary penalties. The other options involve mistakes or administrative errors, which may lead to claim denials but are less likely to trigger FCA.

4. **Answer:** B. A hospital experiencing reduced patient volume due to the opening of a competing medical center nearby.

   Rationale: Strategic risk refers to threats that impact an organization's long-term goals, such as competition from new providers or shifts in patient demographics. Operational, legal, and financial risks are represented in the other options.

5. **Answer:** C. Ask questions to retrieve the patient's demographics and have the patient verbally verify the information back.

   Rationale: When a patient arrives, your registration staff should ask questions to retrieve the patient's demographics and then verbally verify the information back to them.

6. **Answer:** A. Send out automated texts and calls to the patients before their appointments and perform real-time eligibility checks.

   Rationale: By performing real-time eligibility check at the time of the visit, you can decrease the denials significantly due to eligibility and benefit issues. Also, sending out reminder text messages to the patient that are automated is more efficient than calling and will remind them to update that information. The RCMS would want to perform real-time eligibility checks, if this is an option, but also want to cover all bases and make sure signs are placed in the office and that calls and texts are made to the patient prior to the appointment.

7. **Answer:** C. The patient is responsible for $232. The total patient responsibility for today's visit is $232 because you have not met your deductible for both insurances. Based on our contracted rate with the primary insurance, the full amount is collected up front until the deductible has been met.

   Rationale: As a contracted provider with the insurance plan, you are bound to your contracted rates. You can only collect up to the full amount of the allowable until the deductible has been satisfied. If there is a secondary insurance that also has a deductible to be met, you will collect based on the primary allowed.

Join the biggest team in healthcare information management.

As an AAPC member, you'll be part of a global network of 250,000+ career learners and working professionals. Our credentials are among the most highly sought after in the industry — in part because AAPC members are trained for more than passing an exam. They are trained to succeed on the job from day one.

"If you want to rise in the ranks of the Healthcare business portion of the medical field, I highly suggest that you become a member of AAPC and obtain your certifications through them. They will help you to advance and open the door of opportunity for you."

- Latisha Booker, CPC

"APPC has not only provided me with the opportunity to earn multiple credentials but has also opened important doors for me in my career."

- Mary Arnold, CPC, CPMA, CRC, RMA, HR-C

"While taking classes, I was introduced to AAPC. I became a member to help boost my career, and more than 20 years later, I'm still an AAPC member."

– Bradley Miller, CPC, CRC, CDEO

Whether you're just getting started or a seasoned pro, AAPC membership will give you the support, training, tools, and resources to help you launch and advance your career successfully,

Learn more at **aapc.com**

AAPC