

Revenue Cycle Management: From Patient to Payment

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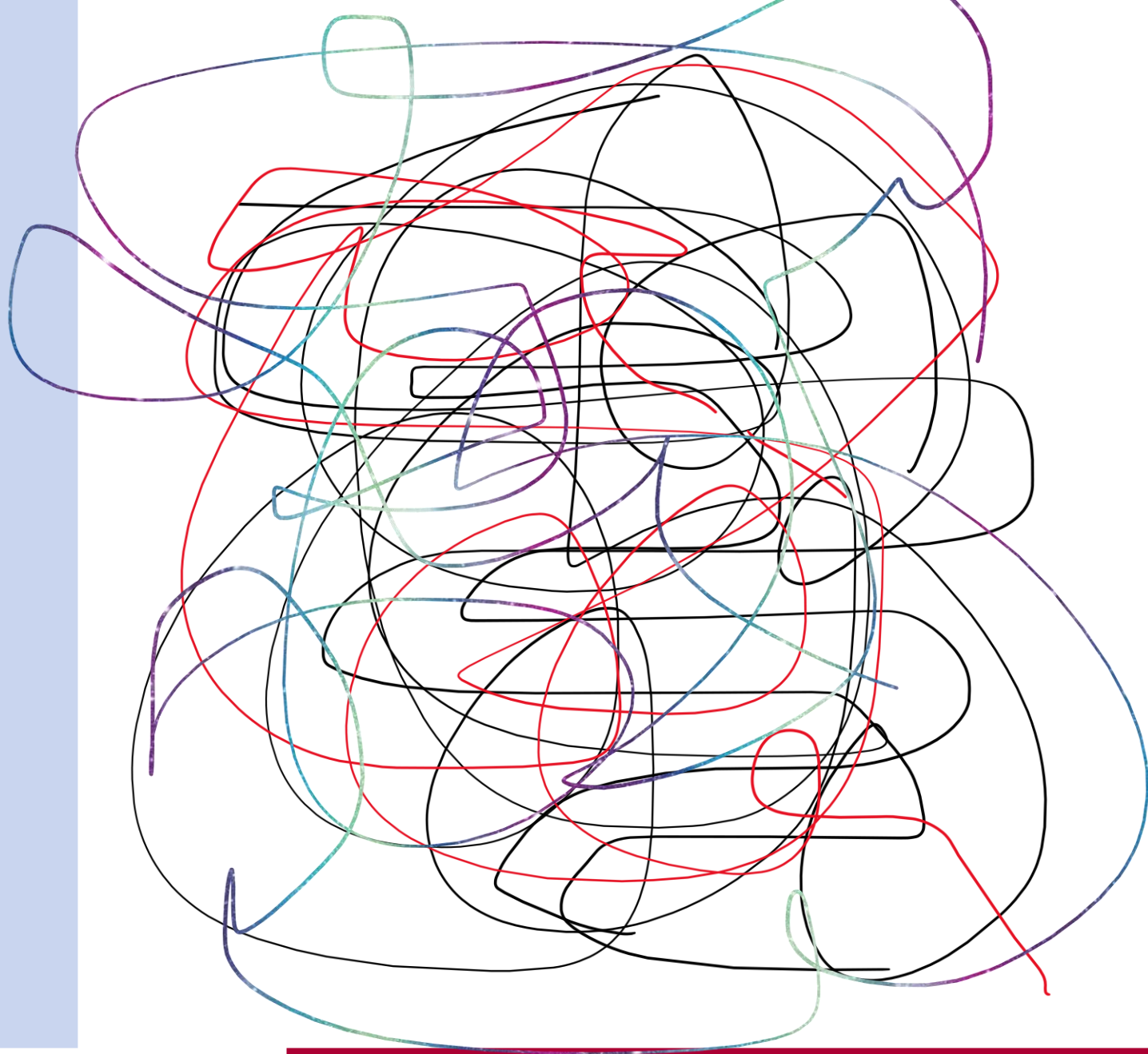
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Understanding the Revenue Cycle



Actual Depiction of the Revenue Cycle Process





FRONT DESK

Patient Registration Essentials

Patient Demographics

- Name
- Date of Birth
- Phone Number
- Mailing Address

Insurance Details

- Primary insurance name
- Policy number
- Group number
- Subscriber's information
 - Name
 - DOB
 - Place of employment

Guarantor Information

- Confirm financially responsible party if different from the patient

Alternative Contact

- Collect information for follow-up in case the patient becomes unreachable

Pre-Visit Paperwork

Streamline the first visit

- Direct patients to the practice website to complete new patient forms
 - Health history
 - Intake forms
 - Financial responsibility
 - Secondary insurance information
 - Emergency contacts
 - HIPAA acknowledgement
 - Medical record transfer requests
- Online completion isn't available
 - Patients should be instructed to arrive 15-30 minutes early to complete them in-office.
 - Give arrival time NOT appointment time

Insurance Verification Best Practices



Verify One Week Prior

Check coverage at least one week before the appointment to allow time for gathering additional information and accommodating schedule changes.



Use Multiple Verification Methods

Utilize practice management systems, payer websites, and real-time online tools to access the most up-to-date benefits information.



Call Insurers When Necessary

If electronic methods are inconclusive, directly call the insurer to confirm coverage specifics, such as copays, coinsurance, and unmet deductibles.



Flag Unconfirmed Coverage

If coverage can't be verified, notify the patient prior to their visit so they can follow up with their employer or insurance carrier.

Efficient Patient Check-In



Verify Patient Identity

Confirm identity and scan insurance cards and photo ID



Collect Signed Forms

Obtain assignment of benefits, financial responsibility, and consent for treatment



Confirm Insurance Eligibility

Verify coverage and benefits are active for the visit date



Collect Patient Payments

Process copays, coinsurance, deductibles, and outstanding balances

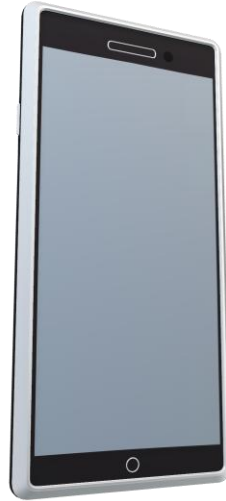


Technology for Efficient Check-in



Self-Service Kiosks

Tablets linked to the practice management system can collect patient data, confirm demographics, calculate and collect payment, and verify insurance.



Mobile Check-In

Patients can complete pre-registration and check-in processes from their own devices before arriving at the office.



Assisted Check-In

Staff can guide patients through electronic check-in processes, ensuring accuracy while reducing paperwork.

Effective Patient Communication

Clear Financial Policies

Establish billing and collection processes centered on proactive communication with patients. Ensure patients understand their expected costs before receiving care.

Online Resources

Direct patients to the practice website for key key resources including including accepted insurance plans, payment payment options, intake intake forms, and patient patient portal enrollment. enrollment.

Transparent Expectations

Clearly display financial policies, explain expectations for payment at the time of service, and outline after-hours, refill, referral, and preauthorization procedures.

Pricing Transparency Tools



Fee Schedule Downloads

Most practice management systems can download insurance-allowed amounts to compare contracted and actual payments.



Third-Party Estimators

Calculate patient responsibility based on procedure codes and payer fee schedules, including copays, coinsurance, and unmet deductibles.



Reference Sheets

Maintain lists showing common patient responsibilities and typical self-pay amounts for non-covered services by plan.

Advance Beneficiary Notice (ABN)

Purpose

If a physician believes Medicare will not cover a particular service, the patient must be notified beforehand using an ABN, allowing them to decide whether to proceed and pay out of pocket.

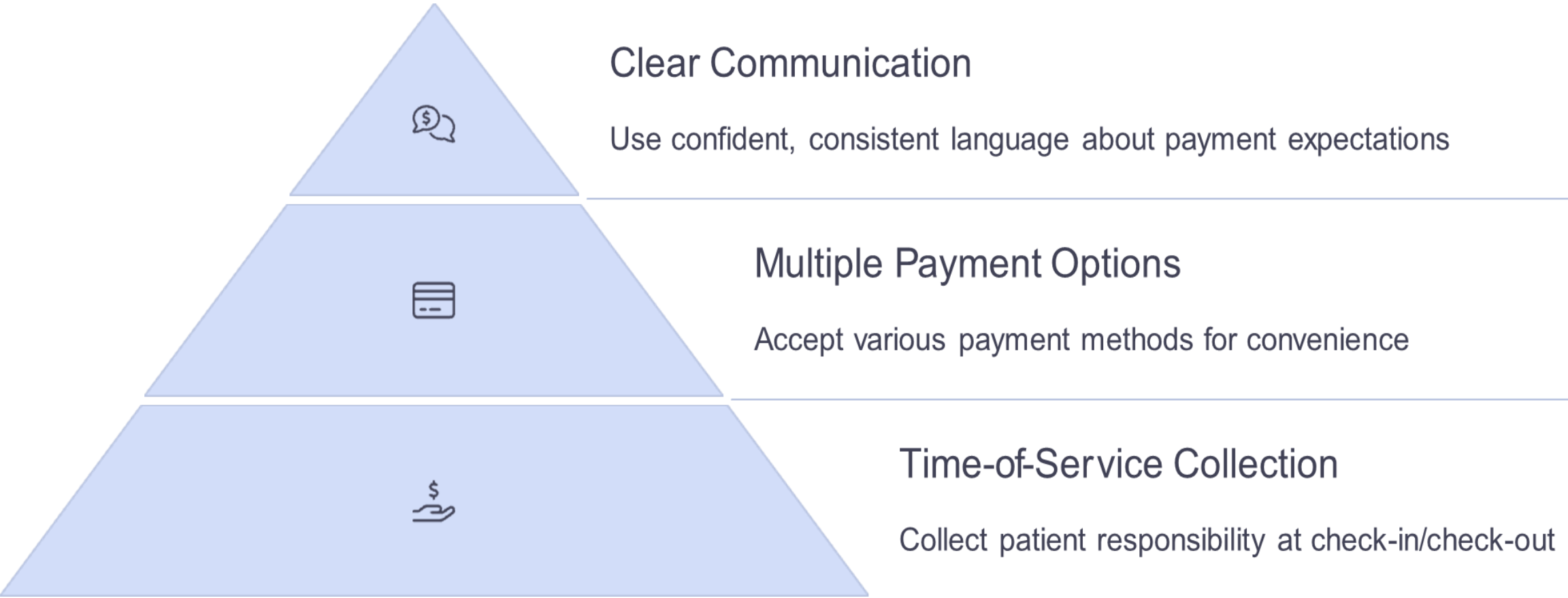
Requirements

The form must be explained verbally, patients should have the opportunity to ask questions, and ABNs must be available in both English and Spanish.

Cost Estimates

Estimates should be within \$100 or 25% of the actual charge to ensure patients can make informed decisions.

Effective Payment Collection Techniques



Patient Check-Out Process



Review Services Provided

Calculate Patient Responsibility

Collect Payment

Schedule Follow-Up



Financial Agreements and Payment Plans

Cost Estimate Worksheet

Prepare a detailed breakdown outlining the patient's expected out-of-pocket responsibility, including total service fee, expected insurance payments, and patient financial responsibility.

Payment Plan Agreement

Create a formal document detailing payment terms and schedule, signed by both the patient and a practice representative, with a copy provided to the patient.

Clear Communication

Ensure the agreement outlines payment expectations and consequences of nonpayment, helping set clear expectations upfront.

"Card on File" Payment Method



Secure Authorization

Patients complete a form authorizing the use of a credit/debit card or bank account for future billing



PCI Compliance

Information is stored through a secure, PCI-compliant vendor integrated with the practice management system



Advance Notification

Patients receive email or text notification before their card is charged



Payment Processing and Posting

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Collect Payments

Accept multiple payment forms during check-in and check-out



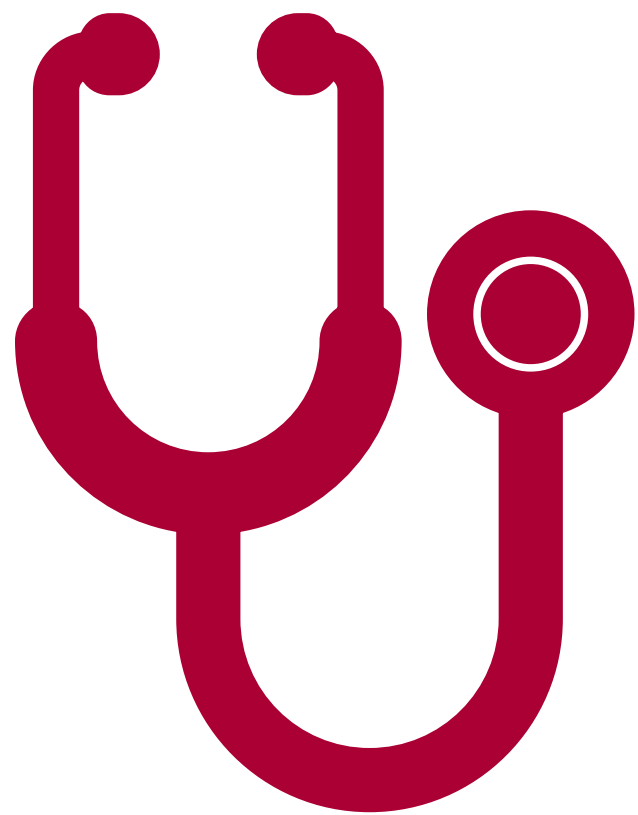
Generate Receipts

Provide electronic receipts for all transactions



Apply Payments

Post to specific charges or as unapplied credits



Patient Visit

Capturing Charges Accurately

Clinical Documentation

Physicians document encounters and assign appropriate codes

Reconciliation

Compare arrived appointments with charge entries



Charge Entry

Documentation becomes the foundation for billing

Verification

Billing staff verify codes and apply necessary modifiers



Billing and Coding

Daily Reconciliation Process

Compare Appointments with Charges

Use system-generated reports or manual tracking methods to ensure all services are billed

Verify Documentation Completeness

Ensure all charts are properly documented to support billed services

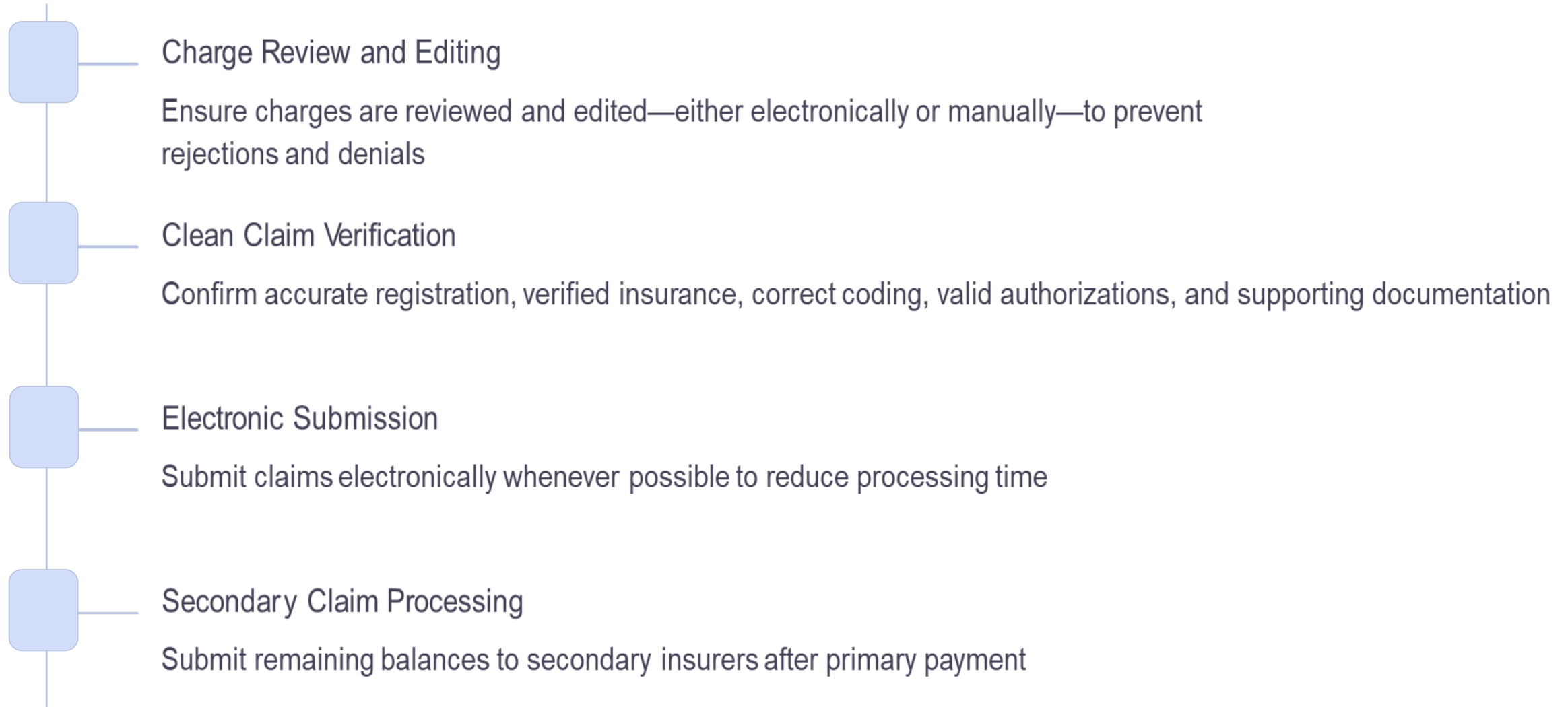
Check for Missing Charges

Review hospital census reports, operative reports, and consultation requests

Confirm ABN Compliance

Verify presence of valid Advance Beneficiary Notices for Medicare patients receiving potentially non-covered services

Claims Submission Process



Coordination of Benefits (COB)

Primary Insurance Processing

The primary insurer processes the claim first, providing an Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) that details payments, adjustments, and denials with associated reason codes.

Automatic Crossover

In some cases—such as with Medicare and certain other payers—claims are automatically forwarded to the secondary payer through a crossover process, provided the correct beneficiary data is on file.

Manual Secondary Submission

If a claim does not automatically cross over, the practice may need to manually submit the remaining balance to the secondary (or even tertiary) payer, which can be time-consuming.

Claims Management Best Practices

Daily Submission

Submit claims daily, with each batch corresponding to a specific date of service, to maintain consistent cash flow and avoid delays.

Electronic Submission

Submit claims electronically whenever possible to reduce processing time and errors.

Filing Deadlines

Most commercial payers require claims to be filed within 90 days from the date of service, though Medicare allows 12 months.

Daily Rejection Monitoring

Work on rejected claims daily to ensure timely resolution and prevent missed deadlines.

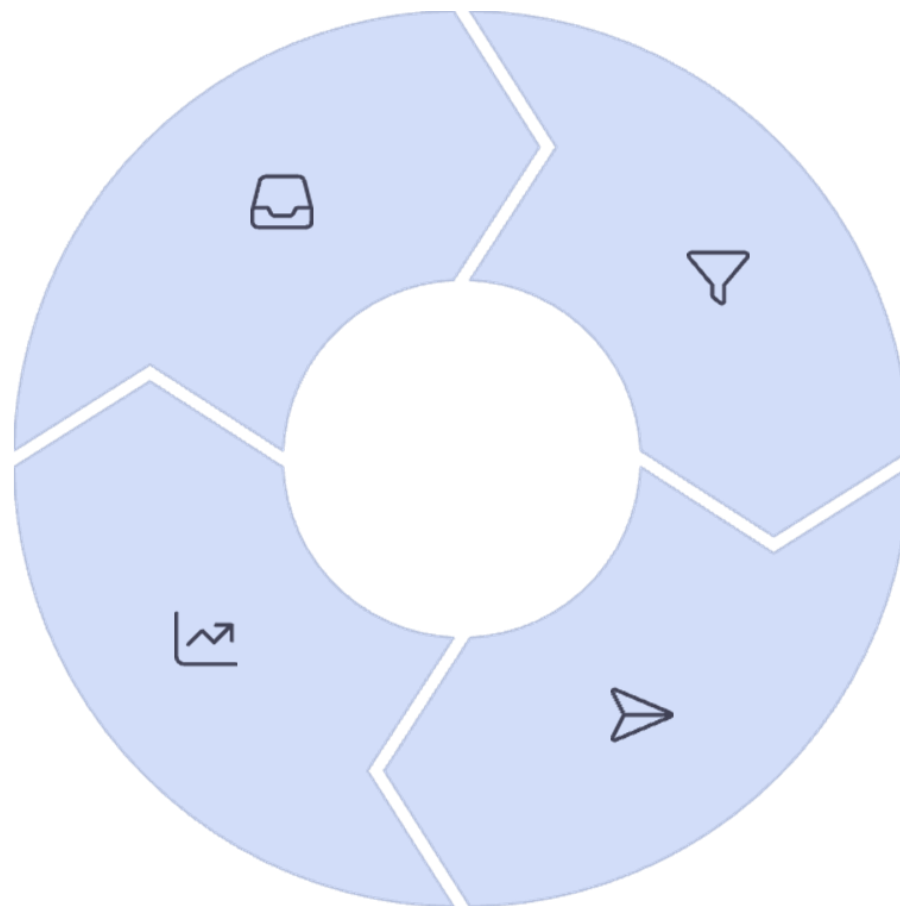
Clearinghouse Functions

Claim Receipt

Clearinghouse receives electronic claims from practice

Status Tracking

Claim progress is monitored through the adjudication process



Claim Scrubbing

Errors are identified and flagged for correction

Claim Transmission

Clean claims are batched and sent to appropriate payers

Payment Deposit Methods

Lockbox Services

Banks receive and process mail, scan checks and EOBs, and deposit funds into the account. Files are then forwarded securely to the practice for posting.

Remote Deposit Tools

Mobile apps, check scanners, or magnetic strip readers used in-office for faster deposits and reduced trips to the bank.

Merchant Processing

Card payments are processed and deposited electronically with minimal delay, improving cash flow.

Payment Posting Fundamentals



Line-Item Posting

Post payments by individual charge line, not just to the general patient account

Payment Verification

Confirm payments align with contracted rates and identify denials or underpayments

Balance Determination

Calculate remaining patient or secondary payer responsibility

Trend Analysis

Recognize patterns requiring follow-up or appeal

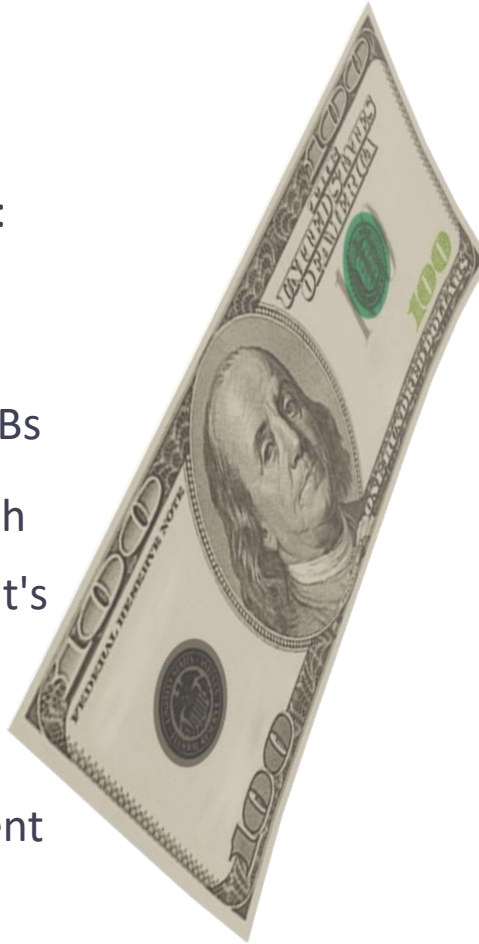
Manual vs. Electronic Payments

Manual Payments

Manual payments come from two main sources:

- Time-of-service payments from patients
- Paper checks from insurance payers with EOBs

Staff match each payment line from the EOB with with the corresponding charge line in the patient's patient's account. If the payment matches the the contracted allowable amount, the system or system or staff will apply a contractual adjustment adjustment for the remaining balance.



Electronic Payments

With electronic payments, payers send funds via:

- Electronic Funds Transfer (EFT)
- Electronic Remittance Advice (ERA) file
- Virtual merchant cards (less common)

The ERA is imported into the practice management software and, when properly configured, automatically posts payments by line item. This system depends on enrollment with each payer, proper interface configuration, and staff oversight.

Prioritizing AR Follow-up



Sort by Payer and Date

Organize open claims by payer and date of service to service to batch follow-ups efficiently



Focus on High-Value Claims

Prioritize high-balance claims and payers with short adjudication cycles



Work from Aging Reports

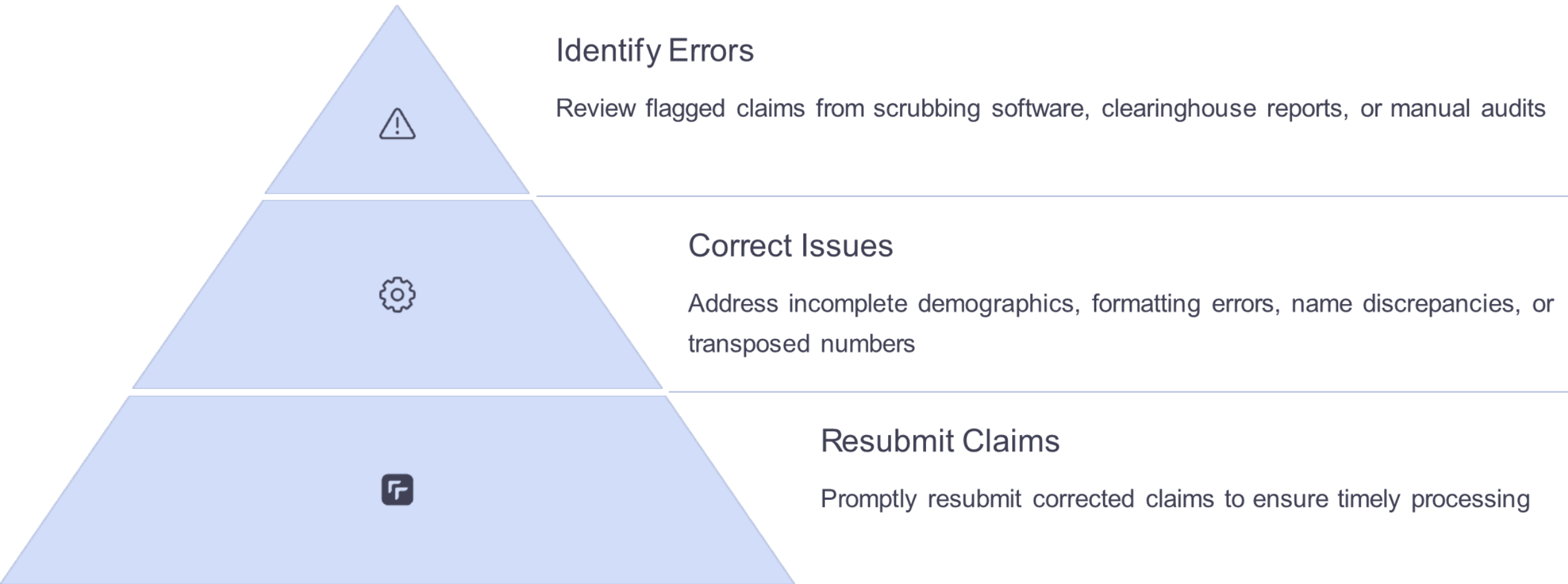
Use comprehensive reports to ensure claims with no payer response are included



Address Older Categories

Work all claims within each aging category every 30 days to meet deadlines

Managing Claim Edits and Rejections



Common Denial Reasons and Actions

Duplicate Claim

Confirm claim status status before resubmitting to avoid unnecessary unnecessary duplicates

Patient Ineligibility

Verify insurance eligibility and benefits prior to each appointment

Place of Service Error

Review procedure procedure and POS POS codes, make corrections, and resubmit as a

Not Medically Necessary

Reference payer guidelines and submit supporting documentation

Incorrect Insurance Carrier

Confirm the correct insurance plan using the the most recent card

The Appeals Process

- Initial Appeal

Submit written appeal with supporting documentation

- Secondary Review

Conducted by nurse, case manager, or specialty physician

- Final Review

Managed by payer's appeal board or committee

Managing Overpayments and Refunds

Legal Obligations

Medical practices must never retain payments that are not rightfully owed. Keeping an overpayment—intentionally or not—is considered wrongful retention (conversion) and is illegal.

Credit Balance Review

Practices should review and resolve credit balances weekly, identifying posting errors, overpayments, duplicate payments, and unapplied patient payments.

Refund Timeframes

Laws mandates that physicians refund patient overpayments within 30 days of identifying the overpayment. Medicare requires identified overpayments be returned within 60 days.

Unclaimed Refunds

If a refund cannot be issued or remains unclaimed, the amount must be turned over to the Unclaimed Property Division.

Recoupments and Offsets

Understanding Recoupments

Payers sometimes issue recoupments or offsets, reducing current payments to recover overpayments from previous claims. These often occur months after the original claim is resolved, complicating account reconciliation and patient communication.

Required Adjustments

When a recoupment occurs:

- The earlier overpaid claim must be adjusted
- A correction must be made in the patient's account
- The entire transaction history must be documented

Clear Communication

For some plans, the terms of the employer contract govern recoupments, payment deadlines, and appeals—not state law.

Managing Financial Hardship

Early Identification

Identify financial hardship early to avoid inefficient collection attempts. Document financial status in the patient's record.

Assistance Options

When appropriate, assist patients with applying for financial assistance or extended payment options.

Medicare Considerations

For Medicare beneficiaries, discounts or waivers must apply only to coinsurance or deductible amounts and only after completing a financial hardship application.

Standardized Process

Implement a standardized policy for evaluating and addressing financial hardship, including use of a uniform application.

Staffing Assignment Strategies

Payer-Based Assignments

Many practices assign staff by payer, giving each team responsibility for a designated group of claims—such as all Medicare accounts. This helps staff build specialized knowledge, establish relationships with payer representatives, allows managers to set performance metrics for each payer portfolio.

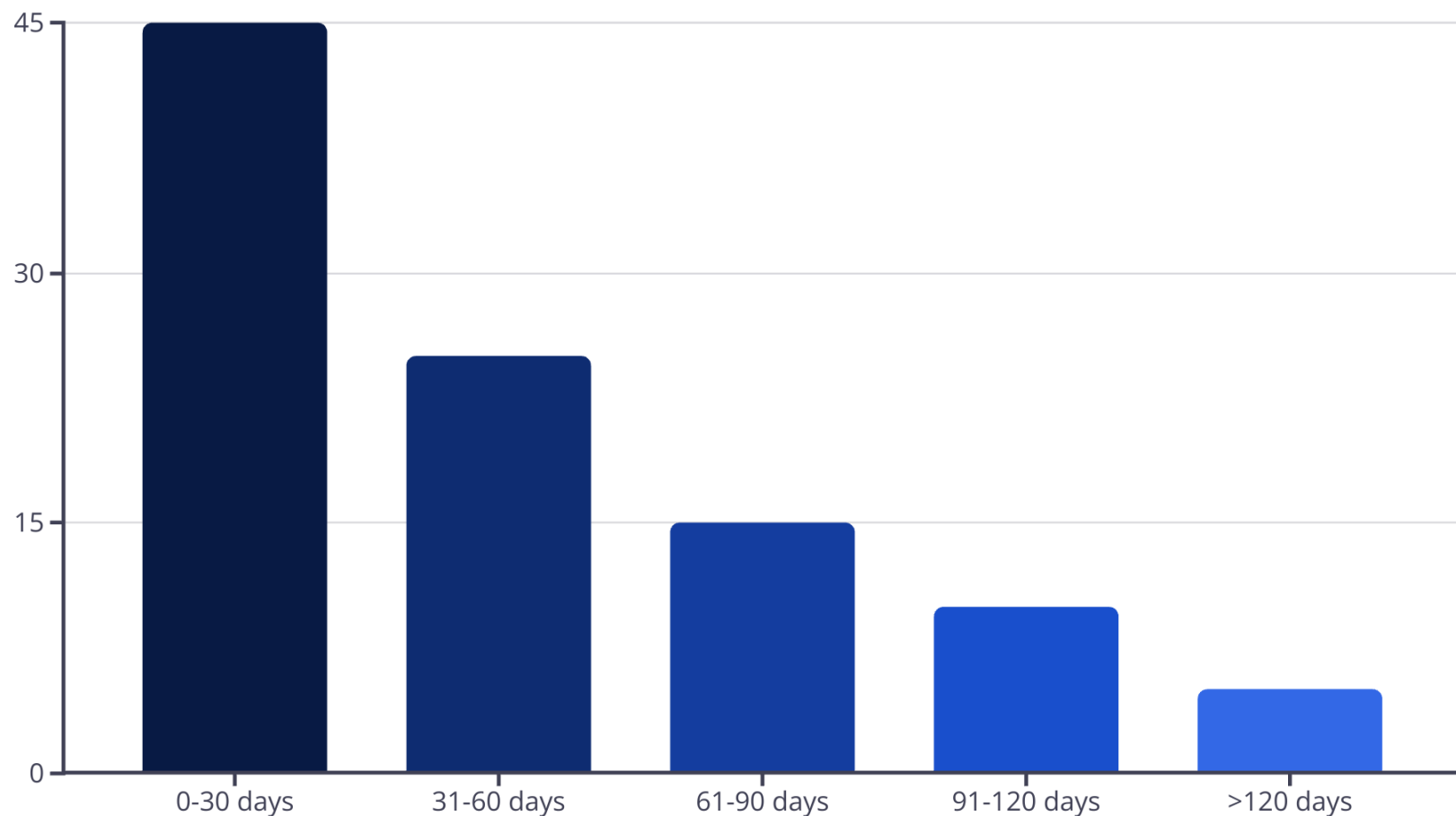
Alphabetical Assignments

Another common strategy is to assign accounts by alphabetical segments of the patient population, such as A–H, I–H, I–P, and Q–Z. This method diversifies exposure across multiple payers and patient types for each staff member, which can help with workflow balance.

Best Practices

Consider rotating assignments quarterly to support cross-training, reduce the risk of fraud, and encourage staff to review each other's work. Allocate dedicated time for AR tasks to ensure consistent and thorough follow-up.

Aging Accounts Receivable



Reports should be generated from the practice management system using DOS to ensure accurate tracking against filing deadlines.

Key Performance Indicators for Revenue Cycle

95%

Clean Claim Rate

Percentage of claims accepted on first submission

30

Days in AR

Average time to collect payment

98%

Net Collection Rate

Percentage of allowed charges collected

3%

Denial Rate

Percentage of claims denied by payers

