



Welcome to the Step by Step: Initiating and/or Enhancing Billable Services Module 4: Revenue Cycle Quality Assurance

RR Health Strategies

- Pam D'Apuzzo, CPC, ACS-EM, ACS-MS, CPMA
- Jean Davino, DHA, MS, CLT

Jean – this slide is your opportunity to tell the audience about yourself, your qualifications, and RR Health Strategies.

Learning Objectives

- Describe billable services and providers
- Discuss carrier contracting
- Describe provider credentialing
- Explore IT (information technology) infrastructure
- Discuss general billing considerations

- Appropriate service options
- Carrier contracting options
- Provider credentialing initiation and tracking
- Essentials of an IT infrastructure
- Staffing the billing department, clearinghouse, electronic fund transfer and lock box

Services and Providers

Services and Providers

Select the type of services to be provided at the Practice/Clinic.

Medical Services:

- Outpatient/Ambulatory Health Services (general medicine, specialty care such as neurology, OBGYN, dermatology)
- Mental Health Services (including Behavioral)
- Home and Community-Based Health Services (physical medicine and rehabilitation)
- Substance Abuse Outpatient Care

- Services and CPT codes are selected based upon specialty
- CPT code description provides information on who can provide service (MD, NPP, etc.) and location of services (Office, ASC, etc.)

Services and Providers

Expanded services to enhance quality and access to care:

- Preventive Services - (Outpatient/Ambulatory Health Services)
- Diabetes Education (Health Education/Risk Reduction or Medical Nutrition Therapy)
- Vaccines (Outpatient/Ambulatory Health Services)
- Telehealth
- Home Health Care
- Laboratory Testing- (Outpatient/Ambulatory Health Services)
- Medical Nutrition Therapy

-Expand the availability of health care services to cover a variety of patients – such as the underserved, disadvantaged, geographically isolated, and special needs populations.

Services and Providers

Select the provider type(s) to render services at your Practice/Clinic.

Provider Types:

- Physician (MD, DO)
- NPP (non-physician practitioners)
 - PA, NP, Chiropractor, Acupuncturist
- Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, Substance Abuse Counselor
- Nutritionists, Registered Dieticians
- Diabetic Counselors

- Selecting the types of services to be provided at the practice/clinic will determine the required type of licensed professionals needed to render those services
- Each State has specific professional licensure guidelines, as well as billing guidelines

Services and Providers

Licensing and Scope of Practice

- Individual states have a Department of Education and Licensing (Office of the Professions)
- The scope of practice for each provider type describes the procedures, actions, and processes that the practitioner is permitted to undertake in keeping with the terms of their professional license
- The practitioner's scope of practice is limited to that which **the law** allows for their specific education and experience, and demonstrated competency

- Understand the scope of practice for each provider type
- The scope of practice is limited to that which the law allows for specific education and experience and demonstrated competency

Carrier Contracting

Carrier Contracting

Key Definitions

- **Health Maintenance Organization (HMO)** HMOs offer comprehensive coverage for both hospital and physician services. They may contract for either capitated or fee-for service reimbursements. Typically, HMO patients have restricted (or no) access to out-of-network services, and may require primary care physicians to act as “gatekeepers” of medically necessary care (referrals).
- **Preferred Provider Organization (PPO)** PPOs offer patient benefits at a reasonable cost by providing incentives to use in-network providers. These incentives can be lower deductibles and copays. Physician reimbursement is usually fee-for-service. Patients who wish to access physicians outside the network usually may do so at a higher out of pocket expense.
- **Point of Service (POS)** A point-of-service plan is a type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services.

- Elaborate on the different types of current healthcare carrier models
- - Describe the differences between the types of plans allowing for a better understanding of how a plan affects office operations, (authorizations), carrier contracting, finances (deductibles) and other important factors

Carrier Contracting

Key Definitions

- **Medicare/Medicaid** These programs have traditional delivery systems and also managed care models in some areas. The managed care products are contracted through various managed care organizations and may require additional contracts and credentialing.
- **Managed Care Organization (MCO)** An organization that combines the functions of health insurance, delivery of care, and administration. Examples include the independent practice association (IPA), third-party administrator, management service organization, and physician-hospital organization.

- Elaborate on the different types of Medicare/Medicaid plans
- Explain the federal government's incentive towards enrolling eligible beneficiaries in managed care programs

Carrier Contracting

The following factors should be considered when determining carrier participation:

- Patient population
- Medicare and Medicaid Local Carriers
- Existing contracted carriers and payor mix (if an established practice/clinic)
- Carrier reimbursement rates
- Covered plan benefits

- Discuss the factors that have an effect on carrier participation, such as:
- Patient population (age, economic situation)
 - Self-pay patients, financial hardships
 - Plan benefits (annual wellness visits, immunizations, laboratory and radiology)
 - Financial considerations such as deductible, copays, coinsurance.

Carrier Contracting

- Research Carriers in your area. Consider the following:
 - Market share
 - Do they have group contracts and are these agreements with large or small employers?
 - Proximity of other participating providers, including specialists to whom you may refer
 - Local in-network hospitals
- Contact the Provider Relations Department
 - Inquire how applications are handled (paper, electronic, Council for Affordable Quality Healthcare - CAQH)
 - Request a copy of the plan's fee schedule
- Review your local Medicare Administrative Contractor (MAC) covered services and fee schedule(s)
- Research regional Managed Care Plans and fee schedules
- Research regional Local and Union Plans and fee schedules
- Research regional ACO (Accountable Care Organizations)/IPAs

- Discuss how best to determine which carriers work best for each individual practice/clinic
- Evaluate the patient population the practice/clinic serves

Carrier Contracting

Important Tips:

- Compile a list of the practice/clinic's billing CPT codes in order to review and compare carrier fee schedules
- Compare your local MAC's fee schedule(s) to the commercial/managed care fee schedules
- Confirm coverage for any highly specialized services performed
- If your practice/clinic is providing a highly specialized service not readily offered by other providers in your area, be sure to advise the carrier during your contract negotiations
- Obtain data from your billing system and review payment history by:
 - (1) Carrier
 - (2) CPT-4 procedure code
- Develop a carrier grid by plan and CPT code to review and compare reimbursement rates for the various plans
- Review and compare existing contracts to identify variances in reimbursement rates and determine which contract terms may need to be reevaluated

-Review tips and best practices to initiate carrier contracting process

Carrier Contracting

The following standards should be clearly listed in the managed care contract:

- Covered Services:
 - Confirm that all services provided by the practice/clinic are considered a covered benefit
- Medically Necessary:
 - Confirm the list of services and exclusions from coverage
- Reimbursement guidelines must be clearly outlined
- The carrier fee schedule should be attached to the contract as an Exhibit or Addendum
- Termination clause:
 - The practice/clinic and provider rights, as well as the MCO's guidelines for contract termination should be clearly noted
- All relevant documents referenced in the contract, but not immediately available, must be requested for review and approval prior to contract execution

- Review standard terms and guidelines for managed care contracting

Carrier Contracting

Accountable Care Organizations (ACO)

- The Federal Government, in an effort to improve outcomes and keep down costs, has proposed a value-based payment form of reimbursement as an alternative and potential replacement for fee-for-service reimbursement
- Value-based care is a form of reimbursement that connects payments for delivery of care to the quality of care provided and rewards providers for both efficiency and effectiveness
- The traditional fee-for-service reimbursement model was based upon quantity of services
- An ACO is a group of healthcare providers who voluntarily come together to coordinate healthcare services and engage in value-based payment models

- Review the possibility/consideration of ACO participation
- Review the benefits of joining an ACO, keeping in mind the future value-based care model

Carrier Contracting

Accountable Care Organizations (ACO)

CMS designed the program to help providers ensure that patients receive the most appropriate care at the right time. ACOs also aim to prevent unnecessary and redundant services while reducing medical errors

- Providers who participate in ACOs are still paid on a fee-for-service basis, but the programs create an incentive to be more efficient by offering bonuses when providers keep costs down. Doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases. Providers get paid more for keeping their patients healthy and out of the hospital
- On the other hand, providers in most ACOs must assume some financial risk for joining. While the potential of savings could be great depending on the agreement, there is also a potential for shared losses. Providers may have to repay Medicare for not providing value-based care to patients
- Additional information on the ACO programs that Medicare offers can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>

-Practices/clinics considering participating with an ACO, should begin to identify organization specific goals for achieving the three-part aim of improving delivery of care, improving health, and reducing growth in costs through improvement

Carrier Contracting

Independent Practice Associations (IPA)

- An IPA is a business entity organized and owned by a network of independent physician practices for many purposes, including negotiating contracts with Managed Care Organizations
- Physician members of an IPA maintain control of their individual businesses, and receive support on enhanced contracting, cost containment measures, improving quality measures and general practice support
- An IPA may offer discounts on malpractice insurance, and group purchasing

- IPAs continue to develop initiatives to support physicians in maintaining independent practices.
- IPA can provide contracting and credentialing at lower costs than independent firms or in-house staff

Carrier Contracting

Independent Practice Associations (IPA)

- Before joining an IPA, a practice/clinic needs to consider many factors including:
 - How long has the IPA been in existence?
 - What plans do they contract with?
 - Can the rates for plans be reviewed prior to contracting?
 - Can we join and only participate in some of the contracts?
 - Do we need to have privileges in contracted hospitals?
 - What is the cost to join and maintain membership in the IPA?
 - Can I also participate with other IPAs?
 - Who manages the IPA?
 - How does this affiliation affect Accountable Care Organization (ACO Participation)?

- When considering an IPA, a main goal of the IPA should be clinicians building collaborative relationships to improve population health with the sharing of patient data

Medicaid Billing

- State governments administer Medicaid programs and regulations and billing requirements vary state-by-state
- Medicaid is the last payer to be billed for a service
- Prior to billing Medicaid, investigate the following:
 - Claim specifics – forms and formats both for paper and electronic claim submission
 - Covered services, thresholds and authorization procedures
 - Fee schedules
 - Clearinghouse functions as they relate to processing Medicaid claims

Review Medicaid billing requirements that vary based on provider specialties

Provider Credentialing

Provider Credentialing

- Credentialing is a process used to evaluate the qualifications and practice/clinic history of a provider
- This process includes a review of completed education, training, residency, board certification and licenses
- The information obtained from the State Licensing Department/Office of the Professions will provide information regarding the licensing and/or professional certification requirements for individual provider types
- The credentialing process may take several weeks to months to complete

- Credentialing is a tedious verification process of a provider's education, licensure, certification and experience
- Maintaining up-to-date provider files is imperative for both H/R and Credentialing purposes

Provider Credentialing

- A provider should refrain from rendering services without proper credentialing in place. Insurance carriers will not reimburse any services performed by a non-credentialed provider
- According to the Federal Register, it is considered fraudulent to bill for the services of a provider under another provider's name and carrier ID number due to credentialing status
- Some insurance carriers will backdate the contract effective date. However, this is not common practice

-Services must be billed in the name and NPI # of rendering provider. The only exception exceptions would be Medicare's incident-to guidelines and locum tenens/ reciprocal billing arrangements

Provider Credentialing

- The Council for Affordable Quality Healthcare (CAQH) is a non-profit alliance of health plans and networks nationwide. CAQH works with partner health plans to streamline the credentialing process for those plans through a database (www.caqh.org)
- Carrier application processes vary and may include completion of a unique credentialing application or a state standardized application
- Due to the complexity of the provider credentialing process, one person in an organization should be designated to handle the process
- If it is a large practice/clinic, more than one staff member should be involved to handle the process and a Credentialing Committee should be formed to oversee the process
- Some practices/clinics elect to outsource credentialing to vendors specializing in this area

- There is an application process for credentialing, which can either be electronic or paper
- The personnel handling the credentialing process must be extremely detail-oriented and organized

Provider Credentialing

- State License
- Drug Enforcement Administration (DEA) Certificate
- Board Certification
- Diploma-(copy of highest level of education completed)
- Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (required if educated outside of the US)
- Certificates of completion for all medical training (internship, residency, fellowship)
- National Provider Identification (NPI)
- Curriculum Vitae (months & years required)
- Hospital Affiliations & Privileges
- Proof of Continuing Education
- Malpractice Face Sheet
- Explanation of any pending or settled malpractice cases during the last five years
- Clinical Laboratory Improvement Amendments (CLIA) Certification
- W-9
- Current drivers license

Professional credentialing verification and documentation requirements will vary according to carrier specific credentialing guidelines.



25

- Credentialing process:

- Check all collected documentation for expiration and/or recertification dates
- If a document has expired, a current document must be obtained prior to submission
- If document scanning is available, create a provider credentialing file and scan all documentation

Provider Credentialing

- A spreadsheet should be developed to better track your practice/clinic's credentialing efforts.
- In addition to the credentialing items noted in the previous slide, the spreadsheet should include the following fields:
 - Carrier Name
 - Application Type (paper, CAQH, electronic)
 - Submission Date
 - Verification of Submission
 - Additional Information Requested
 - Carrier Contact Information
 - Notes

- Explain use of spreadsheet for tracking purposes
- Be careful when entering plan names, as many have similar sounding names (The Empire Plan and Empire BC/BS)
- Complete the application thoroughly

Provider Credentialing

- Once the application process has begun, record the names of the insurance carriers, and the date the applications were completed
- Create a “NOTES” section to maintain pertinent information regarding the process
- Be sure to maintain meticulous records for submissions (copies of the application, electronic confirmation sheet, CAQH reference number, etc.)
- If mailing information, issue all correspondence via Certified mail, Return Receipt Requested

-Although a growing number of payers use the CAQH Universal Provider Datasource® and credentialing software can reduce the paperwork, most practices still manage this information “manually”.

-When applications are completed with supporting documentation, scan/copy the application and all of the supporting documentation for internal purposes

Provider Credentialing

- Follow-up within two weeks of submission to confirm receipt of the application
- Inquire with Carrier regarding their Credentialing Committee meeting schedule
- Document missing information requests in the spreadsheet, along with the corresponding subsequent submission dates of these documents
- Be sure to obtain confirmation of any follow-up submissions

- When speaking with a carrier representative, always be sure to obtain a name and reference number.
- Document all notes and information on the spreadsheet

Provider Credentialing

- The credentialing grid should also be utilized to assist with “expirables management.” The following items will expire and should be carefully tracked to maintain up-to-date Provider credentials:
 - State License
 - DEA License
 - Malpractice
 - Board Certification
 - Hospital Reappointment
 - Driver’s License
 - CLIA Certificate
 - Cardiopulmonary resuscitation (CPR)/Automated External Defibrillator (AED) Certification
- The re-credentialing date for each carrier should also be tracked
- Re-credentialing dates vary by carrier (e.g., annual, every 2 years)

- Track the expiration dates of any documents that can expire. Use the spreadsheet as your tracking tool.
- Expired documentation will halt the re-credentialing process.

IT Infrastructure

IT Infrastructure

An IT infrastructure includes Network, Hardware, and Software.

Networks:

- Internet connection
- Network enablement
- Firewall
- Security systems

Hardware:

- Servers
- Computers
- Switches, hubs and routers
- Data centers
- Offsite storage

-Review the needs/importance of IT infrastructure for the practice/clinic (e.g., PM, EMR, interfaces)

IT Infrastructure

Software:

- The software needed to perform operational functions for the practice/clinic must be selected prior to developing the IT infrastructure
- These programs are complicated and require significant hardware to run them efficiently
- Hardware and Software can be implemented in three (3) distinct ways:
 - In-house implementation
 - Virtual private network
 - Cloud-based

-An IT infrastructure can be costly. Analyze needs and vendors carefully.

IT Infrastructure

Software Selection

Electronic Medical Records (EMR) Software provides the ability to maintain a digital patient medical record. The key functions of an EMR system include:

- Physician access to patient information, including diagnoses, allergies, past histories, laboratory results, medications, etc.
- Access to current and previous test results performed by providers in multiple care settings
- Computerized provider order entry
- Computerized decision support systems to prevent drug interactions
- Secure electronic communication with other providers and patients
- Patient access to health records, disease management tools, and health information resources
- Computerized administration processes, such as scheduling
- Standards-based electronic data storage and reporting for patient safety and disease surveillance efforts

- The EMR system in healthcare has transformed the delivery of patient care.
- Automation of systems, which were once manual, ease the administrative burden of medical staff.
- Better tracking improves the quality of healthcare.

IT Infrastructure

Software Selection

Practice Management (PM) Software provides the mechanism to monitor all operations within the practice/clinic including, but not limited to:

- Maintaining patient demographic information
- Appointment scheduling and insurance verification
- Insurance plan maintenance
- Billing operations
- Report generation

General Software:

- Email/Office Programs (Outlook, Microsoft Word, etc.)
- Security Programs
- Accounting Software

- A practice management system maintains the operations of the practice.
- There are many systems available. Having a better understanding of what functions you need will assist in software selection.

IT Infrastructure

Important factors to consider when selecting software:

- Number and types of providers and clinical support staff
- Number of non-clinical office staff
- Financial considerations – short and long-term
- Security and confidentiality of patient medical records
- Complexity of the software system – user friendly
- Training provided – remote, in-person
- Billing module functionality
- Flexibility/Scalability
- Specialty specific software vs. general software
- EMR templates – ease of creation and use
- Compliance – Health Insurance Portability and Accountability Act (HIPAA)
- Service contract costs

- Keep in mind of possibility of future expansion.
- Perform research and attend software demonstrations to better understand your options.
- Reach out to peers and Software references for their feedback and comments.

Software Selection

- EMR software should have the ability to generate detailed patient and population health reporting data for the quality measures required for value-based programs
- Discuss the reporting package in detail to ensure the reporting capabilities include data requirements for:
 - Medicare Access and CHIP Reauthorization Act (MACRA)/ Merit-based Incentive Payment System (MIPS)
 - ACO
 - Patient-Centered Medical Home (PCMH)
- CMS has certain standards for EMR software and has certified the software brands meeting these standards. CMS' software database may be searched by product or developer. Prior to making a decision, verify the EMR software certification at <https://chpl.healthit.gov>

- The move to “value-based healthcare” requires the ability to generate many different types of data reports. This data is all necessary for the various incentive and quality programs which exist and are continuing to be developed.
- Be sure the system can produce the reports you will need.

Considerations

Selecting a Clearinghouse

A Clearinghouse functions as an intermediary between the practice/clinic and the insurance carriers. The Clearinghouse functionality should include the following key Revenue Cycle features:

- Eligibility verification
- File Status
- Rejection Analysis - Dashboard
- Secondary Claims Processing
- Electronic Remittance Advice (ERA)/Payment Processing
- Proof of Timely Filing
- Paper Claim Submission

- A clearinghouse is a vital component of the billing operations.

Clearinghouse Selection

- Claim scrubbing through a series of edits prior to claim submission
- Claim submission to multiple plans simultaneously (837 file)
- Claim status from the plan allowing for errors to be corrected prior to submission
- Insurance eligibility
- ERA (electronic remittance advice – 835 file, electronic Explanation of Benefits which can be uploaded directly to PM system for automated payment posting)
- Timely filing information for insurance rejections
- Print and submit paper claims, when necessary
- Patient statement processing
- Rejection analysis and reporting tools

- Clearinghouse performs a diverse set of operations necessary for revenue cycle management
- It allows immediate correction of claims for resubmissions.
- There should be extensive user training to better understand the system functionality and reports.

Selecting a Clearinghouse

Additional items to consider when selecting a clearinghouse are:

- Is the software compatible with your PM system?
- Are they contracted with the most common carriers for your practice/clinic?
- What is the clearinghouse's proficiency level with government plans (Medicare/Medicaid) ?
- What is the speed of the scrubbing and claim rejection reports?
- Is the clearinghouse a regional or national company?
- What are the available days and hours for technical support offered, and what is the turnaround time for support issues?
- Are there additional costs involved with the various functions (claim submission, eligibility, etc.)?

- There are a variety of different medical billing software vendors. Each vendor creates a claim file in a different format. It may be an ANSI file or a print image file or a variation of these
- Each insurance payer has different requirements for submitting electronic claim files
- A CMS 1500 claim is the paper format that is universally used. This paper format is converted to an electronic format and uploaded to the clearinghouse for submission to the carriers.
- There are other claim formats, such as a UB-04 for facility claims.

Electronic Funds Transfer (EFT)

- EFT provides a process for insurance plans to direct deposit claim payments directly to a practice/clinic's financial institution
- EFTs offer healthcare organizations a **safe, convenient, and timely alternative to paper checks and other manual forms of payment.**
- Standards for electronic payment and remittance were developed under the HIPAA Regulations and Affordable Care Act
- Payment is processed and deposited into the organization's bank account in approximately two weeks after "clean claim" submission
- Utilization of the EFT function allows for practice/clinic efficiencies:
 - Paperwork reduction
 - Staff time for banking reduced
 - Faster access to funds
 - Easier bank statement reconciliation

- Use of EFT will streamline payments to the practice/clinic.
- Many carriers only utilize EFTs for reimbursement.

Lockbox

- A lockbox is a system whereby paper insurance correspondence and payments, patient correspondence and payments, and all other correspondence are issued directly to the practice/clinic's financial institution, rather than the physical practice/clinic location
- A lockbox requires the practice utilize a designated Post Office box rather than the physical practice/clinic address for remittances
- Checks are deposited in the practice/clinic's designated account, and all related documentation is scanned by the financial institution staff
- The scanned documents are accessible by the designated practice/clinic personnel
- A lockbox can ease administrative burdens for office staff by eliminating inefficient in-house manual processes, such as processing mail, photocopying, and making deposits

- Lockbox helps medical practices streamline HIPAA-compliant mail processing and same-day check deposits.
- Electronic access to scanned documents, including EOBs, simplifies key office and billing processes.

Lockbox

Lockbox considerations:

- Are the checks and explanation of benefits (EOBs) returned to the practice/clinic via paper or an online electronic archiving system?
- How often does the financial institution download claim correspondence and payments?
- Are denial files processed separately from claim payment files?
- What options are available for denials management?
- Will the financial institution provide the practice/clinic with electronic access to records of claims and payments received?
- Is the service HIPAA compliant?
- Does the financial institution provide a temporary solution which enables the practice/clinic to scan EOBs and upload them while the P.O. Box transition is in process?
- Does the financial institution offer interest on the funds in the lockbox account?
- Is the solution Cloud-based?
- Which Lockbox features are standard and which represent additional costs to the practice/clinic?

Process:

1. Practice mail arrives directly to the lockbox service.
2. Lockbox service
 - a. Opens all mail and archives it in a document management system including scanning and indexing for future retrieval,
 - b. Makes images available to practice or Billing Service via a secure, encrypted Web site;
 - c. Deposits all checks received that day
3. Practice administrative staff has direct access to web-driven interfaces for mail and check queries and reports.

Advantages & Disadvantages of a Lockbox

Advantages

- A financial institution may be willing to offset the costs involved if a certain account balance is maintained
- Employee time spent on banking related tasks may now be redirected to other office tasks, such as assistance with internal billing and collections efforts
- Reduces potential fraud and embezzlement activities

Disadvantages

- Funds may be directed to the wrong account
- Missing EOBs and other documents during the scanning process
- Receiving incorrect EOBs
- Potential delays in obtaining copies of EOBs

- Interactive conversation of how the attendees perform their banking functions presently

Case Study

Credentialing

Challenge: Johns Hopkins All Children's Hospital provider enrollment process was slow and inefficient, with an average enrollment time of six months. New physicians were frustrated as this delayed when they could start seeing patients right away.

Solution: It was realized that there were duplicative components of provider enrollment and medical staff credentialing. It was decided to combine these two departments. The information that the medical staff office gathers impacts the enrollment team. Instead of working in silos where crossover information was not accessible, both teams had access to the same information

Result: The hospital successfully cut enrollment days in half for eight of the top 12 payers. In February 2015, less than 50% of all employed providers were active with payers.

- By February 2016, this increased by 20 percentage points.
- By end of 2016, over 77% of employed providers were active with payers, while the volume of providers continuously increased.
- In February 2015, over half of the provider applications were in the queue (non-participating provider status).
- By end of 2016, only 13% remained in the queue, which is a decrease of 38 percentage points

Case study: Is your organization on board with your onboarding process? (n.d.). Retrieved from <https://credentialingresourcecenter.com/articles/case-study-your-organization-board-your-onboarding-process>

Module 1 Highlights

- Selection of medical services and provider types to best suit the Practice/Clinic's mission and goals
- Strategies for optimal contract negotiations with carriers
- Provider credentialing techniques
- IT Infrastructure development
- Clearinghouse considerations for positive Revenue Cycle outcomes
- EFT and the cash flow advantages
- Utilization of a Lockbox for streamlining the collection and payment processes

Module 1 Mini-assignment

- Prepare a list of proposed services and provider types you are considering for your practice/clinic
- Create a spreadsheet of your existing carriers, including initial contract dates, expiration dates, and any known CPT Codes and their associated fees or provide your current carrier contract spreadsheet
- Prepare a provider credentialing grid as described in the “Provider Credentialing” section or review and update your current grid
- List all current practice/clinic software and any challenges you may be experiencing
- If you have a Clearinghouse, list the advantages and disadvantages of the system
- Draft a list of questions regarding utilization of EFT
- Draft a list of questions regarding utilization of Lockbox