




MASTERING THE REVENUE CYCLE: CLEAN CLAIMS, BILLING EFFICIENCY, AND APPEALS

Trang Nguyen, BS HCM, CMRS
 Senior Account Manager, Gold Star Medical Business Service
 (866)942-5655

www.goldstarmedical.net; info@goldstarmedical.net

DISCLAIMER

This presentation is intended for educational and informational purposes only. While every effort has been made to ensure the accuracy of the information presented, healthcare regulations, payer policies, and reimbursement guidelines are subject to change and may vary by state, payer, and individual circumstances.

The information provided should not be construed as legal, regulatory, compliance, coding, billing, or financial advice and is not intended to replace official guidance, written policies, payer manuals, provider contracts, or consultation with qualified professionals.

Participants are responsible for verifying the applicability of any information discussed and for ensuring compliance with all federal, state, and local laws, regulations, and payer requirements.

The presenter is not acting as an attorney, accountant, or governmental representative. For legal or regulatory matters, attendees should consult appropriate professional advisors.

© Gold Star Medical Business Services. All rights reserved. Presentation materials may not be copied, reproduced, distributed, or shared without prior written permission.

SUCCESSFUL REVENUE CYCLE MANAGEMENT IS A TEAM EFFORT!

 <p>FRONT DESK CA NP Intake/Demographics COB VOB/IVR Prior Auth ABN's Collect Cost Share</p>	 <p>DOCTOR/CLINICIAN Establish Medical Necessity Provide Documentation to Support Claim Communicate with Staff when Pt is Released to Maintenance Care</p>	 <p>BILLING CA Check Coding File Claims Follow up Appeals/Denial Mgt. Balance Billing</p>	 <p>OFFICE MANAGER Manage Workflow Analyze Production and Collections Training and Support</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

WHY THIS MATTERS

- Rising denials industry-wide
- Rework is costly
- Many denials are avoidable
- Automation prevents and manages denials
- Distinguish claim rejections (pre-adjudication) vs. denials (after payer processing)

GOAL: Touch a Claim Once!



AUTOMATION ACROSS THE REVENUE CYCLE

- FRONT-END: VERIFICATION OF ELIGIBILITY & BENEFITS, AUTHORIZATION TRACKING (ASH – MNR & UHC – PSF)
- MID-CYCLE: CODING EDITS, SCRUBBING
- BACK-END: CLAIM STATUS, APPEALS, ERA/EFT
- GOAL: CLEANER CLAIMS, FASTER REMIT

AUTOMATION BUILDING BLOCKS

- ❖ ELIGIBILITY & COVERAGE DETECTION
- ❖ CLAIM EDITS/CLEAN CLAIM RATE RULES
- ❖ ELECTRONIC ATTACHMENTS
- ❖ CLAIM STATUS MONITORING
- ❖ APPEAL KITS

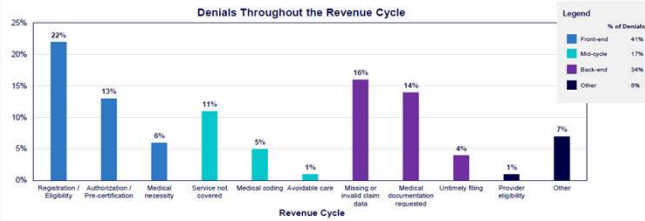
COMMON SOURCES OF DENIALS

- Front-End Demographic Errors
- Medical Necessity & Prior Authorization
- Missing or Incorrect Modifiers
- Same-Day Re-Exams
- Out-of-Scope Procedure Codes

DENIAL DISTRIBUTION CHART

Understanding the distribution of denials is critical to working and preventing denials

Almost half of healthcare providers allocate most of their funds to back-end resolutions, although front-end denials make up 41% (most) of all denials¹.




© 2024 Cognizant | Private | Cognizant Denial Data Analysis | Source: <https://www.cognizant.com/resources/finding-the-formula-for-effective-denials-management>

CLEAN CLAIM RATE (CCR)

Monitor daily rejections	Fix edit rules
Tie edits to denial codes	Target CCR ≥ 95%

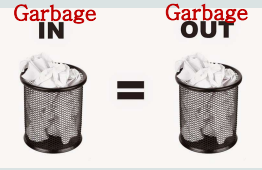
Source: Change Healthcare Denials Index (2022); HFMA Revenue Cycle Benchmarks



FRONT-END FIRST

- 41% of denials start upfront
- Eligibility verification
- Authorization requirement inquiry
- Don't bill yet, flags

Garbage IN = Garbage OUT




The Photo by Unknown Author is licensed under CC BY-SA/NC

Examples:


- Wrong DOB
- Wrong member ID
- Missing authorization
- Wrong provider
- Missing modifier

Source: https://bit.ly/postclickmarketing.com/Global/FileLib/HLM/2022-revenue-cycle-denials-index.pdf?utm_source=chatgpt.com

THE COST OF ONE ERROR



One Preventable Error Can Create 6+ Additional Touches Before Payment is Received



Verify patient insurance coverage

Prevent Denials

- Eligibility and benefits verification

ELIGIBILITY & COVERAGE DETECTION

- REAL-TIME ELIGIBILITY
- COVERAGE DISCOVERY ([OFFICE ALLY](#), [INSURANCE DISCOVERY FC](#), [TRIZETTO](#), [ELIGIBILITY VERIFICATION](#), [TEBRA](#), [INSURANCE ELIGIBILITY SOLUTION](#), [WAYSTAR COVERAGE DETECTION SOLUTION](#))
- PREVENTS 'PATIENT NOT COVERED' DENIALS

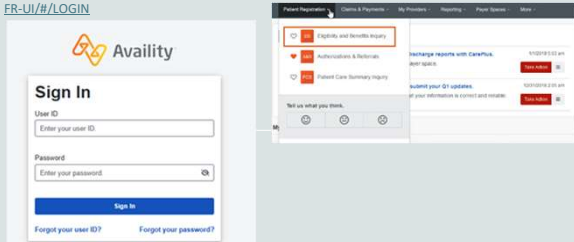
WHERE CAN ELIGIBILITY & BENEFITS BE VERIFIED

Tool	Best Use
ASHLINK	Commercial payer eligibility & benefits
Availity	Commercial payer eligibility & benefits
Medicare MAC Portal	Traditional Medicare Eligibility
Medicaid Portal (AHCCCS)	Medicaid Eligibility
Payer-specific portals	Eligibility & benefits
UHC Provider Portal	UHC Commercial & Medicare Advantage
PM Software	Eligibility & Benefits

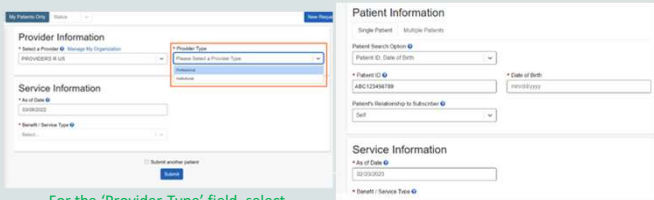
ELIGIBILITY & BENEFITS VERIFICATION

AVAILITY – MOST COMMERCIAL PAYERS

[HTTPS://ESSENTIALS.AVAILITY.COM/STATIC/PUBLIC/ONB/ONBOARDING-UI-APPS/AVAILITY-ER-UI/#/LOGIN](https://essentials.availity.com/static/public/onb/onboarding-ui-apps/availity-er-ui/#/LOGIN)



ELIGIBILITY & BENEFITS VERIFICATION



For the 'Provider Type' field, select Professional — this is the correct option for chiropractic specialty.



ELECTRONIC ATTACHMENTS

- SEND DOCS UPFRONT
- USE UNSOLICITED ATTACHMENTS
- PREVENT STALLS

AUTOMATED CLAIM STATUS

- > PREDICTIVE TIMING
- > ROBOTIC PROCESS AUTOMATION (RPA)/ELECTRONIC DATA INTERCHANGE (EDI) FIRST
- > STANDARDIZED DISPOSITIONS
- > REDUCE MANUAL STATUS CALLS



DENIAL MANAGEMENT



What is denial management is a complex process that differs from claim to claim depending on the patient, payer, and procedure. Some of the most common claim denials are:

- ✓ Demographic Denials
- ✓ Coding Denials
- ✓ Benefit Denials
- ✓ Back-End Billing Denials

When claims are denied or improperly adjudicated...

- Action is MANDATORY
- Must be TIMELY
- Must be Based on Complete understanding of the reason for the denial/improper payment
- Investigation/Appeal must be Documented

INVESTIGATION PROTOCOL

1. Check your PM Software. Did the claim(s) "leave the building"
2. Check your clearinghouse. Is the claim there? Did it get forwarded to the payer?
3. Check for Payer response reports at Clearinghouse. Was the claim accepted?
4. Check clearinghouse for unposted/un-downloaded ERA's
5. Review claim status in the payer portal and take appropriate action based on your findings.

The same payer portals used for eligibility and benefits verification can also be used to research claim status, denials, payment activity, and, in some cases, submit corrected claims.

PHONE CALLS?

- ❖ Phone calls to check claim status should be a **last resort**, even if the payer has IVR capabilities
- ❖ Calls should be made only if:
 - Everything appears to be correctly filed, processed, but no claim on file in system
 - Claim status cannot be determined online (just states 'pending')
 - EOB does not clearly explain the reason for non-payment or denial
- ❖ A Phone call is appropriate if you:
 - Have to appeal a claim and don't know the steps
 - Have to "escalate" the claim to a higher department than customer service

CALLING THE INSURANCE COMPANY

Get Organized!

- Multiple claims investigations in one call
- Different patients, same carrier
- Same patient, multiple DOS
- WHEN are you going to do this?
- Allocate certain hours each week to do NOTHING but calls.
- Uninterrupted time
- Do not disturb!

Insurance Call Documentation Checklist

- ✓ AR Report
- ✓ Clearinghouse Reports
- ✓ EOBs
- ✓ Reference Numbers
- ✓ Follow-Up Dates
- ✓ Next Steps

DOCUMENTING YOUR WORK

Transparency is of UTMOST importance!

❖ *Handwritten notes on the margins of an AR report are not acceptable. You should be working off a new AR report every month.*

❖ *Have a place (in the software, or on a spreadsheet) where you document your activities. Let your provider/Office Manager know where these notes are.*

❖ **DOCUMENT:**

- Denials – Why and what you have done to correct.
- Follow ups to follow ups – if you rebill a claim, task a follow up in 10 days

If You Speak to Someone

- ❖ Record the day/time of call (and length)
- ❖ Who did you speak to?
- ❖ What did they tell you to do to remedy the situation?
- ❖ Find out the Timely Appeal window
- ❖ Get a REFERENCE NUMBER
- ❖ Follow up note when you have taken recommended action.

RISK MANGEMENT

If AR is out of control, it's important to identify the primary culprits and fix the problems so they don't continue to compound

- ❖ *Insurance: What are the top reasons for claims rejections/ denials?*
 - Incorrect/Inaccurate/Missing demographics
 - Incorrect/Improper CPT, Dx coding, missing/misused modifiers
 - Failure to follow LCD, Medical Policy guidelines
 - Insufficient documentation to support a claim (retrospective denials and recoupments)
- ❖ *Patient: What are the top reasons why there are high patient balances?*
 - Improper or no verification of benefits
 - Lack of good OTC collection protocols
 - Never send or sporadically send statements
 - Too many "deals" with patients, too hard to track
 - Prepays – balances "left over" are not being written off

OFFICE MANAGEMENT OVERSIGHT

- Daily: Run day sheets, make sure checks and balances are done
- Weekly: Make sure billing has been done, and all issues in clearinghouse have been resolved
- Weekly: Make sure patient accounts, including insurance demographics, dx codes, etc are current
- Weekly: Go to clearinghouse and carrier websites to pull all EOB's delivered electronically
- Weekly: Print/View Unpaid claims reports, look for claims that should have been paid by now
- Monthly: Print AR each month and look for claims with NO activity that have aged over 30 days.

UNDERSTANDING DENIAL CODES

- CARC = Why the claim adjusted
- RARC = Additional explanation

DENIAL MANAGEMENT

Coding Denials – Coding claims can be challenging, medical coders and biller must understand the procedures, their corresponding procedures and any modifying factors.

Denials can occur when modifiers are misused, or when a diagnosis are inconsistent with procedures, Medicare Patient's MBI # or Name Change,

- For example, chiropractic CPT codes 98940–98942 require the AT modifier on Medicare claims to show the treatment is active and medically necessary, not maintenance care.
- A denial may result from submitting a claim with an MBI# that had been changed

CO-50: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

PR-50: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

CO-16: Claim/service lacks information or has submission/billing error(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

N372 Only reasonable and necessary maintenance/service charges are covered.

M38: Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.

N382 : Missing/incomplete/invalid patient identifier.

DENIAL MANAGEMENT

CARC/RARC	Description
CO-16	CO-16: Claim/service lacks information or has submission/billing error(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N382	N382 : Missing/incomplete/invalid patient identifier.

Common Reasons for Message

- **Invalid or missing patient identifier:** This is the core issue indicated by RARC N382. It means the patient's Medicare Beneficiary Identifier (MBI) number was incorrect, incomplete, or not submitted at all.
- **Mismatched patient information:** The beneficiary's name and Medicare number do not match the payer's records. A simple typo can trigger this denial.
- **Recently changed MBI:** The patient may have reported their Medicare card lost or stolen, which triggers the issuance of a new MBI. You may have billed with the old, now-invalid, MBI.

Next Step

1. Verify Patient Information: Double-check the patient's name and identifier against their Medicare card or other valid identification.
2. Correct Errors: Correct any typos or missing information in the patient identifier fields on the claim.
3. Resubmit the Claim: Resubmit the corrected claim to the payer for processing.

How to Avoid Future Denials

- > Always confirm the patient's insurance eligibility, including their MBI, at the time of service. This prevents billing with outdated information.
- > Make copies of Medicare cards: Keep a copy of the patient's most current Medicare card on file. If the MBI changes, you will have the correct information for future claims.
- > Communicate with the patient: If you suspect an issue, contact the patient to confirm their current insurance information. If their Medicare card is lost or stolen, remind them to inform the Social Security Administration (SSA) to correct the record.

Common Denials Every Office Should Recognize

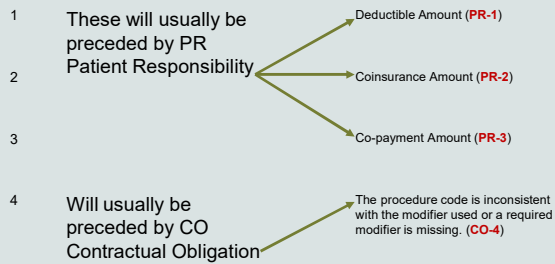
- CO-16
- CO-4
- CO-11
- OA-18
- OA-22
- CO-29
- MA130

COMMON CARC CODES

Claim Adjustments Group Codes – attached in front of a CARC code to indicate responsibility

CO	Contractual Obligation
CR	Corrections and Reversal
OA	Other Adjustment
PI	Payer Initiated Reductions
PR	Patient Responsibility

CARC EXAMPLES



CARC EXAMPLES

11		The diagnosis is inconsistent with the procedure.
16	Most common rejection. CO-16. Claim has not been processed!	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
18		Exact duplicate claim/service (OA-18)
22	Usually preceded by OA Other Adjustments	This care may be covered by another payer per coordination of benefits (OA-22)
27		Expenses incurred after coverage terminated.
29		The time limit for filing has expired.
31		Patient cannot be identified as our insured

RARC EXAMPLES

M14		No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M15		Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M86		Service denied because payment already made for same/similar procedure within set time frame.
MA130	Usually accompanies a CO-16	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information

ONLINE CLAIM CORRECTIONS

Online claim correction via clearinghouses such as ClaimMD, Infinedi, PracticeMate and TriZetto generally allows healthcare providers to identify, edit, and resubmit claims with errors directly through their web portals, improving efficiency and reducing denial rates.

ONLINE CLAIM CORRECTIONS

- ClaimMD provides a user-friendly workflow for correcting and resubmitting both professional and institutional claims. Providers can search for the claim in their portal, use designated fields like Box 22 (for professional claims) or Type of Bill (TOB) for institutional claims, mark the claim as corrected, and enter the original claim number or document control number. Optional features allow a brief explanation of the correction, and all changes are tracked within the platform. Medicare does not accept electronic corrections, so its appeals process must be used instead.
- Infinedi's online editing tools allow providers to access claims needing corrections, view error messages, and fix errors directly within an interactive claim editor. The system provides "Add Info Wizard" tools for enhanced data entry and requires that the correction process include updating the claim frequency code (e.g., 7 for replacement or 8 for void) and entering the original claim number. Once corrections are made, claims can be resubmitted electronically to payers.
- TriZetto offers advanced claim editing features that use AI and predictive algorithms to highlight errors and potential denials before claims are submitted, enabling proactive correction. Claims flagged for errors are detailed with specific explanations, which providers can address in the portal before resubmitting. The "Online Claims Correction (OLCC)" module allows real-time corrections, and edits can be made to all key claim fields before resubmission. TriZetto's processes are designed to improve first-pass claim acceptance rates and minimize denials.

ONLINE CLAIM CORRECTIONS

Practice Mate (by Office Ally) provides an integrated workflow for online claim correction, allowing practices to quickly locate repairable claims, make edits, and resubmit them through the clearinghouse portal for faster resolution.

- ❖ *Claim Correction in Practice Mate*
- ❖ *Automated Error Checks and Clearinghouse Workflow*
- ❖ *Integration and Benefits*

Practices using Practice Mate can efficiently resolve claim errors online, minimize resubmissions, and improve their financial outcomes by leveraging these integrated clearinghouse tools.

USING NORIDIAN TIMELY FILING CALCULATOR

https://med.noridianmedicare.com/web/jfb/topics/claim-submission/timely-filing

Practical Appeal Strategies That Produce Results



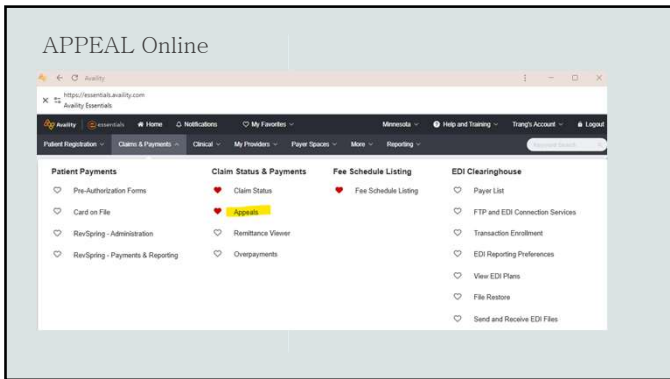
1. Examine the EOB
2. Determine next steps
3. Check timely appeal windows
4. Notify the patient
5. Document everything
6. Task a follow-up
7. Document the outcome
8. Engage the patient

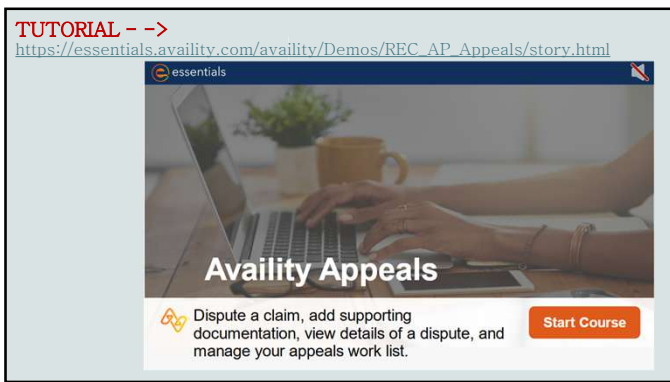
APPEAL Telephone Reopenings

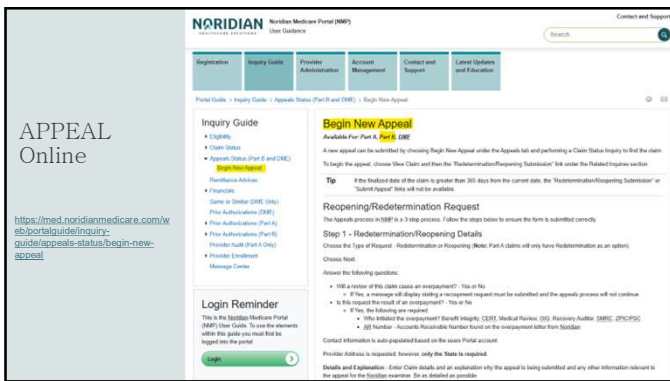
- * In some cases, insurance companies will reprocess claims with a TELEPHONE REOPENING
- * Simple Denials – Missing/Incorrect Modifiers, dx code order errors, etc.

APPEAL Online

- ❖ MOST insurance companies have PROVIDER Portals.
 - Verification/Eligibility
 - Claim Submission
 - Claim Status
 - Appeals/Redetermination
 - ✓ Allows you to rebill/submit corrected claim
 - ✓ Upload provider notes directly through the portal







Utilize Powerful Appeal Letters

Your letter must include:

- > Your identification and the patient's information.
- > The exact reason for the denial provided by the carrier.
- > The corrected information or proof of prior payment history.
- > A clear explanation of why you believe their decision violates standard medical policy.
- > What specific action you are asking the insurance company to take.

Appeals

1. When submitting a letter, include all the information that is requested on forms provided by the insurance carrier.
2. A copy of the original claim and explanation of benefits (EOB), or initial adverse decision letter, if applicable.
3. Any documentation supporting your appeal.
4. Send the appeal by certified or registered mail to ensure it is received by the payer.

EXAMPLE OF APPEAL LETTER

- Send to payer with appropriate documentation
- Send copy of appeal letter to the patient

TYPE ON YOUR LETTERHEAD

-Date-
 -Insurance Company Name-
 -Insurance Company Address-
 -Insurance Company City, State, Zip-
 Name of Patient _____
 Policy Number _____
 EOB Reference number _____

Dear Sir/Madam:

We received notice from your company that benefits for -type of service, ie: Medical, Physical Therapy- services at _____ (name of doctor/clinic), have been denied because the services in question are "not medically necessary" or have been handled "over denied coordination- Please see attached Explanation of Benefits. The dates of service were for _____ (date(s) in the amount) of _____ CPT code(s) billed were _____ (include modifiers, if present), and primary ICD9 Diagnosis code were _____.

These benefits are in coordination with prior claims that were paid based on the exact same billing process. In other words, nothing has changed in the way our office has been billing these claims, yet they are all of a sudden being denied. Upon re-eligibility in to your company's Medical Policy Guidelines, there is no published guideline that prohibits these service authorizations from being billed as they have been. There are no NCCI edits that prohibit these codes from being billed individually, and there is no bundling rule applicable to these codes.

We are writing to let you know that we disagree with your determination. Please find attached comparison documentation to prove that these services are medically necessary, and should be paid/processed as they have been in the past.

Should you uphold your determination after review of documentation, we request a written DETAILED explanation from your company as to why these services were denied, and the name and title/position of the person(s) who made this determination. We also request that you send us the official Medical Policy Guidelines for billing claims to your service and CPT codes that you cannot provide this information, we will request immediate payment for these services in question. If we do not pay for these services, we will send the letter, along with all supporting documents to the patient and the State Insurance Commission of _____ (name of state) for further investigation. We will expect to hear from you within 30 days of the date of this letter. We are also requesting that you send a copy of your explanation to the patient at (address).

Yours truly,

MEDICARE APPEALS PROCESS

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions. There are five levels in the Medicare Part A and Part B appeals process. The levels are:

First Level of Appeal	Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC)
Second Level of Appeal	Reconsideration by a Qualified Independent Contractor (QIC)
Third Level of Appeal	Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
Fourth Level of Appeal	Review by the Medicare Appeals Council
Fifth Level of Appeal	Judicial Review in Federal District Court

REBILLING / CORRECTED CLAIMS

- If you have a claim that comes back processed and denied, and it is correctable/appealable, DO NOT just correct and rebill. Will come back denied as a duplicate claim. Exception, CO-16 REJECTIONS were never processed, can be rebilled
 - *Verify with the payer what the procedure is for a corrected bill*
 - *Remember that each payer may have their own rules. Don't assume you can correct claims the same way for every payer.*
 - *Paper Corrected Claims – type CORRECTED CLAIM in Box 19*
 - *Electronic Corrected Claims – “7” in box 22 with original EOB/Claim #*
 - *Voided Claim – “8” in Box 22 with original EOB/Claim #*

Follow-Up System

- **Daily:** Check tasks for follow up calls and/or activities that are due. Leave task open for follow up on the next working day
- **Weekly:** Make sure billing has been done, and all issues in clearinghouse have been resolved
- **Weekly:** Make sure patient accounts, including insurance demographics, dx codes, etc. are current
- **Weekly:** Go to clearinghouse and carrier websites to pull all EOB's delivered electronically, post EOB's promptly
- **Weekly:** Print/View Unpaid claims reports, look for claims that should have been paid by now
- **Monthly:** Print AR each month and look for claims with NO activity that have aged over 45 days.

INSURANCE
COMPANY
COMPLIANCE

Insurance Companies have rules and regulations that they must follow

- *Prompt Pay Laws*
- *Provider Contracts*
- *Medicare Regulations*
- *ERISA Plans – Commercial Payers who process GROUP HEALTH claims.*

The “ERISA” Trump Card for Commercial Claims

If you are dealing with an employer-sponsored health plan, it is likely governed by the Employee Retirement Income Security Act (ERISA). If that is the case you will want to:

- ◊ Always compare the payer's determination against the patient's Summary Plan Description (SPD).
- ◊ If the payer's internal rules (e.g., giving you only 90 days for timely filing) conflict with the SPD (which may allow 1 year), **ERISA wins**.
- ◊ Send ERISA appeals directly to the Plan Administrator (usually the CEO of the patient's company), and copy the Department of Labor to encourage compliance review.

ARIZONA PROMPT PAY REQUIREMENTS

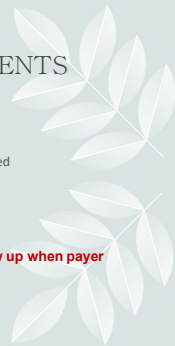
Clean Claims Matter

- ◆ Electronic clean claims generally must be adjudicated within **30 days**
- ◆ Paper clean claims generally must be adjudicated within **45 days**
- ◆ Health plans must notify providers when additional information is needed
- ◆ Delayed payments may be subject to statutory interest requirements
- ◆ Incomplete or inaccurate claims can delay processing

Revenue Cycle Takeaway:

Track claim submission dates, monitor aging claims, and follow up when payer processing exceeds required timeframes.

Reference: <https://www.azleg.gov/ars/20/03102.htm>



Actionable Tools for Revenue Recovery

Attendees can implement these tools immediately to protect their bottom line:

1. Determine priority claims by separating them into categories (e.g., highest volume or monetary amount).
2. Work the trends by tracking payer appeal processes and finding automated ways to group repeated errors.
3. Report on issues using visual denial opportunity reports.
4. Plan for the future by documenting upstream processes to permanently prevent recurring bottlenecks.

Establish “Claim Scrubbing” Checklists

Before claims leave the building, billers should review a pre-billing report. Check for missing patient info, incorrect CPT/ICD-10 codes, missing modifiers, and verify that the primary diagnosis code matches the procedure.

Use AI and Automation Technology

Implement automated claim scrubbers which cross-reference thousands of payer rules in real-time, catching errors pre-submission and potentially reducing days in accounts receivable by 15% and denial rates by 30%.

Adopt the Medicare Advance Beneficiary Notice (ABN)

When performing maintenance care or providing services that Medicare covers only under specific conditions, protect your revenue by having the patient sign an ABN (Form CMS-R-131). When properly executed, an ABN may allow financial responsibility to transfer to the patient if Medicare denies the service as non-covered.

Appeal Tools & Resources



CLAIM MD APPEAL MANAGER

A built-in workflow assistant for denials that automates the appeal process:

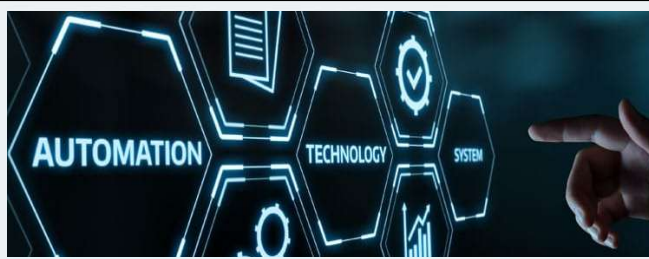
- ❖ **Information Gathering** – Pulls in denial data, payer requirements, and patient/claim details automatically.
- ❖ **Pre-populated Letters** – Generates payer-specific appeal letters to save time and reduce errors.
- ❖ **Printing & Mailing** – Handles logistics so you can move from “denial received” to “appeal mailed” quickly.

★ In short: Appeal Manager streamlines the entire appeal cycle—reducing administrative burden, minimizing mistakes, and speeding up claim overturns.

CONCLUSION



- ❖ Automation is not about replacing billers – it's about empowering them with smarter tools.
- ❖ Cleaner claims = fewer denials = faster payments.
- ❖ Denial management starts before the claim is even submitted.
- ❖ Every prevented denial saves time, money, and stress.
- ❖ The ultimate goal: more efficiency for your office, more focus on patient care.



This Photo by Unknown Author is licensed under CC BY-NC-ND

Q & A

We are here
to Help!



GOLD STAR
Medical Business Services

"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"

- ❖ **Billing Company** - Billing Services
- ❖ **Credentialing** - Provider Enrollment Services
- ❖ **Compliance** - Consulting/Chart Audit/Compliance Manuals
- ❖ **Staff Training** - Staff Education
- ❖ **Gold Star Academy** – Video Base Training Platform
- ❖ **Practice Management** – Practice Coaching Services



HOW TO REACH US

- ◇ Schedule a Complimentary Consultation
 - Self Service Tool: <https://calendly.com/lmaciejewski/consult>
 - Call our Executive Office at (830)613-8325 or Corporate Office at (866)942-5655
- ◇ <https://www.goldstarmedical.net/contact-us>
- ◇ Website: <https://goldstarmedical.net>
- ◇ Facebook: <https://facebook.com/goldstarmedical>

References:

1. <https://med.noridianmedicare.com/web/portalguide/inquiry-guide/eligibility>
2. <https://ao.azahcccs.gov/HelpManuals.aspx>
3. [https://www.azahcccs.gov/commercial/Downloads/FFS Technical Assistance/OnlineClaimSubmissionManual/Section3.pdf](https://www.azahcccs.gov/commercial/Downloads/FFS%20Technical%20Assistance/OnlineClaimSubmissionManual/Section3.pdf)
4. <https://ao.azahcccs.gov/Help/Learn/More.aspx>
5. <https://med.noridianmedicare.com/web/eb/topics/claim-submission/denial-resolution>
