

Medical Billing Mastery Course

Wealth Horizons Academy | \$297

THE COMPLETE GUIDE TO MEDICAL BILLING EXCELLENCE

Medical billing is the financial backbone of healthcare. Accurate, efficient billing protects patient care by ensuring healthcare providers receive proper reimbursement. This course builds the foundational knowledge and practical skills for excellence in medical billing.

MODULE 1: THE MEDICAL BILLING ECOSYSTEM

Understanding the Healthcare Reimbursement System

The Billing Cycle: 1. Patient registration and insurance verification 2. Encounter documentation by provider 3. Medical coding (ICD-10, CPT, HCPCS) 4. Charge capture and claim creation 5. Claim submission to payer 6. Payment posting 7. Denial management and appeals 8. Patient billing and collections 9. Reporting and analysis

Key Players in Medical Billing

- **Provider:** Physician, hospital, or other healthcare entity
- **Patient:** Recipient of services
- **Payer:** Insurance company, Medicare, Medicaid
- **Clearinghouse:** Electronic intermediary that processes claims
- **Billing Specialist:** The professional managing the entire cycle

MODULE 2: INSURANCE TYPES AND VERIFICATION

Understanding Insurance Plans

Commercial Insurance: - HMO (Health Maintenance Organization): Requires primary care physician referrals - PPO (Preferred Provider

Organization): More flexibility in provider selection - EPO (Exclusive Provider Organization): No referrals but network-only coverage - HDHP (High Deductible Health Plan): Lower premiums, higher deductibles

Government Programs: - Medicare: Federal program for 65+ and certain disabilities - Medicaid: State/federal program for low-income individuals - Tricare: Military personnel and dependents - Workers' Compensation: Work-related injuries

Insurance Verification Checklist

Before every appointment, verify: - ☐ Insurance card (front and back copy) - ☐ Policy holder name and relationship to patient - ☐ Policy and group numbers - ☐ Effective dates of coverage - ☐ Deductible amount and amount met - ☐ Copay and coinsurance requirements - ☐ Pre-authorization requirements - ☐ Network participation status

MODULE 3: MEDICAL CODING FUNDAMENTALS

ICD-10-CM (Diagnosis Codes)

ICD-10-CM codes describe why a patient was seen.

Code Structure: A00.0 - Letter: Category (A = Infectious diseases) - Two digits: Specific condition - Decimal: Greater specificity

Coding Principles: - Code to the highest level of specificity - Code the principal diagnosis first - Sequence additional diagnoses in order of significance - Use "unspecified" only when documentation is insufficient

CPT Codes (Procedure Codes)

CPT codes describe what was done for the patient.

Major Categories: - 99000 series: Evaluation and Management (office visits) - 10000-19999: Integumentary/surgery - 20000-29999: Musculoskeletal - 30000-39999: Respiratory - 70000-79999: Radiology - 80000-89999: Pathology/Lab - 90000-99999: Medicine/E&M

E&M (Evaluation and Management) Coding

E&M codes are the most frequently used and most frequently audited codes.

Key Factors in E&M Selection: - Medical decision making (primary) - Total time spent with patient - Level of history and examination - Documentation requirements

MODULE 4: CLAIMS SUBMISSION

Clean Claim Requirements

A clean claim is one that can be processed without requesting additional information.

Required Elements: - Patient demographic information - Insurance information - Provider NPI number - Place of service code - Date of service - Diagnosis codes (ICD-10) - Procedure codes (CPT/HCPCS) - Charges for each service - Rendering provider information

Electronic vs Paper Claims

- Electronic claims: 95% of all claims submitted electronically (EDI 837)
- Paper claims: CMS-1500 form for professional services, UB-04 for facility

Electronic claims process faster (average 14 days vs 30 days for paper) and have lower error rates.

MODULE 5: DENIAL MANAGEMENT

Top 10 Denial Reasons

1. Missing or invalid patient information
2. Non-covered service
3. Authorization/referral required
4. Timely filing deadline exceeded
5. Duplicate claim
6. Coordination of benefits (COB) issue
7. Incorrect or invalid diagnosis code
8. Missing or invalid NPI
9. Service not medically necessary
10. Claim submitted to wrong payer

The Appeal Process

1. Review the denial explanation (ERA/EOB)
2. Identify the specific denial reason
3. Gather supporting documentation
4. Write a compelling appeal letter
5. Submit within the payer's appeal timeframe
6. Track appeal status and follow up
7. Escalate to Level 2 appeal if necessary

Golden Rule: Appeal every denial. The healthcare system is designed to deny first. Persistence pays.

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