30 Years of HBMA

LEADING THE BUSINESS OF HEALTHCARE

RCM Advisor

THE JOURNAL OF THE HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION VOL 30 • QUARTER 1 • 2025

OPERATIONS ISSUE

MAKE YOUR RCM COMPANY MORE Efficient & Profitable in 2025

TABLE OF CONTENTS

VOL. 30 • QUARTER 1 • 2025

NEW FEATURE! TAP THE NAME OF THE ARTICLE & JUMP DIRECTLY TO THAT PAGE.

About RCM Advisor

RCM Advisor is published quarterly for the members of the Healthcare Business Management Association, Inc. (HBMA). Editorial offices are located at:

1540 S. Coast Highway, Suite 204
Laguna Beach, CA 92651
Phone: (877) 640-HBMA (4262)
info@hbma.org / www.hbma.org

EXECUTIVE DIRECTOR
Brad Lund

EDITOR
Madelon I. Berger, MPH, MA, CCS-P, CPC

GRAPHIC DESIGN
JRocket77 Graphic Design

PUBLICATIONS COMMITTEE
Cindy Groux, Chair
Adela Berberovic
Joshua Burd
Kristin Callaway
Ginna Tucker

DIRECTOR OF GOVERNMENT AFFAIRS
Matt Reiter

HBMA MISSION

HBMA provides education, advocacy, collaboration and certification for healthcare billing professionals and providers engaged in the business and technology of healthcare revenue cycle management.

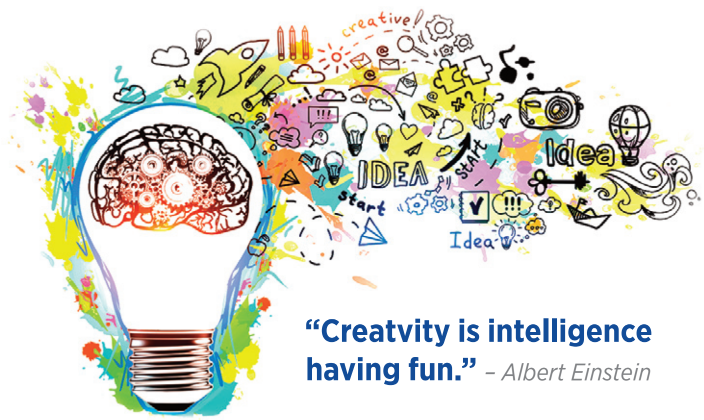
LETTERS TO THE EDITOR
Send to **info@hbma.org**, and include contact information. We reserve the right to edit all letters. All published letters become the property of *RCM Advisor*.

Setting Goals and Using HBMA Resources

Just as HBMA presidents have done in the past, I tasked myself with developing goals to guide my new term as HBMA president. After considering the HBMA, its mission, its diverse membership, and its place in this industry, I have concluded that there really is not a "one size fits all" goal. HBMA is a stellar resource for every size RCM company that services all medical specialties. This diverse membership has equally varied needs. Depending on the life cycle of your business, you could be facing a staffing shortage, or you could be overstaffed, experience too much growth, or too little, a dip in profitability due to reorganization, or a hundred other scenarios.

Whether your challenge is how to plan and utilize totally new technology currently available or one of the other business issues RCM companies face on a daily basis, the HBMA has proven resources, mentors, and information sharing to assist with every aspect of running an RCM company. For this reason, I decided that my primary goal as president will be to increase awareness of the many services, resources, mentoring, and technologies that are currently available and in development which will likely address a significant portion of the steps and tasks each RCM business owner needs to reach and exceed their own goals.

One situation we all face is a rapidly evolving industry, as it has been changing over the past 50 years. An example of the HBMA's resources used by many of us was when RCM companies started global outsourcing. Initially, there was fear, resistance, and failed attempts because RCM businesses, as well as outsourcing companies, were unfamiliar with managing a global workforce. The HBMA provided extensive access, knowledge sharing, and other assets to help members with the transition. Now global staffing is business as usual.



"Creatvity is intelligence having fun." *– Albert Einstein*

Today, RCM companies are faced with designing and implementing AI and workflow automation to remain cost competitive. I see a parallel trajectory for this new phase in the RCM industry, and the role the HBMA has been playing in it. To quote Mark Twain, "History doesn't repeat itself, but it often rhymes."

Whether your challenge is how to plan and utilize totally new technology currently available or one of the other business issues RCM companies face on a daily basis, the HBMA has proven resources, mentors, and information sharing to assist with every aspect of running an RCM company.

As business owners, at least annually, you owe it to yourself, your clients, and your staff to sit back and ask yourself the following three questions:

- What does success mean to you?
- What does success mean to your clients?
- What does success mean to your staff?

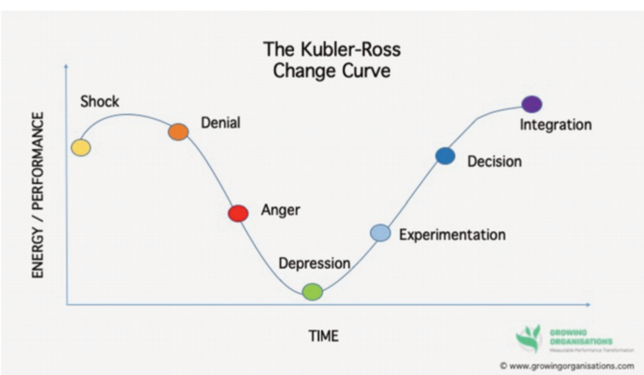
For you, as a business owner, it may mean having a growing company that is increasing in value while providing a comfortable living. For your clients, it likely means optimizing cash flow on a consistent month-to-month basis at a market rate, with the assurance that you have instituted industry level protections against outside threats and disruptions that attack RCM companies. Your staff would probably interpret it to mean a good work environment with a market pay level and room for advancement.

The hard part comes after you sit down and ask yourself these questions. As a business owner and/or manager, you need to plan these steps in order to achieve your goals. More specifically, over the next 12 months, ask yourself, "What are the three steps I can take to come closer to reaching these goals in each of these areas?"

Creativity is the key. Do not box yourself in when thinking about the answers to the questions, assuming you have unlimited financial, human and technological resources. Along with creative thinking, you will need to improve your processes and your knowledge base to enhance your company. If you read this message, you have a company or work for one. You likely have the creativity, self-motivation, and desire to solve the problems that will make you and your company successful.

As you go through this process, keep an open mind and consider all solutions and alternatives. As Einstein observed, "Doing the same thing you did yesterday and expecting a different outcome is the definition of insanity." Contemplating change is difficult for some people, let alone actual change,

Illustration 1



and possibly significant change. But remember, there is no progress without change. Illustration 1 shows the mental process most individuals and groups go through when faced with change. Understand this ahead of time and share it with your team. In order to make meaningful progress, change will play a significant role.

Now that you have boiled the steps down into identifiable tasks, I think you will find, as I did, that most of what you will need to succeed is at your fingertips – HBMA member resources. When outside help is necessary, HBMA vendors can provide not only the product or service, but also assistance in designing solutions that best fit your workflow needs, budget, and technological capabilities.

If you go through the process above and leverage the HBMA benefits available to you through your membership, you will be well on your way to reaching and possibly exceeding your goals. With the vast resources of the HBMA at your fingertips, including the knowledge of other members which you can access through mentoring and networking, I believe you have the recipe for Osuccess. If you need assistance in identifying a specific member benefit, contact Haley Popejoy, Associate Director of Administrative Services at haley@hbma.org and she will identify the best path to access the member benefits you need. You and the HBMA will get you well on your way to creating the future company that you, your clients, your employees, and all stakeholders will be proud of in the months ahead.

– Kirk Reinitz

HBMA President | Kirk.Reinitz@advocatercm.com

NEW HBMA MEMBERS

Professional Billing Department Companies:

- Retina & Vitreous Consultants
- Metro Health Solutions
- MI Financial Services LLC
- On With Life
- Easy Billing Services LLC

HBMA Education Calendar

WEBINARS

REGISTER!

January 14, 2025 / Unseen Biases: Understanding Your Role in Decision-Making

January 29, 2025 / Decoding the 2025 CPT® Code Changes: What You Need to Know

February 18, 2025 / Checking in on the No Surprises Act

VIRTUAL MEETINGS

REGISTER!

January 9, 2025
Member Benefits Highlight

January 22, 2025
2024 Virtual Annual Membership Meeting

February 19, 2025
RCM Exchange: Leaders & Managers

March 19, 2025
RCM Executives Connect

DISTANCE LEARNING

BROWSE!

GET HBMA EDUCATION ON DEMAND! Available 24/7, distance learning covers a wide array of topics to improve your healthcare business: Automation, Privacy & Security, Revenue Cycle Management, Compliance, Legislative Updates, Data, Claims Management, Patient Responsibility, Coding, and much more. Membership pricing available on all modules... many for free!

Building an RCM Technology Power-house-Starting With Denials

Ignite Success: Empowering Leadership and Culture Excellence for Maximum Performance

Regulatory Issues Update

C-Suite Cybersecurity: The Easiest Strategies To Keep You The Most Secure

How to Grow Your Billing Company: A Step-by-Step Plan

RPA in RCM: A Practical Guide for Non-Techies

Let's Change How Your Team Adapts to Change

Tales from the Dark Side: Stories from a Recovering Managed Care Executive

Harnessing the Power of AI for Your Medical Billing Service: A Crawl, Walk, Run Approach to Implementing AI

Change Healthcare Cyber Incident: HIPAA Compliance, Breach Notification and Other Legal Considerations for RCM Companies Part 1

Change Healthcare Cyber Incident: HIPAA Compliance, Breach Notification and Other Legal Considerations for RCM Companies Part 2

Cigna Commercial Payor Day

The State of Payer Reimbursement in 2024: It's Time to Stop Living in Denials

Maximizing Revenue: Key RCM Strategies for Interventional Radiology Practices

Charting the Course: Essential Steps to Protect Your Organization from Ransomware and Cyber Threats

2024 INNOVATION CONFERENCE

- AI Roadmap for RCM Analytics that Drive Outcomes in Claims Follow-up
- Beyond Algorithms: Understanding Liability in AI's Healthcare Revolution
- How We Built Our Own RPA: Automating the Charge Entry and Payment Posting Process Internally
- Innovation in the Front Office
- Revolutionizing Revenue Cycle: The Synergy of Medical Coding and Future Technology
- A Day in the AI Life: A View of the Future of RCM
- AI from the Healthcare Business Perspective
- All Sessions Pack
- Innovation Framework of Healthcare Ventures
- Vendor Showcase
- Is Your Radiology Revenue at Risk? Avoid These Documentation Pitfalls
- Navigating Workplace Conflict & Difficult Conversations
- Revolutionizing Medical Coding: An Introduction to Automated Solutions for Clinicians and Hospitals
- Potential To Impact: How To Unlock Your Highest Potential Through Five Growth Principles
- 2024 Washington Update

SOUND OFF!

TOPIC: Tell us how you feel about networking at HBMA and other conferences.

I miss networking opportunities which have been lost with meeting in virtual environments.

– Julie Sylvestre, Grey Ledge Medical Management

Networking is my number one objective when I attend HBMA conferences. I learn so much from other members and our vendors.

– Emily Osetek

Networking at HBMA and other conferences is the least important thing to me. I am interested in the course content. That is why I choose to attend virtual conferences much more often than in-person conferences. I wish HBMA would offer a virtual conference attendance option. I would attend more HBMA conferences if virtual was an option.

– Mike Jeffery, Medical Reimbursement, Inc.

The #1 benefit of being an HBMA member, and attending the conferences is networking with your peers. Over the years, I have gained many friends who have taught me more about our industry than even the educational contact and speakers. If you are a member who does not regularly attend conferences, you are not taking advantage of the largest benefit the HBMA has to offer.

– Greg Wehrman

Conferences offer a unique chance to build relationships with people in your industry, which can lead to partnerships, collaborations, or future job opportunities. By engaging in conversations, you can share ideas and gain valuable insights into current trends, best practices, and industry challenges. Attending conferences increases your visibility and enhances your reputation within the industry. Additionally, discussing challenges with others often brings fresh advice, new approaches, or effective solutions. Finally, conferences provide access to new projects, potential clients, and collaborations that might not be available elsewhere.

– Penny Gotham

I do like meeting other billing company owners, and I really like the fact that you are holding these all over the country and not just in Vegas. It would also be nice to not hold the fall session in a hurricane area; that is why I did not attend the fall session in Texas. Maybe hold the fall sessions in a non-hurricane area and the spring in those areas – just a thought.

As the Executive Director of Operations, networking at HBMA and other conferences is essential to my role. These events allow me to connect with peers and learn from others' successes and challenges, which then enables me to share these learning and educational experiences with my team, industry peers and clients.

– Rocio Gonzalez, The Medcor Group Inc.

The networking benefits of HBMA have been a lifeline for my business. The networking opportunities provided by HBMA have been so invaluable to me and my company that I genuinely don't know where I would be today without the support of my fellow members. Since joining HBMA in 1997, I have had the privilege of meeting peers who are not only willing but eager to help me succeed in business.

One particular moment stands out as a turning point. During an HBMA conference, I had a casual conversation with a fellow member who simply asked, "How are you doing?" I replied honestly, "If all my clients paid me when I billed them each month, I'd be doing fine." At the time, I was struggling with clients who were months behind on their payments, and as a growing business, this was a painful challenge.

Without missing a beat, he said, "No worries. I'll email you new language to include in every contract going forward and instructions on how to set up an ACH process for all new clients. You can also convert your current clients to this system, allowing you to collect your money on the second Tuesday of every month." True to his word, he followed up promptly with detailed guidance that completely changed how I managed client payments.

The rest is history. Those simple yet powerful changes helped stabilize my cash flow and gave me the financial foundation to continue growing my business. As we prepare to celebrate 33 years in business, I remain forever indebted to him and the countless HBMA members who have supported me when I needed it most.

Beyond the professional support, I am incredibly grateful for the close friendships I have formed along the way. HBMA is more than an association – it's a family of peers who are always willing to lend a hand, share their wisdom, and celebrate each other's successes. I truly would not be where I am today without them.

– Cindy Groux, Health Care Practice Management

Networking offers numerous valuable benefits, including the exchange of knowledge, the opportunity to build credibility, access to new opportunities, and the ability to gain inspiration while engaging in both giving and receiving mentorship. Participating in HBMA events provides rich opportunities for meaningful connections, fostering professional growth and collaboration.

– Andrea Halpern Bryan, Elite Billing LLC

I enjoy networking with other RCM execs. I also enjoy networking with vendors, but it gets pretty intense at times.

If you are not networking at HBMA conferences, you are only scratching the surface of the value the organization has to offer. Talk to your peers. Talk to the vendors. Ask questions. Listen. There is a nearly unlimited supply of wisdom and experience to glean simply by being friendly to people.

– Kyle Tucker, Dexios Corporation

Networking at HBMA and other conferences provide a common ground for building relationships at a professional level, where we get an opportunity to bring diverse perspectives to the table and also look at possible collaborative opportunities between healthcare companies.

– Shoy Antony, Ingenesys Health Solutions Pvt Ltd

GIVE US YOUR OPINION ON THE TOPIC FOR THE NEXT ISSUE'S SOUND OFF!

As an RCM company owner or manager, tell us what business resolutions you are making for 2025 and your SWOT or strategic analyses in order to achieve them.

We look forward to hearing from you!
Check your inbox for a SOUND OFF! email or...

SUBMIT YOUR RESPONSE ONLINE HERE

The entire *RCM Advisor* team wishes you a happy, healthy, and prosperous 2025.

Meet HBMA President, Kirk Reinitz

By *RCM Advisor* Editor

Q. How did you get into the RCM industry?

A. After a several year stint in public accounting right out of college, I went to work for a radiology specialty billing company called Medical Management Sciences, based in Baltimore, Maryland. After a couple years of managing radiology practices, I moved into billing operations and the rest is history.

Q. How long have you had your company?

A. Another individual and I founded what is now Advocate in 1998.

Q. How did you find out about HBMA?

A. As our companies started to grow, I searched for networking associations that could be helpful in providing resources and knowledge in this industry. In 2004 I came across the HBMA and have been a member ever since, greatly benefiting from my membership over the years.

Q. What made you decide to run for the HBMA Board of Directors?

A. Throughout most of my career, I was busy growing and running our company. Now, as the company has matured, it has afforded me time to give back and the HBMA was one of the first places I decided to spend my time.

Q. Do you belong to any other professional or community organizations?

A. I also belong to the Radiology Business Management Association (RBMA), and a CEO organization called Visage. Along with the HBMA, they have all been very helpful in providing support, resources, creativity, and mentoring to both help myself and our business be successful.

Q. Tell us about your family, outside activities, hobbies, etc.

A. When I am not working, I enjoy spending time with family and friends, traveling, skiing, biking, and generally doing anything outdoors. More and more, I enjoy partaking in all this and just relaxing at our lake house in Michigan.

NEW HBMA ACCREDITATIONS

- Fast Track Medical Billing

Spotlight on the Compliance and Ethics Committee

By Bob Trotta, Chair

In the complex landscape of the United States healthcare system, the importance of compliance and ethics cannot be overstated. With the convergence of regulatory requirements, technological advancements, and the necessity for patient-centered care, healthcare organizations, and revenue cycle management companies in particular, must prioritize these areas to ensure the delivery of safe, effective, and equitable services.

If you are reading any industry newsletter or even a local news source, you cannot help but see articles depicting someone arrested for fraud. The latest example I read about was a cardiologist admitting to fraud and giving up his license for a $1.5 million scheme. In our industry, it is an unfortunate reality that healthcare providers and others through healthcare practices attempt to take short cuts or use government agencies as their personal income source. The need for our industry to uphold our values and be vigilant towards bad actors is ever present.

Understanding Compliance in Healthcare

Compliance refers to adhering to laws, regulations, and policies that govern healthcare practices. Our healthcare system is heavily regulated, with organizations subject to various federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and numerous other regulations aimed at protecting patient rights and ensuring quality care. Compliance is essential to avoid legal repercussions and to maintain trust with patients and stakeholders.

Violations of compliance can lead to severe penalties, including hefty fines and the potential for criminal charges against individuals and organizations. For instance, breaches of HIPAA can result in fines reaching millions of dollars. Beyond the legal implications, non-compliance can damage an organization's reputation, leading to a loss of patients and partnerships. In an era where patient trust is paramount, maintaining compliance is critical for operational stability.

The Role of Ethics in Healthcare

While compliance focuses on adherence to laws, ethics addresses the moral principles that guide decision-making in healthcare. Ethical considerations are crucial in situations where the law may not provide clear guidance. For example, in our industry, we see daily dilemmas related to appropriate coding, sufficient documentation, patient consent, and patient billing for coinsurance and deductibles. There are plenty of examples of clients who would not mind if we look the other way or do not ask the tough questions.

Ethics in healthcare also encompasses the commitment to fairness and justice. Ensuring that all patients receive equitable care, regardless of their socioeconomic status, race, or background, is not just a legal obligation, but a moral imperative.

CLICK HERE TO WATCH THE VIDEO!

Interplay Between Compliance and Ethics

The relationship between compliance and ethics in healthcare is intertwined. A strong compliance program establishes the framework within which ethical decisions can be made. Organizations that emphasize both compliance and ethics are better positioned to create a positive culture that encourages transparency, accountability, and continuous improvement. This dual focus can help mitigate risks associated with misconduct, which can have devastating effects on patient care and organizational integrity.

Revenue cycle management companies increasingly recognize the need for comprehensive training programs that encompass both compliance and ethical standards. Such programs equip employees with the knowledge and skills necessary to navigate the complexities of their roles, while fostering a workplace environment that prioritizes ethical behavior. Additionally, leadership must exemplify ethical conduct, reinforcing the notion that compliance is not merely a checklist, but a vital component of organizational culture.

Our History

The Compliance and Ethics Committee has a long history at HBMA since its founding in 1995 as the Ethics and Compliance

The relationship between compliance and ethics in healthcare is intertwined. A strong compliance program establishes the framework within which ethical decisions can be made. Organizations that emphasize both compliance and ethics are better positioned to create a positive culture that encourages transparency, accountability, and continuous improvement. This dual focus can help mitigate risks associated with misconduct, which can have devastating effects on patient care and organizational integrity.

Committee. That committee was integral to helping the Office of Inspector General (OIG) with its initial draft model compliance program that they finalized in late 1998. For over 15 years, HBMA ran a separate compliance conference that provided tools to build a comprehensive program. Since then, we have seen a tumultuous period for the committee. The last compliance conference did not attract many interested companies. We are now at a critical juncture to determine the best way to assist you with building a comprehensive, manageable compliance program.

I would encourage you to consider joining the Compliance and Ethics Committee. We meet virtually on the first Wednesday of every month. We are a diverse group who enjoy learning and debating aspects of a topic that is so often misunderstood and shortchanged. Do you want to make a lasting impact on this industry? Working together we have the opportunity to build a program that elevates compliance and ethics back to a place of prominence in our industry.

We are working on building a new online compliance program that complements the Healthcare Compliance Pros accreditation program as well as improving communication and engagement with HBMA members from this committee on current compliance and ethics topics, including cybersecurity, due diligence on prospects, and your role in evaluating the impact of AI on your operations and those of your clients.

Please contact me at bobt@mcbcollects.com or 973-320-7399 for more information on joining the Compliance and Ethics Committee. ■

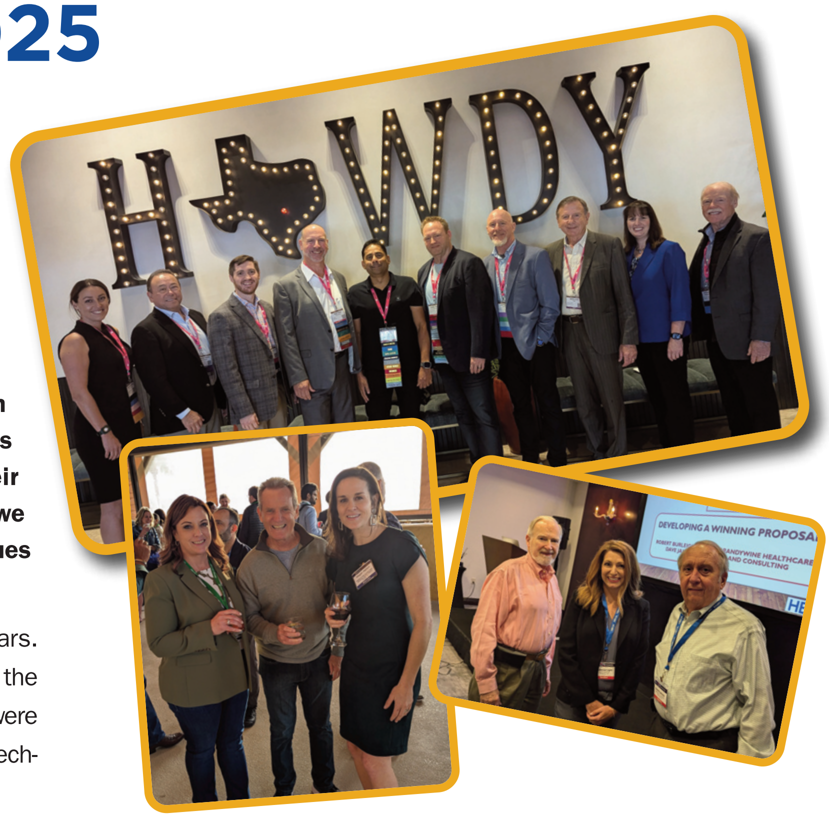
WELCOME NEW HBMA MEMBERS

Revenue Cycle Management Companies

- Zybex, Inc.
- GDG Square LLC (Post Acute Hospitalists)
- Spectrum Specialized Billing
- Applite Solutions LLC
- Providers Care Billing LLC
- NOVAZENITHAI. PVT.LTD
- Medical AR Management Services, LLC aka MedAR
- MB Strategy Group
- 314e Corporation
- Claimocity, Inc.
- Med Karma Inc
- Vistec Partners
- ASPRCM Solutions LLC
- ACCTWise Consulting Services, LLC
- A2Z Healthcare Consulting Services LLC

Highlights of HBMA's 2024 Accomplishments with More to Come in 2025

By Brad Lund, Executive Director, HBMA



In recent years, HBMA struggled a bit to find the appropriate "value proposition" for its members and the Revenue Cycle Management (RCM) industry. That difficulty began to unwind in 2022 with the emergence of several visionary members who brought forth high quality information and education which HBMA members found valuable to enhance the success of their companies. As we review HBMA's 2024 fiscal year, we are proud to say that HBMA is flourishing and continues to successfully support its members.

HBMA has experienced many changes over the last few years. Some were made in response to outside events, such as the pandemic and the Change Healthcare cyberattack. Others were the result of the increasing evolution of industry tools and technologies available to RCM companies.

As we review HBMA's 2024 fiscal year, we are proud to say that HBMA is flourishing and continues to successfully support its members.

This past year started with the Change Healthcare cyberattack which affected most, if not all, of HBMA's members. HBMA hosted a **Town Hall** that proved to be one of the association's largest virtual gatherings to date, with over 560 individuals in attendance. The association expanded upon the Town Hall by further providing payor and educational sessions, helping to answer the question, "Now, what do we do?"

This event was closely followed by the **HBMA 2024 Innovation Conference** in Tucson, AZ, which garnered twice as many attendees as expected. HBMA structured its conference education around what RCM companies might expect from various innovations, including automation, AI, Robotic Process Automation (RPA), and ChatGPT. Several sessions provided case studies surrounding these innovations and their impact on the RCM industry. Another session showcased innovations from an RCM company perspective, presenting details, such as financial cost, time invested, and the current result of launching a customized RPA program.

Additionally, the **Membership Committee** initiated two regularly scheduled networking calls: **RCM Exchange: Leaders &**

Managers and **RCM Executives Connect**. The RCM Exchange: Leaders & Managers call allows all HBMA member types to participate in breakout rooms where they discuss one of two topics. The first focuses on executive matters, and the second concentrates on leadership issues. RCM Executives Connect is only limited to RCM and Professional Billing Department (PBD) company executives and focuses on one executive subject per call. These networking calls have been very well received and continue to assist HBMA members in identifying and discussing key issues among their peers.

The **Government Relations Committee** has been a hub of activity this year! They have been busy meeting with representatives of Congress and CMS and submitting numerous vital responses to proposed government actions and laws. Committee members also traveled to Baltimore to meet with CMS officials in person. HBMA members can view the myriad efforts of this committee on the HBMA website under the "Government Affairs" tab.

Most recently, HBMA completed the **2024 Revenue Cycle Fall Conference** in Austin, Texas – and what a conference it was! Having over 230 attendees, 43 exhibitors, and 27 speakers in attendance made it an event to remember. HBMA's goal of increasing conference attendance and participation has certainly been achieved.

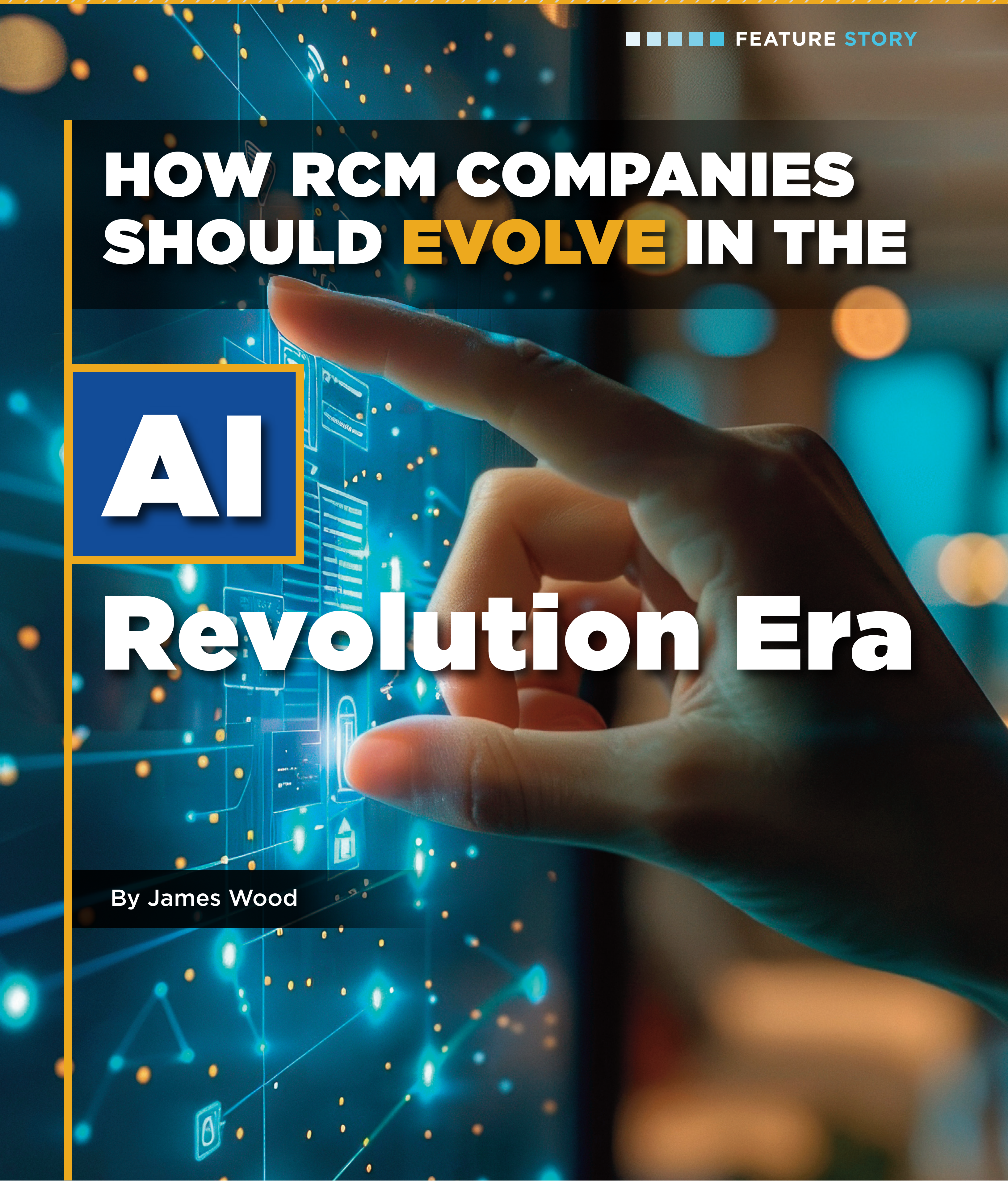
2025 will bring new and exciting developments and advances. The **Certification Committee** has been hard at work redesigning the current CHBME program, which is expected to launch by mid-year 2025. The **Compliance and Ethics Committee** is also working on improving compliance education for HBMA members. At present, they are mapping out a brand-new virtual compliance course.

Another significant area will be ongoing education for our members. HBMA is planning on producing 25 webinars in 2025 in addition to free education. We will continue to offer webinar package options for one flat rate for companies to purchase that will allow all company staff to attend. Our in-person events will include the **Innovation Conference** from March 12-13 in Atlanta, GA. The Education Committee recently completed the curriculum for this conference, and it is sure to provide an information packed program. Our **Annual Revenue Cycle Conference** will be held from October 6-8 in Niagara Falls, NY.

In addition to committee work, in 2025, HBMA will be focusing on member benefits. Monthly webinars will inform both members and non-members about the benefits of membership in HBMA and how to use various tools that HBMA provides.

HBMA's mission is to provide education, advocacy, collaboration, and certification for healthcare billing professionals and providers engaged in the business and technology of healthcare revenue cycle management. To maintain this mission, HBMA continues to grow and adapt to this ever-changing industry to support its members. Volunteering on a committee is highly recommended in order to derive the most benefits from HBMA membership. Those interested in doing so may reach out to HBMA's national office at info@hbma.org. ■

HOW RCM COMPANIES SHOULD EVOLVE IN THE AI Revolution Era



By James Wood

As a healthcare revenue cycle leader, the question people constantly ask me is, "*What is all the fuss about implementing AI in revenue cycle management companies?*" Well, if you are a revenue cycle leader and curious about implementing AI in your company, then this article will be a valuable educational piece.

The integration of Artificial Intelligence (AI) into healthcare revenue cycle management (RCM) is no longer a futuristic concept – it is happening now. To remain competitive, healthcare RCM companies must evolve and leverage AI to optimize operations, enhance patient satisfaction, and improve financial performance. This article explores how you can embrace AI in RCM, the challenges of not doing so, and the tangible benefits it brings, including real-world Return on Investment (ROI) examples.

The Scenarios of AI in RCM Companies

Recent surveys indicate a significant uptick in AI adoption among RCM companies. According to a 2022 Black Book Market Research report, over 80% of healthcare CFOs plan to increase their investment in RCM AI technologies within the next three years. This surge is driven by the need to handle complex billing processes, reduce denials, and improve cash flow.

Why the Push Towards AI?

Several pressing factors are accelerating the adoption of AI in healthcare RCM, and you are likely already feeling their impact.

REGULATORY COMPLEXITY

Healthcare regulations are continually evolving, making compliance a moving target. Conducting manual processes presents a struggle to stay current with updates like annual changes in billing codes from the Centers for Medicare & Medicaid Services (CMS). AI can automatically update coding systems, reducing the risk of claim denials due to outdated codes and ensuring compliance with regulations like HIPAA through enhanced data security.

FINANCIAL PRESSURES

Rising operational costs, declining reimbursement rates, and margin compression are squeezing profits. Manual processes are labor-intensive and costly. For example, processing a single claim manually can cost $7 to $9, while automation reduces it to $1 to $3 per claim. AI helps lower operational costs by automating repetitive tasks and identifying revenue opportunities, increasing your revenue capture.

PATIENT EXPECTATIONS

Patients today expect transparency, convenience, and quick resolutions in billing and payments. Confusing bills and long waiting times for inquiries lead to dissatisfaction. AI enhances the patient experience by providing:

- **Transparent Billing:** Easy-to-understand bills that break down charges clearly.
- **Personalized Communication:** Real-time responses through AI-driven chatbots.
- **Flexible Payment Options:** Personalized payment plans based on patient behavior analysis.

Challenges Faced by RCM Companies Without AI

If your organization has not adopted AI in RCM, you are likely to encounter several obstacles:

INEFFICIENCIES IN MANUAL PROCESSES

Manual data entry and claim processing are time-consuming and error prone. This leads to delayed reimbursements and increased operational costs. For example, an RCM company processing 5,000 claims per month manually may incur additional labor costs of $50,000 annually due to inefficiencies.

HIGH DENIAL RATES

Without AI-driven analytics, identifying patterns in claim denials becomes challenging. This results in repeated mistakes and revenue losses. A typical denial rate of 10% on monthly claims worth $1 million equates to $100,000 in delayed or lost revenue.

INADEQUATE PATIENT ENGAGEMENT

Traditional systems often lack the ability to provide personalized and timely communication with patients regarding their billing and payment options. This can lead to confusion, frustration, and decreased patient satisfaction. Without AI-driven tools to tailor interactions and offer real-time responses, you risk losing patients to competitors who provide a more seamless and engaging billing experience.

The integration of Artificial Intelligence (AI) into healthcare revenue cycle management (RCM) is no longer a futuristic concept – it is happening now. To remain competitive, healthcare RCM companies must evolve, and leverage AI to optimize operations, enhance patient satisfaction, and improve financial performance.

INABILITY TO SCALE

As your patient volume grows, relying on manual processes becomes increasingly unsustainable. Manual data entry, claim processing, and follow-ups consume significant staff time and resources. This limitation hampers your ability to handle increased workloads efficiently, leading to backlogs, delayed reimbursements, and overworked staff. Without AI automation to streamline operations, scaling your business effectively becomes a significant challenge.

Types of AI Applications in RCM

AI in RCM is not a one-size-fits-all solution. It encompasses various applications that address specific areas of the revenue cycle:

SCHEDULING

AI-powered scheduling tools optimize appointment bookings by analyzing patient preferences, provider availability, and historical no-show data. This maximizes resource utilization and reduces wait times, enhancing patient satisfaction through more convenient and efficient scheduling.

PRIOR AUTHORIZATION

Automated prior authorization systems quickly verify insurance coverage and obtain necessary approvals. Streamlining this process reduces delays and administrative burdens, minimizing the risk of claim denials due to authorization issues and expediting patient access to needed services.

ELIGIBILITY VERIFICATION

Real-time eligibility checks confirm patient insurance coverage before services are rendered. This proactive approach minimizes the risk of uncompensated care, reduces billing errors, and ensures that patients are informed about their financial responsibilities upfront.

CHARGE CAPTURE

AI ensures that all billable services are accurately recorded by identifying missing charges and correcting coding errors automatically. This prevents revenue leakage, improves billing accuracy, and enhances compliance with coding standards, ultimately boosting your organization's financial performance.

MEDICAL CODING

Natural Language Processing (NLP) algorithms interpret clinical documentation to assign precise medical codes. This enhances compliance by reducing coding errors, accelerating the billing cycle, and lowering the risk of audits and associated penalties.

PAYMENT POSTING

Automated payment posting accelerates reconciliation by swiftly matching payments to the correct accounts. This reduces administrative workload, minimizes posting errors, and provides real-time financial visibility, aiding better cash flow management.

DENIAL MANAGEMENT

AI analyzes denial patterns to identify root causes and trends. Predictive analytics can forecast potential denials, allowing you to take proactive measures to prevent them, thereby reducing denial rates and improving overall revenue recovery.

ACCOUNTS RECEIVABLE

Machine learning models prioritize accounts based on the likelihood of payment. This enables you to focus collection efforts on accounts most likely to pay, improving cash flow, reducing days in accounts receivable, and optimizing resource allocation.

PATIENT COLLECTIONS

Automated reminders and personalized payment plans enhance patient collections. AI tailors communication

strategies based on patient behavior, increasing patient engagement and the likelihood of timely payments while improving the patient experience.

The ROI of Implementing AI in RCM

Investing in AI automation in healthcare is not only about staying current – it is a strategic move that offers substantial returns.

FINANCIAL BENEFITS

- **Increased Revenue**
  By reducing denials and ensuring accurate billing, your revenue capture improves. A healthcare RCM company processing $10 million in claims monthly implemented AI-driven denial management. With an average denial rate reduction from 10% to 5%, the company recovered an additional $500,000 per month, translating to $6 million annually.
- **Cost Savings**
  Automation reduces the need for extensive manual labor, thereby lowering operational costs. Automating eligibility verification and prior authorization can reduce staffing needs by 20%. If your company spends $1 million annually on staffing for these tasks, that is a savings of $200,000 per year.
- **Improved Cash Flow**
  Faster claim processing and payment posting accelerate revenue cycles. Reducing the average days in accounts receivable (A/R) from 60 days to 45 days improves cash flow. For monthly revenues of $5 million, this acceleration means $2.5 million more available cash at any given time.

OPERATIONAL EFFICIENCY

- **Enhanced Productivity**
  Staff can focus on complex tasks rather than mundane, repetitive ones. AI-powered medical coding reduces coding time per claim by 50%, allowing coders to handle twice the number of claims daily.
- **Scalability**
  AI systems handle increased workloads without compromising performance. As patient volume increases by 30%, AI systems absorb the additional workload without the need for proportional staffing increases, saving on potential hiring costs of $150,000 annually.
- **Compliance Assurance**
  AI keeps you updated with regulatory changes, reducing compliance risks, such as avoiding a single compliance penalty that could cost upwards of $50,000.

■ **PATIENT SATISFACTION**

- **Transparent Billing**
  Clear and accurate bills enhance patient trust. Improved billing accuracy reduces patient billing inquiries by 25%, enhancing patient satisfaction and reducing call center costs by $30,000 annually.
- **Efficient Communication**
  Personalized interactions improve the overall patient experience. AI-driven communication increases patient payment compliance by 15%, resulting in an additional $180,000 collected annually on patient balances of $1.2 million.

Steps to Successfully Evolve with AI

■ **ASSESS YOUR NEEDS**

Begin by thoroughly evaluating your current revenue cycle processes to determine where AI can have the most significant impact. Conduct an internal audit to identify inefficiencies, bottlenecks, and areas where manual tasks lead to errors or delays.

■ **SELECT THE RIGHT PARTNER**

Choose technology providers with proven experience in healthcare RCM AI solutions. Ensure they offer scalable options that integrate seamlessly with your existing systems and comply with healthcare regulations like HIPAA for data security.

■ **IMPLEMENT GRADUALLY**

Start by introducing AI in high-impact areas such as denial management or medical coding. A phased implementation allows your team to adjust to new processes, minimizes disruptions, and provides opportunities to refine strategies as needed.

■ **TRAIN YOUR TEAM**

Invest in comprehensive training programs to help your staff understand and effectively utilize the new AI technologies. Empowering your team enhances adoption rates and ensures that the technology is used to its full potential.

■ **MEASURE OUTCOMES**

Establish clear key performance indicators (KPIs) to monitor improvements in efficiency, accuracy, and financial performance. Regularly review these metrics to assess the return on investment and identify further areas for optimization.

Overcoming Common Implementation Challenges

■ **DATA SECURITY CONCERNS**

Healthcare data is highly sensitive, and breaches can have severe consequences. Ensure that any AI solutions you implement comply with HIPAA and other regulatory requirements to protect patient information and maintain trust.

■ **STAFF RESISTANCE**

Change can be intimidating for employees accustomed to traditional processes. Involve your team early in the implementation, emphasizing how AI will simplify their tasks rather than replace them, to encourage acceptance.

■ **BUDGET CONSTRAINTS**

Implementing AI requires an upfront investment, which can strain budgets. However, the long-term ROI justifies the cost. Consider phased rollouts to manage expenses effectively while gradually realizing the benefits of AI technology.

The Future of AI in Healthcare RCM

As AI technology advances, its applications in RCM will become even more sophisticated.

■ **PREDICTIVE ANALYTICS**

Future AI systems will not only analyze past data, but also predict future trends, enabling you to anticipate challenges and opportunities. This proactive approach allows for better decision-making and strategic planning to optimize your revenue cycles.

■ **ENHANCED PATIENT ENGAGEMENT**

AI chatbots and virtual assistants will provide real-time support to patients, answering billing questions and setting up payment plans. This personalized interaction improves patient satisfaction and encourages timely payments, strengthening patient-provider relationships.

■ **INTEGRATION WITH TELEHEALTH**

AI will seamlessly integrate RCM processes with telehealth services, ensuring accurate billing for virtual visits. This integration minimizes errors, enhances reimbursement rates, and supports the growing demand for virtual healthcare solutions.

BLOCKCHAIN FOR SECURITY

The combination of AI and blockchain technology could revolutionize data security, making RCM processes more transparent and secure. This ensures data integrity, protects patient information, and builds trust in your financial operations.

Conclusion

The AI revolution is reshaping the current situation of healthcare revenue cycle management. By embracing AI, you position your organization to improve efficiency, enhance patient satisfaction, and boost financial performance. The challenges of not adopting AI are significant – inefficiencies, higher denial rates, and inability to scale can hinder your growth.

As a revenue cycle leader, your proactive steps toward integrating AI into RCM will set you apart in a competitive market. Start by assessing your needs, selecting the right technologies, and preparing your team for the transition. The return on investment is not just in dollars but also in improved operations and patient relationships. ■

James Wood brings 25 years of billing, technology, and healthcare leadership experience to Billing Paradise where he serves as Chief Growth Officer. He has extensive knowledge of payor trends, billing statistics, and robotic process automation (RPA) which is valuable in this industry.

Move Beyond Coding with CAC

Dramatically Increase Coder Productivity with AI Computer-Assisted ICD-10 Coding Capture.

By Mark Anderson

Payors are becoming increasingly concerned about the issue of medical necessity. Medicare generally defines medically necessary services as those that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Other payors have their own variations on the definition, but essentially, medical necessity requires doing the right thing for the right patient at the right time and place. Claims for services that do not meet medical necessity requirements are typically denied straight out; if they are paid in error, the reimbursement may be recouped in the future. The denial explanation may be "non-covered service" or "not medically indicated."[1]

Therefore, correct ICD-10 coding is essential, but paying for the annual training of a certified coder ($2,295 to $3,095)[2] can get expensive, as can the average cost of coding an encounter. Considering that the average physician treats approximately 34 patients per day and given industry standards, a typical medical coder can code between 15 to 25 cases per hour (depending on specialty), which translates to around 100 to 160 cases per day for an eight-hour shift (assuming breaks and time to search for required data and forms). This means that the average practice needs 3.0 to 4.7 certified coder hours per day per FTE physician. Given that the average salary for medical coders in the U.S. in 2022 was $58,055 annually, this translates to an annual cost of $23,222 to $32,252 per physician for medical coder cost to ensure that correct ICD-10 coding is documented and to confirm that each physician

When it comes to achieving revenue goals and complying with regulatory requirements, coding speed and accuracy are essential. To meet this need, the revenue cycle management (RCM) industry has started adapting new software with industry-leading clinical natural language processing (NLP) engines that incorporate advanced Artificial Intelligent (AI) Computer-Assisted Coding (CAC) modules designed to be flexible and scalable to increase accuracy, efficiency, productivity, and flexibility of clinical diagnostic coding.

can justify risk adjustment coding issues. That works out to coding costs of between $3.42 to $4.74 per clinical encounter.

When it comes to achieving revenue goals and complying with regulatory requirements, coding speed and accuracy are essential. To meet this need, the revenue cycle management (RCM) industry has started adapting new software with industry-leading clinical natural language processing (NLP) engines that incorporate advanced Artificial Intelligent (AI) Computer-Assisted Coding (CAC) modules designed to be flexible and scalable to increase accuracy, efficiency, productivity, and flexibility of clinical diagnostic coding.

ALPHA RCM CAC Project

A smaller RCM service vendor located in the southeast that handles billing, revenue cycle, and collections services for 21 practices, with a total of 95 primary care providers (physicians and PAs), also wanted to start offering ICD-10 coding assistance so they could help their provider clients reduce coding costs, reduce potential denials, and improve risk adjustment coding. The RCM service vendor implemented an advanced AI CAC module to accomplish these goals. The CAC software they selected was designed to be flexible and scalable for any sized RCM vendor and was designed and configured with the help of the RCM vendor to increase accuracy, efficiency, productivity, and flexibility. The CAC software vendor partnered with this RCM service vendor to implement and test the CAC vendor's overall quality and performance and test and validate how the CAC software might help reduce payor claim denials, improve claims processing timing, and ensure risk-adjustment coding requirements.

The project took 90 days from contract signing to testing the first 100 encounter progress notes (SOAP notes) generated by two different EHR software products. The results were impressive. The RCM service vendor CAC software read the patient's clinical progress note within an average of 30 seconds; the CAC software provided the coder with the recommended appropriate ICD-10 codes with 98% coding accuracy. The coder selected the recommended ICD-10 codes and attached the code to each of the appropriate line-item CPT codes based on Correct Coding Initiatives (CCI edits). Based on initial testing, it was determined that the average coder could increase hourly coding from 22 encounters to 48 encounters, an impressive 118% improvement. Over the course of the first month, overall coder productivity decreased slightly, but overall, the number of coded encounters per coder hour increased from 22 to 41, with an average improvement of 86%.

After conducting a third-party audit, the following benefits were documented:

1. Quick interface with two different EHR software products within 45 days.
2. Flexible Cost Structure – RCM paid a flat per claim fee to scale up and down easily with patient flow.
3. Reduced coding time by 48% – reduction of staff hours by 38% after the first month.
4. Reduction of up to 28% of initial denials within 60 days.
5. Provision of a HIPAA-compliant dashboard for audit trail and performance tracking.
6. Risk-Free Implementation – the RCM received quick financial benefits from no implementation fee and free coding for the first month.

7. Error-free AI-enabled coding resulted in RCM realizing over 98% coding accuracy.
8. Automatically identified charts that have potential queries for seamless validation and acceptance.
9. Leveraged NLP and patented AI to automatically suggest billable ICD-10 CM, PCS, and CPT codes from different types of clinical documents.

Summary

As the industry moves from Fix-based reimbursement to Outcomes and Quality based reimbursement, one of the new strategies will be to clearly document patients' core diagnostic codes as well as all co-morbidities. To accomplish this, physician practices will need a new technology designed to extract all potential clinical findings and outcomes at the lowest costs. Selecting and Implementing an AI Computer-Assisted ICD-10 coding capture system, designed to save time while maximizing quality incentive programs, is the future of enhanced reimbursement in the healthcare RCM industry. For HBMA members, it will be imperative to include an AI Computer-Assisted ICD-10 Coding process within their company if offering to stay competitive. There are no proven technologies that will cut the cost of effective quality driven coding available in the market today. Therefore, it is time for all HBMA members to start looking into AI Computer-Assisted Coding in 2025. ■

Mark Anderson, CEO of AC Group, Inc. is one of the nation's premier IT research futurists dedicated to health care and is also the COO of East Texas Health System. He has 52 years of experience in healthcare as a CEO, CFO and the corporate CIO at 4 IDNs and has worked with over 300+ hospitals and over 26,000 physicians. Additionally, since 2010, Mr. Anderson has worked with 28 ACOs to move from FFS to VBR, has created over 20 Care Coordination and Patient Engagement programs, and has developed the 7-Stages of VBR functionality matrix. Additionally, Mr. Anderson has served as an Expert Witness on numerous legal cases dealing with healthcare technologies, hospital protocols, HIPAA and security breaches, and numerous malpractice cases.

Resources

1 https://www.aafp.org/pubs/fpm/issues/2011/0300/p31.html

2 https://www.aapc.com/resources/online-medical-coding-training-courses

Building Effective Retention Strategies in Healthcare Through Training and Development

By Nicola Hawkinson, DNP, RN, RNFA, CPC

Employee retention is a pressing concern across industries, but in healthcare – and particularly within revenue cycle management (RCM) – it has become crucial to long-term success. The healthcare sector faces a dual challenge: a growing demand for services and an increasing shortage of skilled professionals. In this context, retention is more than a measure of employee satisfaction; it is a key factor in an organization's ability to provide quality care and maintain operational efficiency.

In a sector where mistakes can have profound consequences and continuity is essential for patient care and billing accuracy, the role of training in retention cannot be overstated. This article explores comprehensive retention strategies, with a special focus on how continuous training and development can support an engaged, competent, and loyal workforce.

Redefining Retention: Setting Clear Goals

To improve retention, healthcare organizations must first define what retention means for them. Retention benchmarks vary significantly, depending on industry norms, job roles, and organizational goals. The traditional expectation of long-term employment – common just a decade ago – is fading, with the average tenure today dropping to four years, and even less for younger generations.

For healthcare organizations, where specialized knowledge and skills are vital, setting clear retention goals aligned with realistic benchmarks can prevent undue pressure. For instance, aiming for a five-year tenure might be ambitious, but could serve as a realistic target. Retention goals need to align with the organization's operational requirements, particularly for roles within RCM, where the continuous cycle of billing, coding, and claims management requires stability and consistency.

Understanding the New Employee Landscape: Shifting Needs and Priorities

Today's workforce values work-life balance, recognition, and meaningful work over traditional perks like job security alone. While competitive salaries and benefits remain important, they are no longer enough to retain top talent. Employees now prioritize flexibility, purpose, and recognition, presenting both challenges and opportunities for healthcare employers.

Healthcare organizations, especially in RCM roles that may seem repetitive, need to find ways to imbue daily tasks with meaning. Managers can connect routine tasks to the organization's broader mission, emphasizing how each role contributes to patient care, even if indirectly. In doing so, they can foster a sense of purpose that enhances employee commitment.

Training as a Pillar of Retention: Building a Skilled and Satisfied Workforce

Training and development are central to employee retention, especially in fields like healthcare that are constantly evolving due to regulatory changes, technological advancements, and shifting patient needs. Regular training not only builds a more capable workforce, but also fosters a sense of growth and progression that employees increasingly seek.

1. **Onboarding and Orientation Programs**
   Effective training starts with onboarding. A structured onboarding program can significantly impact an employee's long-term engagement and retention. In healthcare, where knowledge and precision are critical, onboarding should go beyond administrative basics. New hires need to understand their roles along with the complex workflows, compliance requirements, and patient-centered mission of the organization. Providing this foundation ensures employees feel equipped and valued from day one.

   Mentorship during the onboarding phase can also aid in retention. Assigning a mentor to each new hire provides a support system, allowing them to ask questions and seek guidance. This connection can ease their transition, build confidence, and reduce early turnover.

2. **Ongoing Skills Training and Professional Development**
   Continuous training is essential in healthcare, where regulations and technologies evolve rapidly. For example, RCM staff may require updates on new billing codes, compliance regulations, and electronic medical record (EMR) systems. Regular training keeps employees competent and compliant while reducing the risk of costly errors.

   Offering skill enhancement opportunities, whether through workshops, online courses, or conferences, make employees feel valued and engaged. For healthcare roles that involve repetitive tasks, skill development can prevent stagnation by introducing variety and new challenges, further strengthening retention. Furthermore, cross-training within different areas of RCM can foster a more adaptable workforce, enabling employees to fill various roles as needed, which also benefits organizational flexibility.

3. **Adapting to Technological Advancements**
   The integration of AI, data analytics, and automation in RCM has introduced new training requirements. Employees may feel anxious about new technology, fearing it could threaten their jobs. Training can alleviate these fears by showing employees how technology can enhance their work rather than replace it.

HBMA RE-ACCREDITATIONS

- **Applied Medical Systems, Inc.**
- **Comprehensive Billing Consultants**
- **ConsensioHealth Comprehensive Billing Consultants**
- **Healthcare Data Management, Inc.**

Employee retention is a pressing concern across industries, but in healthcare – and particularly within revenue cycle management (RCM) – it has become crucial to long-term success. The healthcare sector faces a dual challenge: a growing demand for services and an increasing shortage of skilled professionals. In this context, retention is more than a measure of employee satisfaction; it is a key factor in an organization's ability to provide quality care and maintain operational efficiency.

For instance, teaching RCM staff to use automated tools for routine tasks can help them shift focus to more complex, rewarding aspects of their jobs, such as managing denials or analyzing revenue trends. By keeping employees up to date on technological skills, healthcare organizations improve productivity and also demonstrate commitment to their employees' professional growth and adaptability.

Fostering Open Communication and Building Connections

Retention training goes hand-in-hand with open communication. Employees want to feel that they can express their concerns and that their input matters. Monthly meetings or one-on-one check-ins allow managers to gauge employee satisfaction and address issues before they escalate. For remote teams, virtual gatherings where employees can discuss non-work topics foster camaraderie and reduce isolation.

Feedback should be encouraged and two-way, with employees knowing their opinions are valued. Managers can also benefit from frontline insights, which provide invaluable perspectives on operational challenges and workflow efficiencies. Structured feedback channels like surveys and performance reviews provide a safe space for employees to share their thoughts, helping to build trust and improve engagement.

Customizing Flexibility and Managing Workloads

Flexibility has become one of the most important factors for employee satisfaction. In healthcare, where strict schedules often dominate, this might mean allowing customized work hours, telecommuting options, or compressed work weeks, such as summer Fridays, as short-term goals. Flexible scheduling enables employees to balance personal and professional demands, which can alleviate burnout.

However, balancing flexibility with productivity require clear goals and accountability. Managers can help employees prioritize tasks, ensuring that essential duties are completed without unnecessary pressure. This is especially important in RCM roles, where timeliness is critical to effective billing and revenue management. Clear, achievable performance goals, along with regular check-ins, help maintain productivity without overwhelming employees.

Career Growth Opportunities: Supporting Advancement and Personal Development

A lack of career growth opportunities is one of the most common reasons why employees leave organizations. In healthcare, where training and specialization are highly valued, offering career advancement pathways can significantly boost retention. For RCM employees, a career ladder might include steps from data entry roles to coding specialists, to managerial positions.

Offering educational programs, such as certifications in coding or data analysis, allow employees to expand their skill set and feel that their work is part of a long-term career. Conferences and professional seminars further reinforce employees' sense of growth and provide exposure to industry best practices, new technologies, and emerging trends. Employees who see a future within the organization are far less likely to seek opportunities elsewhere.

When budget constraints limit training opportunities, consider job shadowing within different departments. For example, billing

employees can observe front-desk operations to gain insights into patient flow, copays, and pre-authorization requirements. This cross-functional training deepens their understanding of the complete revenue cycle, fostering an appreciation of how their work impacts the larger healthcare process.

Recognizing and Celebrating Successes

Recognition is a powerful retention tool. Employees who feel valued are more likely to stay with their organizations, so it is important to celebrate their contributions – both big and small. Simple gestures like a thank-you note or team lunch can go a long way. Formal recognition programs, such as employee-of-the-month awards or annual performance bonuses, provide employees with tangible rewards for their hard work.

Celebrating achievements also strengthens team morale. For example, engaging employees in themed office activities like holiday decorations or team-based competitions creates a sense of community. Small incentives for these activities, like gift cards, make employees feel appreciated and reinforce their role in the organization's culture.

Addressing Compensation and Fair Pay Structures

Transparent and fair compensation practices are vital to retention, especially in healthcare, where disparities can lead to dissatisfaction. Employees talk, and when compensation appears opaque or inequitable, they are more likely to seek opportunities elsewhere. A well-structured, transparent pay scale fosters trust and ensures that employees focus on their work rather than perceived inequalities.

Offering competitive compensation that reflects industry standards is important, but even more crucial is maintaining a balance that reflects each employee's role, experience, and contributions. An equitable pay structure shows employees that they are valued and respected, which can strengthen their loyalty.

Emphasizing Transparency in Organizational Vision and Direction

Employees want to feel part of something meaningful, particularly in fields like healthcare where mission and impact are paramount. Regularly sharing the organization's vision, mission, and strategic goals keep employees connected to the bigger picture. Transparency around business objectives, new initiatives, and organizational priorities helps employees understand the importance of their roles and fosters a sense of unity.

In healthcare, transparency is particularly crucial as the sector evolves. Regular updates on industry shifts, regulatory changes, and compliance requirements keep employees informed and prepared. When employees know that their organization is committed to growth and integrity, they are more likely to invest in their roles and stay long-term.

Enhancing Retention Through Training-Driven Engagement

Training as a retention strategy is effective because it addresses employees' desires for skill development, growth, and job satisfaction. For healthcare organizations, where the knowledge and skills of the workforce directly impact patient care, prioritizing training is not just beneficial but essential. From onboarding to continuous education, training supports retention by making employees feel competent, valued, and capable of contributing to the organization's mission.

When training is seen as an investment rather than an expense, it becomes an asset to the organization. Well-trained employees are better equipped to handle industry challenges, reduce errors, and improve operational efficiency, which ultimately benefits both the organization and its patients. For example, training in data analysis can enable RCM employees to manage denials more effectively, reducing revenue loss and improving financial stability.

Conclusion: Training for Long-Term Success in Retention

Retention in healthcare is a complex issue that demands a multifaceted approach. While competitive salaries and benefits are important, they are no longer sufficient to keep employees engaged. Instead, retention strategies must encompass a holistic view of employee needs, including work-life balance, career growth, and ongoing professional development.

By prioritizing training and development, healthcare organizations can create a workforce that is not only competent but also committed and loyal. Training provides employees with the tools they need to succeed and gives them a sense of purpose and direction within the organization. When employees feel that their organization is invested in their growth, they are more likely to invest in the organization in return.

Retention is no longer about merely keeping employees on board; it is about creating an environment where they can thrive, grow, and contribute meaningfully. By adopting retention training strategies that align with today's workforce expectations, healthcare organizations can reduce turnover, improve morale, and build a productive, resilient team that is prepared to meet the demands of the future. ■

Nicola Hawkinson, DNP, RN, RNFA, CPC, is a distinguished healthcare professional, educator, and visionary leader with extensive expertise in medical staffing and revenue cycle management. In addition to her multi-specialty clinical expertise, she also contributed to the field as an editorial board member for Spine Universe, frequently writing articles and continuing education tutorials.

In 2008, Nicola founded SpineSearch, a premier recruitment, education, and consulting company dedicated to orthopedic spine surgeons, neurosurgeons, and pain management physicians. Under her leadership, SpineSearch has grown to service facilities and practices nationwide, providing tailored solutions that address the unique needs of the spine and orthopedic community.

Nicola further expanded her services in 2019 by launching Core Medical Revenue Cycle Management which addresses the specific requirements of the medical revenue cycle process, offering boutique, specialized services tailored to the spine surgery and medical community.

FEATURE STORY

WHAT IS Denials Management?

By AAPC's Thought Leadership Team

Printed with Permission by AAPC / aapc.com/resources/what-is-denials-management

Medical billing denials management is the process of investigating, analyzing, resolving, and preventing denied insurance claims for medical services provided by a physician or other qualified healthcare professional.

Healthcare professionals send medical claims to healthcare payors, like Medicare or commercial health insurance companies, for payment of medical procedures, services, or supplies. The payor adjudicates (evaluates and determines the outcome for) the claim in a timely manner. If there are no issues with the claim, the payor pays the contracted amount. The provider receives payment, and the healthcare organization gains revenue. When a claim is rejected or a denial occurs, however, the healthcare provider does not receive reimbursement for the medical care provided to the patient.

Common reasons for rejected or denied claims include coding errors, duplicate claims, lack of medical necessity, patient eligibility issues, and insufficient documentation. A high denied-claims rate hurts a physician practice's financial bottom line because they are not getting payment for services rendered. Managing denials to decrease denial rates helps healthcare providers ensure they are billing medical services properly and receiving adequate payment for their services in a timely manner. Effective denials management can significantly improve the healthcare practice's financial health and patient satisfaction.

Before diving into denials management, it is important to discuss the terms claim rejection and denial. Different entities may have their own definitions for these terms or use rejection and denial interchangeably. A typical view in the healthcare industry is that a claim rejection is caused by incorrect or missing data and occurs before the claim has been fully processed by the payor; for example, a payor or the provider's clearinghouse or claims scrubber scans the claim and finds there is no insurance subscriber listed, or a Medicare number is invalid, causing a rejection. A denial on the other hand

Managing denials to decrease denial rates helps healthcare providers ensure they are billing medical services properly and receiving adequate payment for their services in a timely manner. Effective denials management can significantly improve the healthcare practice's financial health and patient satisfaction.

applies to a claim that the insurance carrier processes and deems unpayable. Providers may have to follow one set of requirements for handling rejections and another for denials. An individual responsible for denials management may work on both rejections and denials to reduce delays in claims processing and payment.

What Is the Denials Management Process?

The denials management process in medical billing helps healthcare organizations ensure their medical providers are properly compensated for medical services, procedures, equipment, treatment, and care.

Here are key steps in the denials management process:

1. **Understand and Identify Denials:** The first step in denials management is to identify claims that have been rejected due to clerical deficiencies or denied by the insurance company. Most states require insurers to pay claims within 30 or 45 days. Practices should run reports of outstanding claims beyond a set period (such as 45 days), reach out to the payor (using the process outlined by the payor), and inquire on the status of the claim. Many payors have portals providers can easily access to identify a claim, see the status of denials, and either apply the corrections to the claim or start the appeals process. Billers also must regularly check the payor's explanation of benefits (EOB) and electronic remittance advice (ERA) statements for claims to identify denials and see what caused them.
2. **Analyze and Categorize Denials:** Once denials and rejections are identified, practices should categorize them based on the reason. Common categories include coding errors, duplicate claims, lack of medical necessity, or issues with patient eligibility. It is important to analyze the causes to identify patterns or trends. This helps in identifying systemic issues that are leading to a high number of denials. Many rejections and denials are the result of obvious errors, such as late filing, being illegible, wrong patient identifier information (for example, wrong address, age, or gender), and no preauthorization. Sometimes the issue is just a case of wrong, insufficient, or nonexistent documentation. Errors on a practice's end are avoided easily by double-checking claims prior to submission.
3. **Correct and Resubmit Claims:** After the reason for rejection or denial is understood, the practice corrects and resubmits the claim, if appropriately based on the case and the procedure outlined by the payor. This may involve providing additional documentation, verifying patient eligibility, double checking the payor's EOB to ensure correct and compliant claims submission, or correcting coding errors such as separately reporting bundled codes or applying incorrect CPT® codes, diagnosis codes, and modifiers. Payor policies, including Medicare local and national coverage determinations, are resources to peruse for payor coverage rules, including details about medical necessity, coverage limitations, and claim requirements. After reviewing the claim, the medical biller or denials professional makes the necessary changes and may include a documentation addendum before resubmitting.
4. **Appeal When Necessary:** If a claim is denied, the provider must determine if the denial was appropriate and if the claim error was on the provider's end, so they can correct and resubmit it. An appeal is made if the denials specialist or biller disagrees with a coverage or payment decision. If the claim was submitted correctly and the insurance company should have reimbursed the provider according to the payor's EOB, then an appeal is necessary. With Medicare appeals, the Social Security Act establishes five levels in the appeals process:

Level 1 Redetermination by a Medicare Administrative Contractor

Level 2 Reconsideration by an independent review entity

Level 3 Decision by the Office of Medicare Hearings and Appeals

Level 4 Review by the Medicare Appeals Council

Level 5 Judicial review in a U.S. district court

Medicare has different CMS forms for each level of denials appeals.

5. **Prevent Future Denials:** The final step in the denials management process is to use the information gathered to prevent future denials and rejections. This could involve training staff in correct medical coding practices, talking with the provider about improving documentation, or implementing better patient eligibility verification processes at the front desk.

These steps can help improve revenue cycle management and ensure providers are adequately compensated for their services.

How Do Healthcare Claim Denials Affect Medical Practices?

When a claim is denied, the insurance company refuses to pay for the services rendered. For the provider, the financial impact of healthcare claim denials is loss or delay of payment and the additional cost of having to rework the claim. Too many denials will significantly hurt healthcare providers' revenue and their patient satisfaction. Here are the ways denials will negatively affect a practice or healthcare organization:

- **Lost Revenue:** The most direct impact on a healthcare practice is the loss of revenue. If a claim is denied, the healthcare provider may not be compensated for their services, leading to lost income.
- **Increased Administrative Costs:** Denials also lead to increased administrative costs. The process of identifying, categorizing, analyzing, and appealing denials requires time and resources, which adds to the operational costs of a healthcare provider.
- **Delayed Revenue:** Even if a denial is eventually overturned on appeal, the revenue is delayed. This can impact cash flow and make financial planning more difficult.
- **Patient Satisfaction:** Frequent denials can also lead to patient dissatisfaction. If patients are billed for services that they believed would be covered by insurance and are not, having to pay out-of-pocket for healthcare services will lead to confusion and frustration.

Effective denials management helps prevent these issues, making it crucial to maintaining the financial health of a healthcare practice.

What Skills Are Useful in Denials Management?

Denial management requires a combination of detective work and common-sense problem-solving skills. Besides having the ability to process and reduce denials, a big part of managing denials is filing appeals. Anyone speaking with the healthcare insurance carrier regarding a claims appeal – whether it is a biller, coder, denials manager, or provider – should have the knowledge and detailed information necessary to discuss that appeal and review the operative note or encounter note with the payor. The practice's representative must be able to understand the rationale for documentation, coding, and billing, and be able to explain why the claim is correct, compliant, and should have been paid and treated differently.

Someone who is managing denials and appeals requires a specific set of skills, including:

- **Knowledge of medical coding:** Understanding HCPCS Level II, ICD-10-CM, and CPT® codes and ensuring the codes support physician documentation will help prevent denials due to coding errors.
- **Understanding insurance policies:** Professionals in this field need to understand different insurance policies, coverage details in the EOB, and the reasons why claims might be denied.
- **Analytical skills:** The ability to analyze denial patterns and identify systemic issues is important for preventing future denials.

- **Communication skills:** Strong written and verbal communication skills are essential. Denials managers need to communicate with insurance companies, healthcare providers, and sometimes patients.
- **Attention to detail:** Given the complexity of medical billing and the potential for errors, attention to detail and investigating the reason for denials will help put an end to unnecessary denials.
- **Problem-solving skills:** The ability to solve problems and find solutions is important, especially when it comes to overturning denied claims.
- **Knowledge of the revenue cycle:** Understanding the entire revenue cycle will help to identify where issues are occurring, where the cash flow is bottlenecked, and how to fix it.

What Certifications and Careers Are Available in Denials Management?

In addition to working to resolve and prevent denials, denials management professionals give feedback to staff and providers to improve clinical documentation. The feedback facilitates ongoing documentation improvement to meet all requirements of the medical record and help avoid future denials. There are denials management courses and several certifications to help employees gain denials expertise and specialized knowledge in the healthcare industry:

- A professional coding certification demonstrates proficiency in coding of diagnoses, procedures, and services for physicians and nonphysician practitioners.
- A professional billing certification demonstrates skills related to maintaining various aspects of the revenue cycle, particularly patient and payor billing and collections.
- Inpatient and outpatient documentation expert certifications validate expertise in reviewing inpatient or outpatient documentation for accuracy to support coding and clinical requirements.

These certifications can help demonstrate a job candidate's knowledge and skills in the area of denials management and appeals, making the candidate more attractive to employers who are hiring for the following positions in the healthcare industry:

- The denials management specialist identifies and analyzes denied claims, works to overturn denials, and implements strategies to prevent future denials.
- An appeals specialist prepares and submits appeals for denied claims. These specialists need to understand the reasons for denials and how to effectively argue why the claim should be paid in accordance with payors' EOB and ERA statements.
- The revenue cycle analyst analyzes the entire revenue cycle, including denials, to identify areas for improvement. They may work on strategies to reduce denial rates and improve revenue.
- Although the medical coder is not exclusively focused on denials, medical coders play a crucial role in preventing denials. They need to accurately code services to ensure they are billed correctly and not denied by insurance companies.
- The billing manager's role is to oversee the entire billing process, including denials management. They need to ensure that processes are in place to effectively manage and appeal denials. These roles require a good understanding of medical coding, insurance policies, and the healthcare revenue cycle.
- A certified professional specializing in denials management can use their skills to reduce denied claims and increase practice revenue. Their expertise reduces administrative costs and improves reimbursement speed to ensure steady and predictable cash flow.

By reducing denials, practices can also improve the patient billing experience, leading to enhanced patient satisfaction, increased patient retention, and referrals. ■

The AAPC Thought Leadership Team is the author of the content and holder of the copyright. They are a distinguished consortium of experts, visionaries, and thought leaders committed to shaping the landscape in the industry. With a deep understanding of the profound impact our industry has on society, this council serves as a guiding force, driving the development and implementation of ethical standards in coding practices.

Bipartisan Call for Medicare Payment Reform Paves Path for Action

Bruce A. Scott, MD
Printed with Permission by American Medical Association

Growing bipartisan support for Medicare reform in the U.S. House of Representatives is clear evidence that our sustained physician advocacy is moving us closer to fixing our badly broken physician payment system.

A "dear colleague" letter signed by 233 Republican and Democratic House members supports not only blocking the 2.8% payment cut for physicians treating Medicare patients due to take effect on Jan. 1, 2025, but also calls for a permanent annual update tied to the Medicare Economic Index (MEI) that reflects the increasing cost of delivering patient care. The 2.8% reduction is compounded by the fact the current cost to maintain a physician practice is increasing by 3.6%, as measured by that same MEI.

Speak Up for Medicare Reform

The need for Medicare physician payment reform has never been greater. The AMA shows how the current system is unsustainable – and how you can urge Congress to support solutions.

This letter is a direct result of physician-led advocacy by the AMA and dozens of state and specialty societies across

Considering that, adjusted for inflation, Medicare payments to physicians have plummeted by 29% since 2001. That means for a sizable number of physicians nationwide, the current rate of Medicare payment is lower – and some cases, far lower – now than it was when we graduated from medical school. And of course, the cost of maintaining a practice during that same time has soared.

the country whose members have been significantly impacted by declining Medicare reimbursement.

Both of the reform measures called for in the letter – stopping the payment cut and adding an inflation-based update – are critically important in maintaining patient access to Medicare. Unless Congress acts during the coming lame duck session, 2025 will mark the fifth consecutive year of payment cuts for physicians and extend a devastating decline in Medicare physician reimbursement that already stretches beyond two decades.

Considering that, adjusted for inflation, Medicare payments to physicians have plummeted by 29% since 2001. That means for a sizable number of physicians nationwide, the current rate of Medicare payment is lower – and some cases, far lower – now than it was when we graduated from medical school. And of course, the cost of maintaining a practice during that same time has soared.

Ensuring Patient Access to Care

Physicians have been paying the price for a broken Medicare payment system for far too long. That is especially true for physicians like me in small, independent practices that have endured significant payment cuts in a time of steadily increasing practice costs, sometimes forcing us into difficult decisions to cut staff positions or limit the number of new Medicare patients we see.

Ensuring that physicians can maintain the fiscal viability of their practices through an inflation-based annual update is critical to ensuring patients have access to Medicare in the future. Taking that long-overdue action merely brings physicians into alignment with the rational and automatic yearly inflationary payment increases granted to hospitals, skilled nursing facilities and others who serve Medicare patients.

The 233 members of Congress supporting the latest call to action on physician payment reform recognize the ever-widening gap between the amount Medicare pays for care and costs physicians incur in providing it and have committed themselves to supporting legislative action to close that gap.

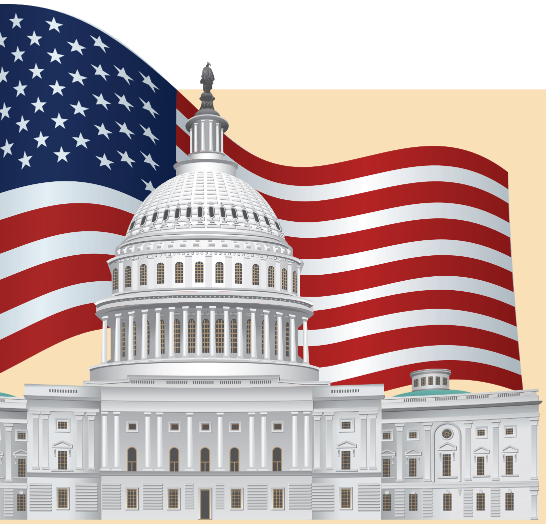
An unsustainable Medicare physician payment system jeopardizes patients and puts physician practices at risk. Absent a rational and predictable Medicare payment system, physicians will continue to struggle to adequately pay staff in a competitive labor environment, acquire new equipment and make other investments, and maintain the financial viability of their practices.

All patients – not just Medicare patients – are put at risk when our flawed and outdated payment system forces physicians to close their doors. That risk is heightened for Medicare patients in rural and underserved areas of our nation.

It is no secret that our nation is experiencing deep political division over a broad range of issues. But the fact that a solid majority of House members are coming together at this moment to support a permanent fix to Medicare physician reimbursement reflects the urgency and depth of need for prompt and decisive action. Instead of gridlock, we have agreement. Instead of conflict, we have compromise. The stage is set to resolve a problem that has plagued physicians and patients for far too long.

The AMA stands ready to work with all interested parties to pass these crucial policy changes before the end of the year. Doing so will produce a financially viable and more predictable Medicare physician payment system that protects access to high-quality care where it is needed most. Congress must cancel the scheduled 2.8% payment cut, enact targeted reforms to budget neutrality requirements, and provide physicians with a payment system that truly reflects the cost of care. ■

Bruce A. Scott, MD is President of the American Medical Association.



How the 2024 Election Results Impact the RCM Industry

By Matt Reiter

After months of a dramatic and exciting campaign season, the 2024 presidential and congressional election is now in the rear-view mirror. Control of the White House and both chambers of Congress were up for grabs in a highly competitive election. When election day finally arrived, the Republican party came away victorious, keeping control of the House of Representatives and winning control of the White House and Senate.

President

Former President Trump won a decisive electoral victory over Vice President Kamala Harris. Trump won all seven "battleground" swing states while not losing a single state that he won in 2020. His margin of victory in those swing states was narrow, but wider than the margins with which President Biden won those states in 2020. Trump also won the popular vote by a very narrow margin for the first time in his three presidential elections. He will follow President Grover Cleveland as the second president to serve two non-consecutive terms.

Senate

As was widely expected, the Senate flipped from Democrat to Republican control. Several incumbent Democrats successfully defended their seats, despite Trump's victory. However, Democrats went into the election with a very slim majority and many unfavorable races. Republicans will control the Senate with a 53 to 47 majority.

Republicans controlling the Senate has hugely important implications for the Trump administration. The Republican victory in the Senate means it will be much easier for President Trump to confirm his cabinet and judicial nominees. It could also provide an opportunity for Trump to appoint new Supreme Court justices, should any vacancies arise during his term.

House of Representatives

The House Republicans will control 220 House seats; the Democrats won 215 seats. However, this can change, depending on how many Representatives Incoming President Trump nominates for Cabinet positions.

Several healthcare professionals were elected to Congress (it is a coincidence that they all represent their respective state's 3rd district).

- **South Carolina 3rd District:** Sherri Biggs (R), psychiatric nurse practitioner
- **Utah 3rd District:** Mike Kennedy (R), family medicine doctor
- **Missouri 3rd District:** Bob Onder (R), allergy and asthma doctor
- **Oregon 3rd District:** Maxine Dexter (D), pulmonologist and critical care physician
- **Minnesota 3rd District:** Kelly Morrison (D), OB/GYN physician.

Many health professionals are retiring from Congress, which could leave fewer Congressional allies on key issues such as physician reimbursement and telehealth. It is refreshing to know that these allies will be replenished with new healthcare professionals.

Future of the Filibuster

Control of the Senate means less if a party does not control at least 60 seats. This is because of the Senate's rule,

Many health professionals are retiring from Congress, which could leave fewer Congressional allies on key issues such as physician reimbursement and telehealth. It is refreshing to know that these allies will be replenished with new healthcare professionals.

commonly referred to as the filibuster, which requires at least 60 votes to advance most legislation. Republicans will not have 60 seats, and it is highly unlikely they will be able to attract enough Democrats to reach that threshold for most (if not all) of their legislative agenda.

Senate Republicans will also have a new leader for the first time since Kentucky Senator Mitch McConnell ascended to this role in 2007. McConnell is not running for re-election as Republican Senate Leader. John Thune won a secret Senate election for McConnell's position. Public support for the filibuster has gradually eroded as it has consistently stood in the way of legislation championed by both parties. Senator McConnell was a staunch defender of the filibuster and Speaker-elect Thune defends it as well.

Budget Reconciliation

The filibuster can be circumvented using the budget reconciliation process when one party controls the House, Senate and White House. Republicans will likely rely on this legislative procedure since the filibuster will remain in place, but it is an obstacle to the Republican legislative agenda.

Budget reconciliation allows the Senate to pass legislation with a simple majority instead of the 60-vote threshold. Due to neither party's ability to overcome the filibuster, most recent major legislation was passed using this procedure including the Affordable Care Act, the Tax Cuts and Jobs Act, the American Rescue Plan Act and the Inflation Reduction Act.

While politically advantaged, reconciliation bills are disadvantaged from a policy standpoint in that they can only include provisions that directly impact federal spending and revenue.

Lame Duck

Congress returned to the Capitol in mid-November to kick off the "lame duck" session of Congress. Congress was out of D.C. since September and has not meaningfully addressed most legislative issues since July. We are now in a sprint to the finish line.

Congress had several important issues to address before the end of the year. These included funding the federal government, extending Medicare telehealth coverage flexibilities, and averting as much as a nine percent reduction to Medicare payments to clinicians. Senators and Representatives also attempted to advance their personal legislative priorities before the end of the year.

Previewing the Next Two Years

Every presidential transition is filled with uncertainty and opportunity. President-elect Trump has announced he will nominate Robert F. Kennedy, Jr. as HHS Secretary and Dr. Mehmet Oz as CMS Administrator. There is a common saying in Washington that "people are policy." These nominees will have a huge impact on what the priorities for these agencies will be over the next four years.

Our work during the presidential transition and new Congress is the same, regardless of the election results. There will be new people in important government positions in both the executive branch and Congress. New Congresses are always a sprint out of the gate. We expect a flurry of activity in January. Those initial months are crucial for making key officials aware of our industry's priorities and how we can be a resource for their work.

Many of HBMA's advocacy priorities will continue to be important topics that must be addressed in the 119th Congress. These include sustainable Medicare reimbursement reforms, reducing administrative burdens such as prior authorization, and cybersecurity.

2025 has some important deadlines for some important policies. For example, expanded eligibility for Affordable Care Act (ACA) premium assistance expires at the end of 2025, as do many of the provisions of Trump's signature tax reform legislation, the 2017 Tax Cuts and Jobs Act. Congress will have to either extend these policies or allow them to expire. It is safe to assume that Congress will extend the tax bill policies. But the ACA subsidy eligibility enhancement could expire which would revert the policy back to limiting eligibility to people earning up to 400% of the federal poverty level.

Congress could also repeal and/or replace some or all of the Inflation Reduction Act (IRA), which was passed by Democrats using budget reconciliation.

We expect that the incoming Congress and Trump Administration will be largely supportive of the Medicare Advantage (MA) program. MA has always enjoyed more support from Republicans than Democrats. Dr. Oz is a big advocate of the MA program. He also wants to slash Medicaid and include work requirements. While Republicans could be open to some reforms, we expect a generally friendly political environment for the MA plans over the next few years.

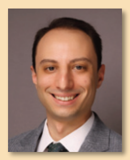
We also expect Republicans to continue emphasizing healthcare price transparency and expanding site neutral payments in Medicare.

It remains to be seen if Republicans will keep or change Biden Administration regulations such as the Federal Trade Commission's (FTC's) ban on non-competes and the Consumer Financial Protection Bureau's (CFPB's) proposed rule to prohibit patient medical debt from consumer credit reports.

It is safe to say that many of the same policy topics will continue to be priorities in the next Congress, just with different perspectives on those issues than what we have seen over the last few years.

Lastly, it is important to note that Congress is not great at multi-tasking. Sometimes, a policy issue can consume all of the oxygen in the Capitol at the expense of other policies. Will certain campaign priorities such as the economy or immigration policy consume all of Congress' attention at the expense of policies such as prior authorization?

It is best to look at change as an opportunity. HBMA is well positioned for the new Congress and presidential administration. Our advocacy priorities enjoy bipartisan support and many of our key Congressional allies are returning to Congress and their positions on key committees. As with every new presidential administration, we look for opportunities to align our priorities with those of the new administration. We believe there will be significant overlap between the Trump administration's priorities and ours on topics such as burden reduction, value-based payments, telehealth, and Medicare payment reforms. ■



Matt Reiter is a Principal at Capitol Associates, a bipartisan government relations firm specializing in federal health policy. He represents HBMA on federal legislative and regulatory policy.

WELCOME HBMA VENDORS

THANK YOU FOR YOUR SUPPORT!

- Prosper Ai
- ClaimRev

The Importance of HIPAA-Compliant Safeguards

By Chad Schiffman

Several months ago, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) announced a settlement with Bryan County Ambulance Authority (BCAA) in Oklahoma over a ransomware incident due to a significant cybersecurity vulnerability in healthcare. This settlement not only highlights the real and increasing threat of ransomware, but also serves as a reminder to all healthcare providers and business associates of their responsibility to comply with HIPAA's Security Rule.

For billing and revenue cycle management companies, this settlement and OCR's ongoing focus on Security Risk Analysis (SRA) and cybersecurity provide some important insight into the importance of safeguards that should be in place to ensure cybersecurity and HIPAA compliance across operations. The settlement between BCAA and OCR provides some important takeaways that demonstrate this importance.

Cyberthreats Are Real and Increasing

The healthcare industry remains one of the primary targets for cyberattacks, especially ransomware. Since 2018, OCR has reported a 264% increase in large breaches linked to ransomware, which explains their focus on ensuring that adequate cybersecurity measures are in place. Because billing and revenue cycle management companies often access, create, store, and transmit protected health information (ePHI), it is critical to ensure that HIPAA-compliant administrative, physical, and technical safeguards are in place to proactively protect the information.

Importance of HIPAA-Compliant Risk Analysis

OCR's settlement with BCAA enforcement action came under the Risk Analysis Initiative, emphasizing the need for a HIPAA-compliant risk analysis. The SRA process involves identifying potential risks and vulnerabilities to ePHI within an organization's information systems. In the case of BCAA, failure to perform a compliant risk analysis, including assessing safeguards, led to this significant ransomware attack that affected 14,273 patients.

Consequences of Non-Compliance

BCAA agreed to pay $90,000 in penalties and entered into a three-year corrective action plan with OCR. In addition to the financial cost and monitoring from OCR, enforcement actions such as this can bring reputational risks and scrutiny. Organizations that complete an accurate and thorough SRA and have safeguards in place have a much better defense and can avoid the consequences of non-compliance. Instead, OCR may provide additional guidance and recommendations to prevent future incidents.

Tips for Ensuring HIPAA Security Compliance

Based on OCR's guidance, the following activities help organizations, such as billing and revenue cycle management companies, to ensure compliance with the HIPAA Security Rule.

1. Perform, review, and update as necessary, an accurate and thorough SRA. This includes regularly assessing where ePHI resides within the organization and information systems and analyzing implemented safeguards.
2. Based on SRA, document and implement a risk management plan to address identified vulnerabilities with reasonable and appropriate safeguards.
3. Maintain documented and implemented policies and procedures addressing all HIPAA requirements.
4. Provide ongoing security awareness training and training on security procedures to reduce the risk

The healthcare industry remains one of the primary targets for cyberattacks, especially ransomware. Since 2018, OCR has reported a 264% increase in large breaches linked to ransomware, which explains their focus on ensuring that adequate cybersecurity measures are in place.

of a cyberattack and provide a culture of safety within the organization.

To Enhance Cybersecurity Resilience

To help protect against future incidents, OCR recommends the following:

1. Ensure that business associate agreements (BAAs) or other contracts or agreements are in place with all vendors who access, create, store, modify, or transmit ePHI on behalf of your organization. The agreements should include a security incident protocol.
2. SRAs should be a regular part of operational activities, reviewed at least annually, and updated as needed.
3. Implement audit controls and system monitoring. Once implemented, regularly review system activity, and implement controls to detect unauthorized access.
4. Utilize multi-factor authentication and encryption to protect ePHI from unauthorized access.
5. Learn from incident responses from past occurrences and improve security safeguards based on emerging threats (such as ransomware).
6. Provide workforce training that is consistent with roles and responsibilities within your organization. Training should instill a culture of security and compliance within the organization.

In Summary

The settlement with BCAA demonstrates the potential risks for healthcare entities and their associates when cybersecurity and HIPAA compliance are not prioritized. For billing and revenue cycle management companies, this provides an important reminder to review and update, if needed, safeguards to comply with HIPAA requirements and reduce the impact and likelihood of a potential cyberattack. ■

Chad Schiffman joined Healthcare Compliance Pros (HCP) in 2014 as the director of compliance. He has more than 20 years combined experience in healthcare, information technology and compliance consulting services. Chad is primarily involved in consulting with healthcare clients about their HIPAA and HIPAA HITECH-related issues including breach determination, breach mitigation and corporate OIG and CMS compliance.

How to Protect Your Facebook Account from Hacking and Cloning

By Burton Kelso

Did you know that about 300,000 Facebook accounts are hacked or cloned daily? A day does not go by without someone messaging me on Facebook, looking for help with their hacked or cloned Facebook account. In today's digital age, protecting your Facebook account from cloning and hacking is more crucial than ever. Criminals target Facebook accounts because many of you fail to put the right protections in place to prevent cloning or hacking. You might think your Facebook account does not contain important data, but criminals can steal information such as your personal details and credit card numbers, causing damage to your digital marketing brand. This comprehensive guide will walk you through the essential steps to secure your account, recognize potential threats, and take proactive measures to keep your personal information safe. Here is what you need to know.

Facebook is the most targeted social media platform by cybercriminals because it potentially gives them access to three billion user accounts they can use to launch socially engineered phishing attacks to scam people out of personal information and money. Criminals will try to either steal your account from underneath your nose or clone your account to trick your followers into falling for scams.

Here are some signs that your Facebook account may have been hacked or cloned.

- Your name, birthday, email, or password suddenly change.
- Friend requests are sent to people you do not know.
- Messages you didn't write are sent from your account.
- Posts you didn't create appear on your timeline.
- You can no longer access your Facebook account.
- Your profile picture has changed.
- You notice changes with your Facebook business accounts.

If your Facebook account has been cloned, there is not much to worry about. Facebook account cloning means that criminals have created a duplicate of your Facebook account. It does not mean you have been hacked, but it can be a blow to your digital reputation.

If your Facebook has been hacked, you will no longer have access to your account. Even if you try to perform the account recovery, you will not be able to log in.

It can be devastating if your Facebook account is cloned or hacked, so it is important to take the following steps to keep it out of the hands of crooks:

- **Stop sharing your Facebook account with strangers.** Did you know people can find your Facebook account using Google? So can criminals. Make sure you hide your Facebook account by doing the following:

  a) In the **Privacy** section, find the option **Do you want search engines outside of Facebook to link to your profile?** and disable it.

- **Start using strong passwords and stop using simple passwords.** Let's face it, you are terrible at creating passwords – we all are. Your best bet is to move away from using passwords and create passphrases. A passphrase is a password created with two unrelated words along with special characters and numbers. Examples include: *ButteryTurtle1045!* or *RockTypist!325*. Once you start using passphrases, your Facebook accounts will stay completely safe.

- **Turn on two-factor authentication and don't let it turn on you.** Two-Factor or Two Step Authentication is the process of setting your Facebook account to require two stages to log in. Once it is enabled, you will need to

Facebook is the most targeted social media platform by cybercriminals because it potentially gives them access to three billion user accounts they can use to launch socially engineered phishing attacks to scam people out of personal information and money. Criminals will try to either steal your account from underneath your nose or clone your account to trick your followers into falling for scams.

enter a code that is sent to your phone or generated by an authentication app whenever you log in from a new device or browser. This adds an extra layer of security to your account. This is how to turn it on.

a) **On Mobile Devices:**

- Open the Facebook app and log in to your account.
- Tap the **Menu** icon (three horizontal lines) at the bottom right (iOS) or top right (Android).
- Scroll down and tap **Settings & Privacy**, then select **Settings**.
- Tap **Security** and **Login**.
- Under the **Two-Factor Authentication** section, tap **Use two-factor authentication**.
- Choose your preferred security method. It is recommended to use SMS or text messaging.

b) **On Windows or Macintosh Computers:**

- Log in to Facebook and click the down arrow in the top right corner.
- Select **Settings & Privacy**, then click **Settings**.
- Click **Security and Login** on the left-hand side.
- Scroll down to the **Two-Factor Authentication** section and click **Use two-factor authentication**.
- Choose your preferred security method and follow the prompts to set it up.

■ **You do not need to let strangers see you or your friends.** One thing that will make your Facebook account attractive to criminals is when they can see your friends. This makes it easier for them to simply clone your account and allow them to target your connections. Use these tips to hide your friends list:

Go to **Settings & Privacy > Settings > Privacy**.

Change the audience for your posts to "**Only me or Friends**."

Limit who can send you friend requests and who can look you up using your email or phone number.

■ **Consider getting a verified account.** Facebook offers verified accounts that promise to keep your account safe from criminals. These accounts, known by their blue checkmark next to your profile picture, are secured from criminals by making you provide a government ID to verify that you own the account. They require verification whenever you make changes to your account, such as changing your profile picture or name. Plus, you get access to Facebook support in the event something happens to your account.

Hopefully, these tips will help keep your Facebook account safe from criminals. If you have any questions, please reach out via email or on social media, I am always available. ■

Burton Kelso is the Chief Tech Expert at Integral, an IT support and computer services company, TEDx, and a national speaker, as well as a media tech expert who regularly appears on national and international TV and radio shows, offering viewers easy tips on computers, technology, internet lifestyle, and gadgets. He loves technology, he has read all of the manuals, and he is serious about making technology fun, safe, and easy to use for everyone! Burton can be reached at burton@burtonkelso.com

Sign Up for My Tech Tips Newsletter. Click the link to sign-up and subscribe and you will receive every tip directly in your inbox each week.

Introducing the New Telemedicine Codes

By Melody W. Mulaik, MSHS, CRA, RCC, RCC-IR, CPC, COC, FAHRA

On April 30, 2020, the Centers for Medicare and Medicaid Services (CMS) issued a second Interim Final Rule in response to the COVID-19 pandemic. This expanded the extensions and waivers related to the use of telemedicine services and was predominantly in response to stakeholder feedback. CMS would allow for the use of audio-only telemedicine services in addition to the real-time audio/video telemedicine services. Since that time, there have been many updates, changes, and guidelines to telemedicine codes by CMS.

CMS expanded the list of telemedicine services to allow for permanent and provisional services. Physicians would bill for telemedicine services which identify the location of the patient and how the visit was conducted, and then bill for those services per the place of service (POS) where the physician would typically work. All visits were paid at the same rate, regardless of whether the visit was in person or virtual.

After the public health emergency (PHE) ended, Congress directed CMS to extend telemedicine services through December 31, 2024. However, this extension did not apply to all services as it did during the PHE. For example, beginning January 1, 2024, physicians could still provide telemedicine visits; however, payment for office-based services was based on the location of the **patient**, not the physician. Physicians working in the office-based setting now bill for telemedicine visits utilizing the office/outpatient visit E/M codes with modifier 95 to identify it was telemedicine and the POS “02” or “10,” based on where the patient was for the visit. If the patient was at some other originating site, and not their home, POS “02” is reported, and the physician is paid at the facility rate. If the patient was at home, then POS “10” is reported, and the physician is paid at the non-facility rate.

Physicians in the hospital setting will still use modifier 95 to identify that the visit was performed as telemedicine, then document where the patient and physician were located using the POS that corresponds to the facility setting where they are working. For example, if the physician is working in an on-campus outpatient department of the hospital, they will report POS “22” and will be paid at the facility rate. CMS has finalized this process for billing telemedicine services into 2025, and beyond, pending any action by Congress which may change things.

In the 2025 CPT® Manual there is a new Telemedicine service subsection which includes seventeen (17) new telemedicine codes available for providers to report these visits. With the establishment of these codes, the regular E/M visit codes (99202-99205, 99211-99215) may no longer be utilized to report telemedicine office visits. Additionally, the existing audio-only codes 99441-99443 have been deleted.

The new codes are reported for the work involved with the delivery of telemedicine (audio-visual and audio-only) office visits. They are structured like current office and other outpatient E/M codes with four (4) levels defined by Medical Decision Making (MDM) or time. There are separate codes for new and established patients and an additional code for a “virtual check-in,” used for the evaluation of an established patient to determine whether the patient needs to be seen in person. All visits must be medically appropriate to address patient care, and the patient and/or family/caregiver must agree to the visit either verbally or in writing.

These codes are intended for use by physicians and other qualified health professionals (QHPs). As a reminder, QHPs are providers who are able to bill for services under their own name and number, typically, Nurse Practitioners (NPs) and Physician Assistants (PAs) who bill for E/M services.

These codes are **NOT** intended for: routine telecommunications related to previous encounters (e.g., communication of lab results), non-real-time communication, oversight of clinical staff (e.g., chronic care management or principal care management), time establishing the connection or arranging the appointment, services less than five minutes, or online digital communication (except telecommunication device technology for deaf patients).

The audio-video and audio-only codes can only be reported once per calendar day and may not be reported on the same day as an in-person E/M visit. If both a telemedicine visit and an in-person E/M visit occur on the same day, then the elements and time of these services are summed and reported in aggregate, ensuring that any overlapping time is only counted once.

New Codes

The first set of codes (98000 – 98007) are for synchronous (real-time/interactive) audio-video visits:

CPT® Code	Definition
98000	Synchronous **audio-video visit** for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	. . . . . and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	. . . . . and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	. . . . . and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)
98004	Synchronous audio-video visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	. . . . . and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	. . . . . and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	. . . . . and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

The next set of codes (98008 – 98015) are for synchronous audio-only visits:

CPT® Code	Definition
98008	Synchronous **audio-video visit** for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	.. . . . . low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	. . . . . moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CPT® Code	Definition
98011	. . . . . high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)
98012	Synchronous audio-only visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	. . . . . low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	. . . . . moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	. . . . . high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

And finally, and of the most interest of all, is the new "virtual check-in" code.

CPT® Code	Definition
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an **established patient**, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

This new code is intended to be used as a virtual check-in for an established patient who contacts the provider office to determine if a more extensive visit type is required (e.g., in person office or another outpatient E/M). Video technology is not required for the use of this code.

If the virtual check-in leads to an in-person E/M on the same date of service, then the time spent on the check-in would be added to the more extensive E/M visit to determine the total visit time. It is not appropriate to bill 98016 along with another E/M visit on the same service date. It is also not appropriate to bill 98016 if the patient will be seen within the next 24 hours or soonest available appointment.

Code 98016 is similar to the existing HCPCS code G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).

Reimbursement

As with the creation and implementation of all new CPT® codes, it is important to review how the codes will be reimbursed, if at all. In the 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS has assigned the new codes 98000-98015 a procedure status indicator of "I", which means there is a more specific code (i.e., existing office/outpatient E/M codes) to be used for Medicare and that they will not accept these new

In the 2025 CPT® Manual there is a new Telemedicine service subsection which includes seventeen (17) new telemedicine codes available for providers to report these visits. With the establishment of these codes, the regular E/M visit codes (99202-99205, 99211-99215) may no longer be utilized to report telemedicine office visits. Additionally, the existing audio-only codes 99441-99443 have been deleted.

codes. Providers would utilize modifiers and place of service (POS) codes, as defined by Medicare, to identify the correct location of the patient, if applicable, for payments. According to Medicare, effective January 1, 2025, the geographic location and site of service restrictions on Medicare telehealth services once again took effect. Even though there are new telehealth codes from the AMA, this does not require CMS to recognize and reimburse the codes for telehealth services.

Of note, the new brief communication virtual check-in code, 98016, was finalized to be implemented by CMS. Due to this change, CMS is deleting HCPCS G2012 and accepting the RUC-recommended values work RVU of 0.30 and will provide reimbursement for this code (assuming all criteria are met).

It is unknown at this point how commercial payors will address reimbursement of these new codes so individual payor guidelines and communications should be reviewed.

Summary

It is good news to have new codes to accurately describe telemedicine visits. However, as with many new code sets, we find that it will take some time for CMS, and potentially, commercial payors as well, to accept and provide reimbursement. Getting a new code for virtual check-ins is a win that hopefully all commercial payors will quickly jump on board to accept.

As we move into 2025, you should have conversations with your clients regarding their use of these codes to ensure appropriate billing and reimbursement expectations. ■

Melody W. Mulaik, MSHS, CRA, RCC, RCC-IR, CPC, COC, FAHRA, is the president of Revenue Cycle Coding Strategies. She is a frequent speaker and author for nationally recognized professional organizations and publications. Melody's areas of expertise include coding and compliance, management engineering, and operations improvement, and she is nationally recognized for her extensive radiology expertise.

Innovation and Creativity – It's Everyone's Responsibility

By Dave Jakielo

Today's business environment changes by the hour, and you need to be willing to change right along with it, so remember – status quo is no, no, no. In the past, experience meant everything, but not anymore. For continued success, you will need a combination of experience and wisdom. If you have experience, that means you know what happened in the past, but wisdom allows you to adjust to what will be needed in the future.

Harry Fosdick once said, "The world is moving so fast these days that the person who says it can't be done is generally interrupted by someone doing it." Keep his words in mind as you try to develop innovative ways to improve your company. Remember, you need to be creative or perish. Standing still is impossible; you are either moving forward or going backward.

One of the fastest ways to improve your company is to make sure you tap into the collective brainpower of all your employees. Today, most companies have five generations making up their workforce, and each generation has their unique perspectives, so why not take advantage of the rich blend of experience and wisdom each generation possesses?

It is important to keep in mind that innovation and creativity will never occur within an organization that overregulates, overmanages, or overcontrols their employees. You need to encourage and reward input from everyone in the company.

Many managers think it is their sole responsibility to produce new and innovative ways to improve processes throughout their organization. Given their busy schedules, they never seem to have any time to develop and implement innovative ideas. Many firms keep doing the same things over and over, and when asked why, they respond with the famous phrase, "Because we have always done it that way."

It should not be the responsibility of any one person to generate ideas; rather, involve as many people as possible. Whatever happened to the idea of brainstorming sessions? You cannot expect input and new ideas from your team if you never ask for them or are not available to gather as a group and discuss the challenges you may be facing.

We know it is true that one of us is not as smart as all of us. So, tap into your team for creative and innovative ideas. It is important that when someone makes suggestions, you do not automatically shoot them down. If you always reject people's ideas for improvement, they will stop giving you any.

Some of the reasons we reject other people's suggestions are because:

- Change is challenging; some people may not like it, and you want to keep the peace.
- It was not your idea, so you think it will never work, or you do not want to give credit to the person who made the suggestion.
- The learning curve is too tough.
- Thinking if it is such a promising idea, wouldn't everyone be doing it?
- Changing a process is risky, and you avoid risk at all costs.

Every day, when you show up at work, you should always ask yourself how you can do things better, faster, or less expensively.

If you want to stimulate innovation and creativity, you should follow some of these rules. Set aside thinking time, block out distractions, and concentrate on possible solutions. I recommend a minimum of 30 minutes per day. Do not listen to naysayers. There will always be someone out there trying to tell you why something will not work. Try it anyway. And don't forget about exercise. Taking a brisk walk while trying to develop innovative ideas or solve challenges works for many folks.

It is important that you do not have such a fear of failure that you refuse to try new things. The saddest summary of life contains three descriptions:

- Could have
- Might have
- Should have

It is important to keep in mind that innovation and creativity will never occur within an organization that overregulates, overmanages, or over-controls their employees. You need to encourage and reward input from everyone in the company.

It is essential to remember that leaders need to realize that their importance to any organization is not judged by the amount of work they can accomplish every day; their value skyrockets if they can accomplish things through others.

Now, get out there and always remain on the road of continuous improvement in processes, products, and, most importantly, in yourself. ■

Dave Jakielo is an international speaker, consultant, executive coach, and author, and is president of Seminars & Consulting. Dave has been helping companies grow and improve their profitability for over four decades. Dave is a past president of the Healthcare Business Management Association and the National Speakers Association, Pittsburgh Chapter. Sign up for his FREE weekly Success Tips at www.Davespeaks.com. Dave can be reached via email at Dave@Davespeaks.com or by phone at 412-921-0976.

HBMA Vendor Directory

4D Global
7047 E Greenway Pkwy, Ste. 250
Scottsdale, AZ 85254
800-508-9890
4dglobalinc.com

AdvancedMD
698 West 10000 South
South Jordan, UT 84095
801-984-9500
www.advancedmd.com

AllZone Management Solutions
3795 La Crescenta Ave., Ste. 201
Glendale, CA 91208
866-854-2714
allzonems.com

Alpha II, LLC
2074 Summit Lake Drive
Tallahassee, FL 32317
850-668-3922
alphaii.com

Anatomy Financial
50 E 3rd Ave.
San Mateo, CA 94401
408-593-4440
anatomyfinancial.com

Availity
5555 Gate Pkwy, Ste. 110
Jacksonville, FL 32256
904-538-5632
availity.com

AZZLY, Inc.
2770 Indian River Blvd., Suite 202
Vero Beach, FL 32960
772-567-0206
azzly.com

Bristol Healthcare Services
12454 Pine Creek Rd.
Cerritos, CA 90703
800-253-7320
bristolhcs.com

Ceequence RCM Services, Inc.
1130 US Hwy 46 W, Suite # 27
Parsippany, NJ 07054
646-862-6367
ceequence.com

ClaimRev
19202 S 129th E Ave.
Bixby, OK 74008
918-200-6938
claimrev.com

Coding Network, The
324 South Palm Drive
Beverly Hills, CA 90212
310-459-4186
codingnetwork.com

CTECH LLC
1607 E. Big Beaver Rd., Ste. 102
Troy, MI 48083
248-526-0078
www.ctechus.com

daisyBill
34 W. 15th St. 3rd Floor
New York, NY 10011
646-847-7711
daisybill.com

DocVocate
610 Faye Ln.
Redondo Beach, CA 90277
951-235-2923
docvocate.com

eBridge, Inc.
1018 N Ward St.
Tampa, FL 33607
813-387-3870
www.ebridge.com

Ecare India Private Limited
27-28 BR Complex Woods Rd.
Chennai, Tamil nadu, India
FL 600002 IN
813-409-1986
ecareindia.com

Elite Services, Inc.
4300 S. Madison St.
Muncie, IN 47302
765-284-1478
eliteps.com

Finance System, Inc.
5703 National Rd. East
Richmond, IN 47374
765-598-5591
financesysteminc.com

First Financial Resources, Inc.
492 Old Connecticut Path, Ste. 101
Framingham, MA 01701
508-231-9303
ffrcollects.com

FrontRunnerHC
36 Cordage Park Cir.
Plymouth, MA 02360
517-403-0763
frontrunnerhc.com

Healthcare Compliance Pros
90 West 500 South, #157
South Jordan, UT 84095
801-895-3835
hcp.md

i3 Healthcare Solutions
40 Burton Hills Blvd., Ste. 415
Nashville, TN 37215
800-203-7981
i3verticals.com/healthcare

ImagineSoftware
8757 Red Oak Blvd.
Charlotte, NC 28217
704-553-1004
imagineteam.com

iMagnum Healthcare Solutions, Inc.
26077 Nelson Way Unit 502
Katy, TX 77494
410-999-0303
imagnumhealthcare.com

Inbox Health
470 James St., Ste. 001
New Haven, CT 06513
866-686-0846
inboxhealth.com

Inovalon
4321 Collington Rd.
Bowie, MD 20716
813-580-5614

JPI Data Resource
7514 St. John Dr.
Gonzales, LA 70737
888-581-8560
JPIDR.com

Luminai
15 N Ellsworth Ave.
San Mateo, CA 94401
818-674-0932
luminai.com

Magical
169 Madison Ave., #2214
New York, NY 10016
416-111-1111
getmagical.com

Matrix Imaging
6341 Inducon Dr. E
Sanborn, NY 14132
704-778-5858
matriximaging.com

HBMA Vendor Directory

Maverick Medical AI
6519 Arbor Point
Flowery Branch, GA 30542
678-751-3381
maverick-ai.com

MedEvolve
1115 West 3rd Street
Little Rock, AR 72201
800-964-5129
medevolve.com

Medical Software Solutions, Inc.
6363 State Highway 161, Ste. 350
Irving, TX 75038
410-370-0836
medsoftwaresolutions.com

MediCodio
5912 Stoneridge Mall Rd
Pleasanton, CA 94588
925-913-0400
medicodio.com

MedInformatix
5777 W Century Blvd, Ste. 1700
Los Angeles, CA 90505
310-704-3565
medinformatix.com

NexTrust, Inc.
1755 Prospector Ave, Ste. 201
Park City, UT 84060
435-940-9123

Office Ally
1300 SE Cardinal Court, Ste 190
Vancouver, WA 98683
801-995-2040
cms.officeally.com

ONQ
668 Woodland Way
Rockwall, TX 75087
469-613-7454
onqoc.com

Open Practice
300 Executive Pkwy W, Ste 300
Hudson, OH 44236
234-380-8345
OpenPractice.net

Outbound AI
999 3rd Ave.
Seattle, WA 98104
206-659-5165
outbound.ai/company

PatientPay
600 Park Offices Dr, #300
Durham, NC 27709
888-730-9374
patientpay.com

Performance Resources
86721 Pine Grove Rd
Eugene, OR 97402
541-953-8769
www.prol.ws

PHIMED Technologies
5401 Roberts St
Shawnee, KS 66226
800-909-7240
phimed.com

Pledge Health
1603 Fagan St, 304
Chattanooga, TN 37408
217-697-9728
pledge.health

PracticeSuite, Inc.
PO Box 48347
Tampa, FL 33646
813-607-2255
pratacticesuite.com

Prosper AI
550 West 45th St., #2303
New York, NY 10036
857-265-5911
getprosper.ai

QWayHealthcare, Inc.
1249 South River Rd, Ste 106
Cranbury, NJ 08512
609-905-7929
qwayhealth.com

RadPayor
7200 N Mopac Expwy, Ste 375
Austin, TX 78731
800-550-1933

Raxia
57 Avon Road
Wellesley, MA 02482
913-405-2046
www.raxia.com

RCCS
PO Box 429
Cedar Park, TX 78630
877-626-3463
rccsinc.com

Revenue Management Solutions (RMS)
9020 N May, Ste 100
Oklahoma City, OK 73120
405-463-6022
rmsweb.com

Rivet
50 W Broadway, Ste 333
PMB 46032
Salt Lake City, UT 84101
888-492-0083
rivethealth.com

RXNT
1449 Whitehall Rd
Annapolis, MD 21409
800-943-7968
rxnt.com

Skit USA, Inc.
135 Madison Ave, 7th Floor
NY, NY 10016
skit.ai

Specialized Collection Systems
7023 La Entrada Dr
Houston, TX 77083
281-381-7371
SCScollects.com

SuperDial
580 California St., Suite 1200
San Francisco, CA 94104
415-779-2540
superdial.ai

Tebra Technologies, Inc.
1111 Bayside Dr, Ste 150
Corona Del Mar, CA 92625
866-938-3272
tebra.com

TELLEM Enterprises LLC
1940 W Beach Blvd, Suite 801
Gulf Shores, AL 36542
470-365-6936
TELLEMEnterprises.com

TKSoftware, Inc.
11495 Pennsylvania St., Ste 220
Carmel, IN 46032
317-228-0857
tksoftwareinc.com

Waystar
888 W. Market Street
Louisville, KY 40202
844-692-9782
waystar.com

ZOLL
11802 Ridge Pkwy #400
Broomfield, CO 80021
303-801-0000
zolldata.com