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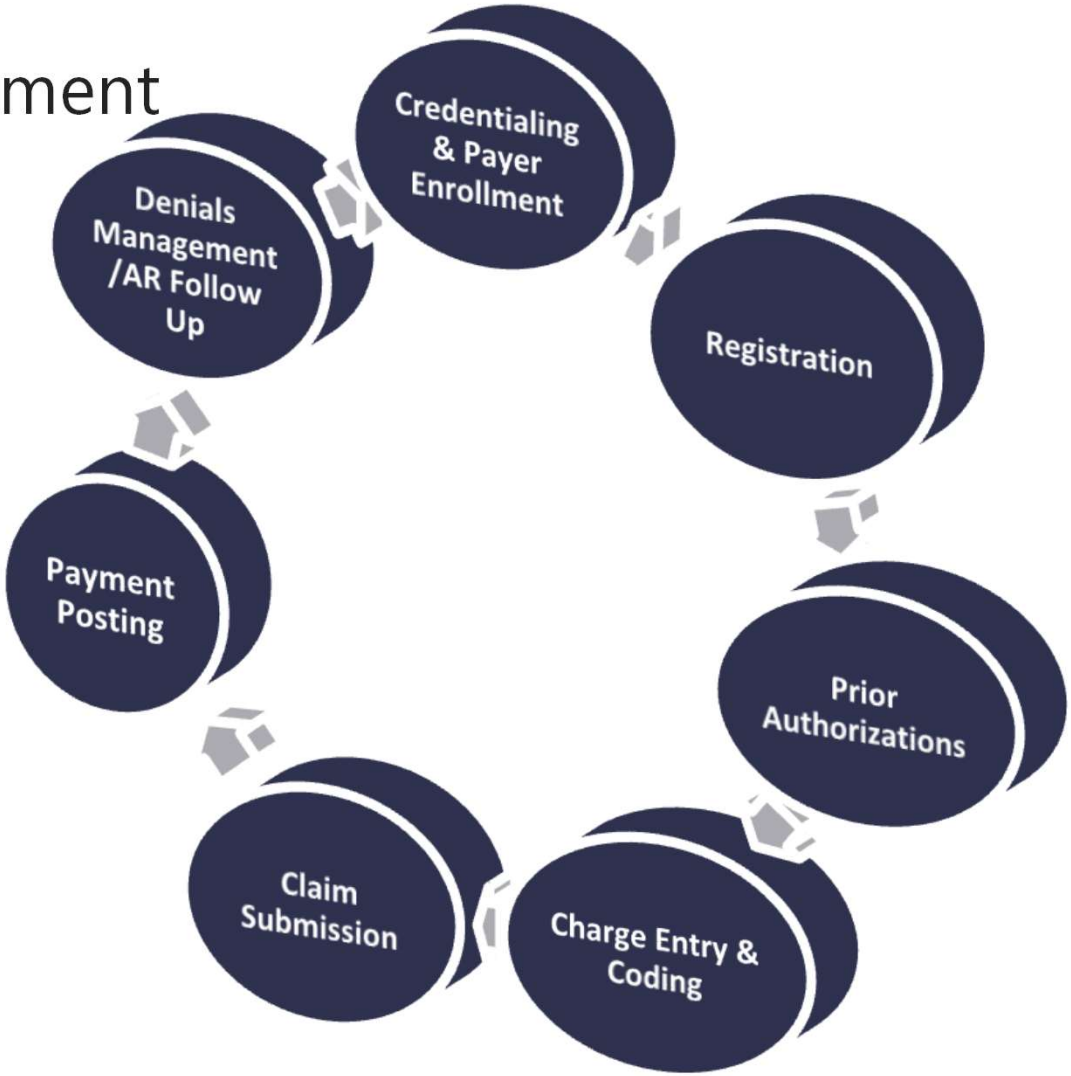
Medical Billing & Insurance 101

October 9, 2025

Agenda

- Credentialing & Payer Enrollment
- Registration
- Prior Authorizations
- Charge Entry & Coding
- Claims Submission
- Payment Posting
- Denials Management & Accounts Receivable



Effective revenue cycle processes are essential for maintaining the financial health of healthcare organizations.

Credentialing & Payer Enrollment

Credentialing

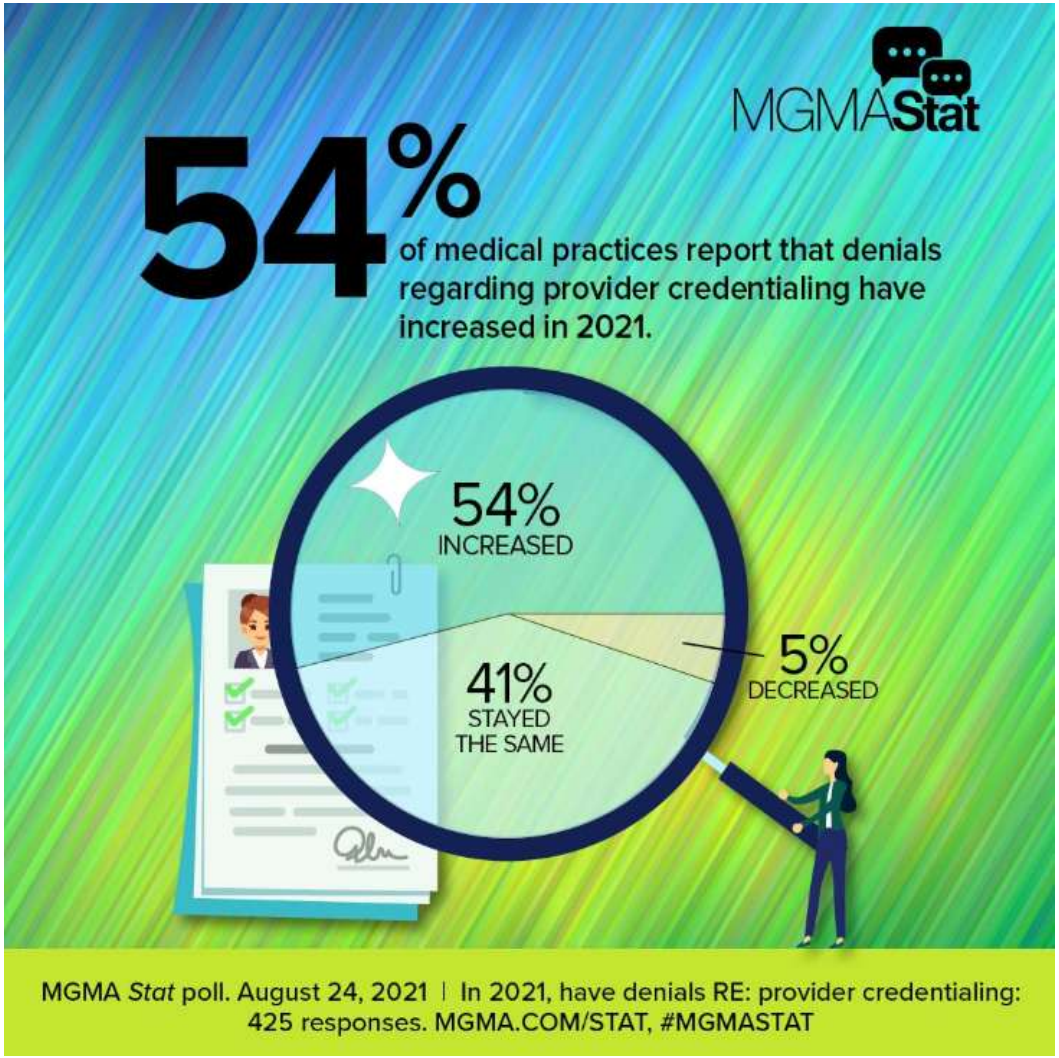
- The process of collecting and verifying important facts about the provider, such as proof of identity, education & training, board certification, to ensure the organization has full trust in the validity and reputation of the provider before he or she is hired

Payer Enrollment

- Payer enrollment follows directly after credentialing
- After an organization has credentialed a provider the same or similar information will be provided to payers the provider will participate with

Credentialing & Payer Enrollment

- Create a streamlined and consistent process for each payer so information is submitted timely and accurately
- After payer enrollment application is submitted, it can take weeks to months before the provider is approved
- To avoid uncompensated care, it's crucial to complete payer enrollment prior to provider caring for patients



Registration

Insurance and Benefit Verification

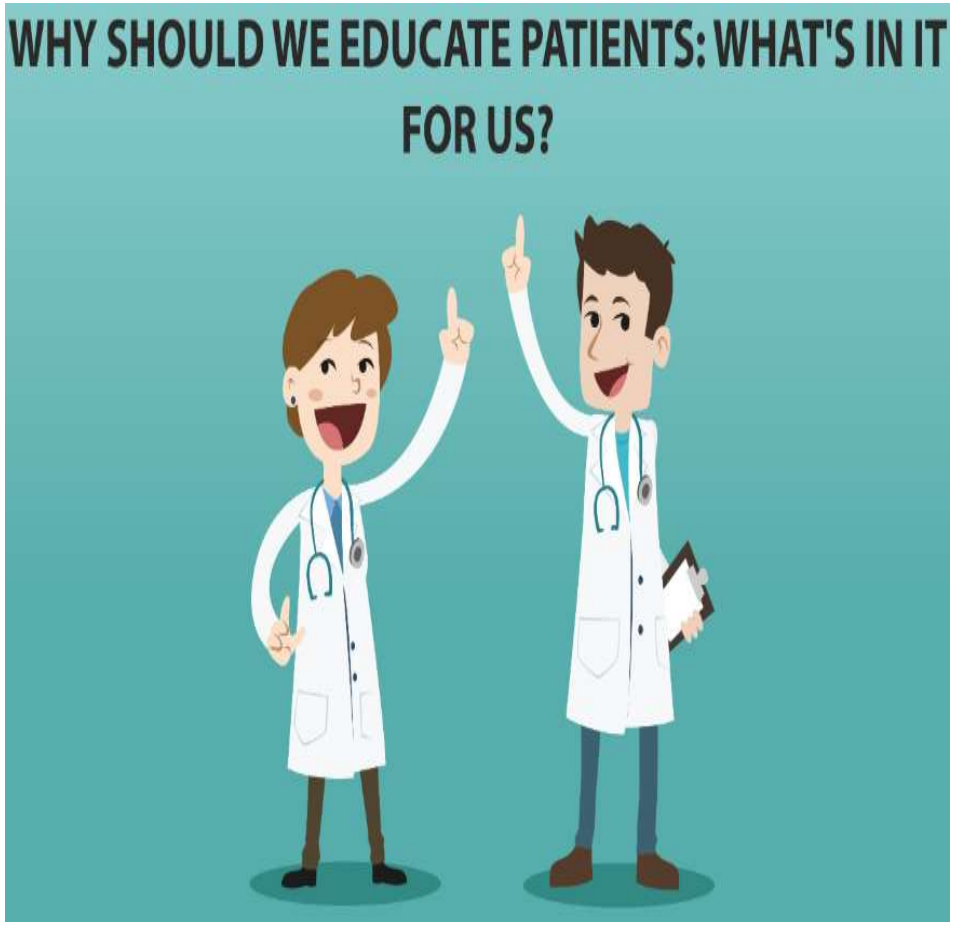
Insurance and benefit verification are key both prior to appointment and at the time of check in

Initial verification of both active coverage and benefits should take place at the time of scheduling

Review of benefits should take place at the time of scheduling and explanation of possible out of pocket expenses should be provided to the patient

Eligibility and benefits should be confirmed 48 hours prior to the patient's appointment to ensure nothing has changed with the patient's benefits or eligibility

Registration



Benefits of verification prior to patient appointment

- Reduces claim denials
- Improves cash flow
- Enhances patient satisfaction

Prior Authorization

- Authorizations are typically required for imaging, surgical procedures, and specialty medications
- Understand the patient's benefits prior to providing services
- If authorization is needed but not obtained there is a risk of not being reimbursed for services provided

Charge Entry & Coding

Charge Entry

Charges should be entered within 48 – 72 hours of care being provided

Provider notes should be completed within 24 – 48 hours of care provided

Accurate entry of charges rendered and billed reduce risk of errors that can lead to claim denials

Coding

New cpt codes are implemented in January of each year

Knowledge and requirements of these codes are crucial to a successful practice

Charge Entry & Coding

Coding

- Complete internal and or external review on an annual basis
- Provide clear understanding of expectations to staff regarding communication and changing of codes. Often times, there is a breakdown between providers and the billing office. Regular communication and feedback is needed to have a successful team.
- Utilize technology built within the practice management system and or clearinghouse
- Understand payer rules and guidelines

Claim Submission

- Claims should be submitted daily, if applicable, to help create a consistent cash flow
- Monitor claims after submission
  - Claim rejections can take place within the billing system or clearinghouse
  - Correct rejections and resubmit claims
- Clearinghouse clean claim rate ≥ 98%

Payment Posting

ERA & EFT Enrollment

Enroll in electronic remittance advices (ERAs) and electronic funds transfer (EFT) to receive quicker payment and reduce administrative burden

Elect for electronic payment posting within practice management

Eliminate payer credit card payments when possible

Payment Posting

Post payments into practice management system after money has been deposited into the bank

Balancing

Balance practice management system daily and monthly to payer deposits.

Denials Management

Cost

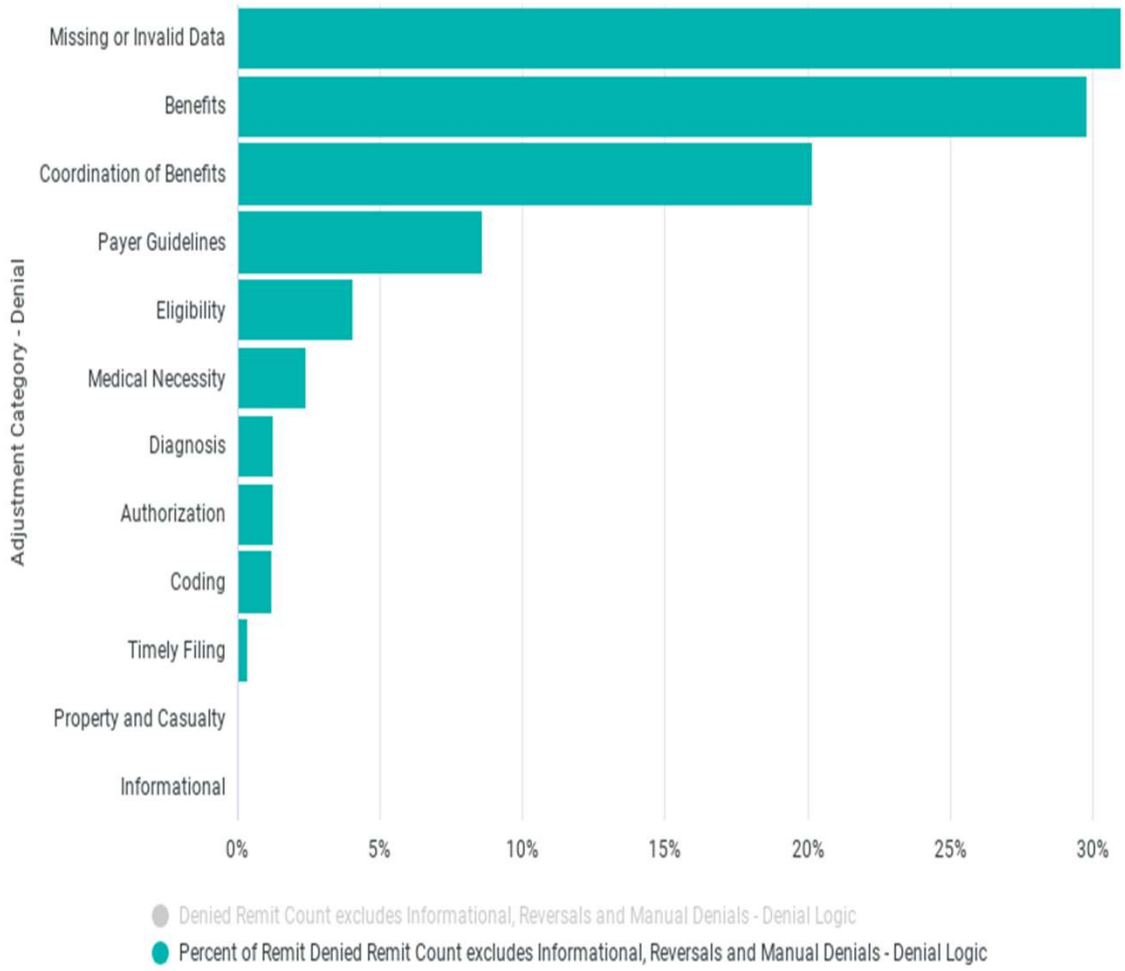
On average, it costs $27 to re-work a denied claim

Identify the root cause

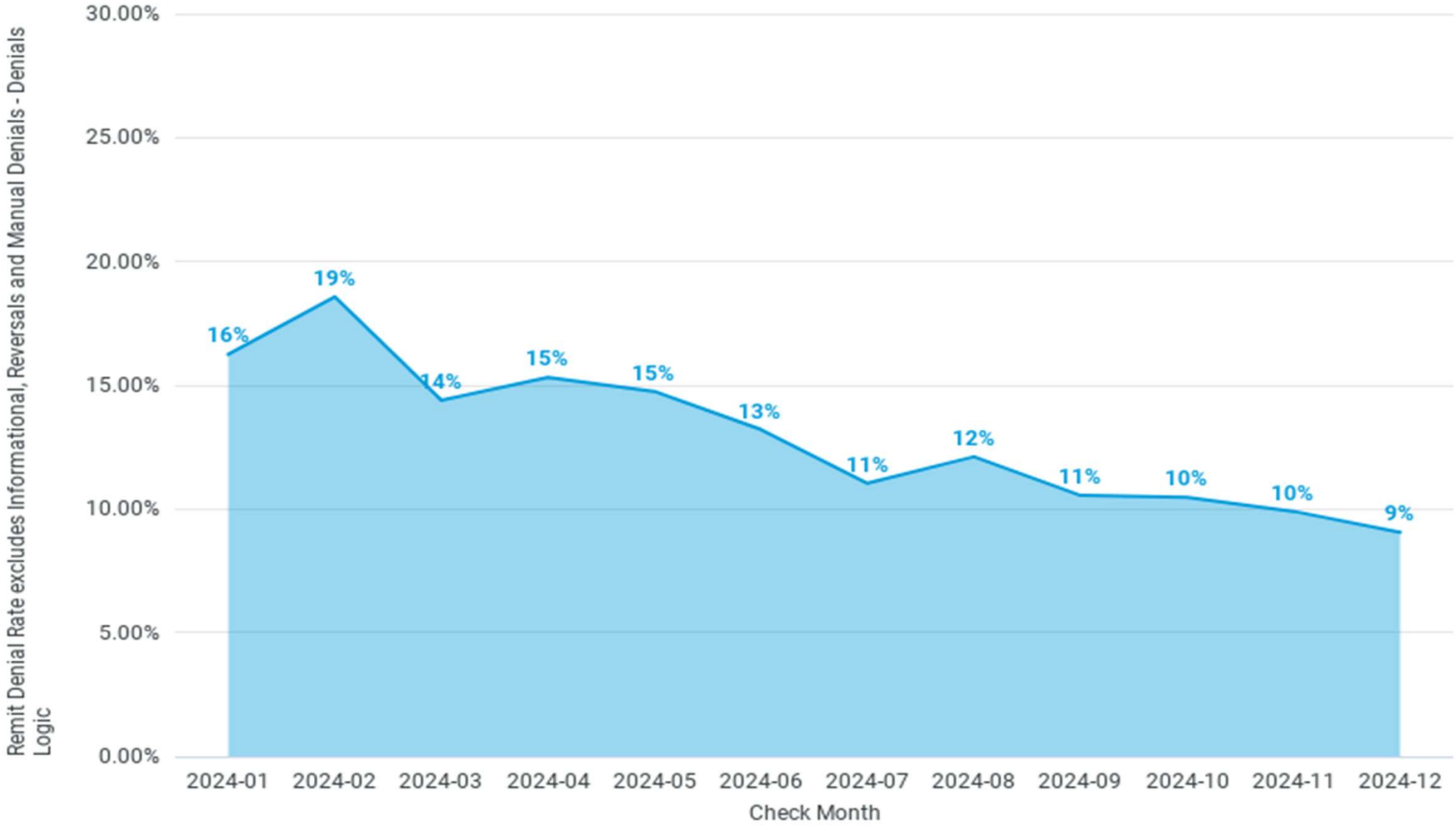
Some of the most common reason for denials include missing or incorrect information, provider out of network, bundling, medical necessity and procedure not covered by payer

Prevention

Determine which denials are preventable and put measures in place to prevent in the future



Denials Management



Accounts Receivable

Insurance AR Reports

- Run AR reports monthly to monitor AR by payer and aging category

Insurance AR Follow Up

- Understand payer timely filing guidelines and prioritize review of outstanding claims based on this.
- Most payers provide portals that claim status can be reviewed on. Utilization of these can save time in the follow up process.
- It is important to understand guidelines if corrections need to be made to a claim or a redetermination or appeal needs to be submitted.

Payer Class	0-30	31-60	61-90	91-120	121-150	151-180	181-up
<Unapplied>	-$6,400	$0	$0	$0	$0	$0	$0
BCBS	$10,095	$530	$1,678	$3,697	$927	$1,203	$6,809
Commercial	$97,033	$8,442	$4,411	$4,196	$1,827	$490	$8,775
Medicaid	$3,345	$1,177	$898	$561	$712	$564	$4,173
Medicare	$128,718	$6,926	$1,012	$5,657	$502	$165	$2,172
Motor Vehicle Accident	$182	$0	$0	$0	$0	$0	$0
Self Pay	$653	$248	$19	$17	$143	$0	$716
Work Comp	$420	$629	$494	$240	$0	$0	$0
Patient	$15,000	$19,369	$8,290	$10,187	$7,581	$4,695	$21,509
Total AR	$249,045	$37,320	$16,802	$24,554	$11,692	$7,117	$44,155
% of Total AR	64%	10%	4%	6%	3%	2%	11%

	9/6/2024	10/3/2024	11/1/2024	1/9/2025
Current	$112,210	$70,099	$79,096	$115,790
Sum of 31-60	$10,419	$6,117	$5,931	$40,030
Sum of 61-90	$5,797	$2,427	$472	$2,845
Sum of 91-120	$5,127	$2,925	$806	$1,633
Sum of > 120	$14,418	$9,112	$7,373	$5,456

Goal to keep 90+ days in AR <20%

Accounts Receivable

Patient Statements

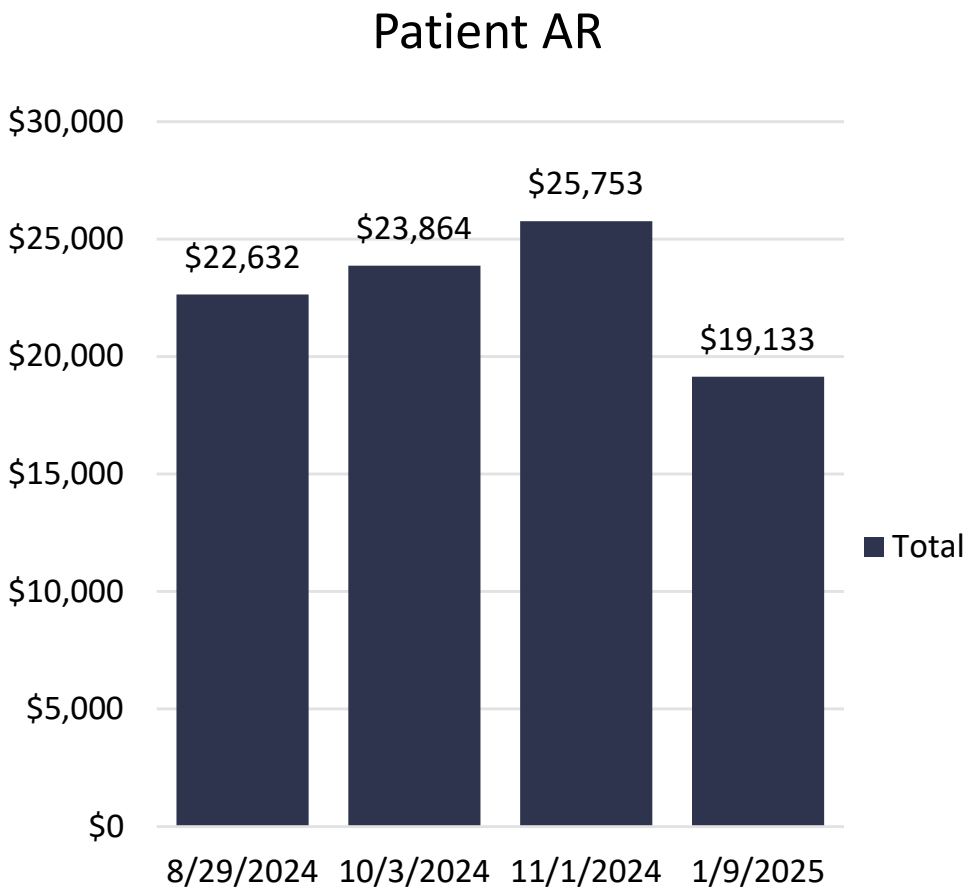
Establish schedule for sending patient statements (i.e. generate statements weekly)

Patient AR Report

Generate and track patient AR monthly

Patient AR Follow Up

Establish financial policy to set patient expectations and for practice to follow. If available, utilize technology to send patient statements



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Questions?

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Jennifer Campbell, BS, CMPE, CPC, CPB

Manager, Healthcare and Life Sciences

E: jennifer.campbell@claconnect.com

T: 314-925-4430

Lyndi Weakley, CPB, CIMC

Senior, Healthcare and Life Sciences

E: lyndi.weakley@claconnect.com

T: 314-925-4495

Resources

https://www.apaservices.org/practice/reimbursement/government/2025-medicare-changes

https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates#behavioral-health

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57480

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