

30
Years
of

HBMA



LEADING THE BUSINESS OF HEALTHCARE

RCM Advisor

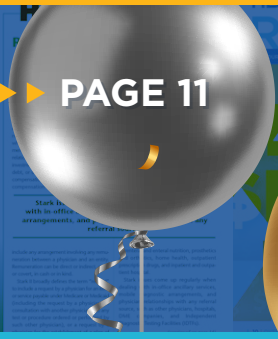
THE JOURNAL OF THE HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION VOL 30 • QUARTER 2 • 2025

HAPPY

30th

Anniversary

RCM ADVISOR



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Navigating Cultural Differences

Appreciate Workplace Diversity

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Revisit Chargemaster Rates

Consider Cost and Value of Services

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Automate Administrative Tasks

Use AI for Patient Engagement



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About **RCM Advisor**

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

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

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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*.



Staying Ahead of the Technology and Regulation Curves

As we can all agree, the revenue cycle management (RCM) industry has outsized complexities when compared to other industries. Hence, operating a small to medium-sized RCM business is incredibly challenging. With this increasing level of intricacies comes the potential for additional costs and risks. Continuous monitoring and early identification of issues can help you develop a proactive stance to changing complexities and the associated risks to your business. Becoming aware of these issues at the earliest possible moment enables greater flexibility in choosing more options in your response.

As innovative technologies and regulations continue to come online, the RCM industry is poised for significant transformation. RCM providers and their clients face a complex web of challenges and opportunities. Among the key trends shaping the RCM industry that should be on every RCM company's radar include:

increasingly rely on seamless interfacing with electronic medical records (EMRs), there is an enhanced need for platforms with robust interoperability. Data integration can prove to be effective in addressing claim accuracy, timeliness, and overall efficiency.

- **Data security and privacy concerns.** Cybersecurity must be at the top of any RCM company's list of risks. Cybersecurity risks pose an existential threat to every RCM company. RCM companies and their clients must invest in robust cybersecurity measures.

Managing a business in an extraordinarily complex, rapidly changing industry requires strategic foresight, adaptability, operational excellence, and innovation. As owners and managers of RCM companies, we must figure out the way forward by making well thought out strategic and tactical business improvements, adopting well-vetted AI and workflow

Investing in workflow automation and AI technologies do not have to break the bank. Before jumping to a cost prohibitive large scale AI solution, evaluate your current systems for opportunities to automate current workflows. Next evaluate where a more robust AI solution might warrant investment.

- **AI-driven claim denials.** Payors are adopting AI to automate claim denials, requiring RCM companies to stay updated on changing policies and to implement advanced analytics to effectively respond.
- **Staffing shortages continue.** The RCM industry continues to face a persistent shortage of qualified staff which impacts costs, efficiency, and claim processing.
- **Technology integration challenges.** Integrating new technologies into existing workflows can be complex, requiring additional investment and training.
- **Integration and Interoperability with EMRs.** As clients

automation solutions, monitoring and adapting to regulatory changes, ensuring data privacy and security, and keeping stakeholders informed of the dynamics we all face. Do we accomplish all this while reducing or at a minimum, holding the line on overall costs? Sounds simple, right?

Investing in workflow automation and AI technologies do not have to break the bank. Before jumping to a cost prohibitive large scale AI solution, evaluate your current systems for opportunities to automate current workflows. Next, evaluate where a more robust AI solution might warrant investment.

Workflow automation and AI can address issues facing most every aspect of RCM, including staffing shortages, cost

reductions, quality improvements, and adhering to and auditing for regulatory compliance. For example, leverage analytics to anticipate denial trends and identify future denial risks to enable a more targeted and rapid response to denials. Test innovative ideas or adaptations in controlled environments before scaling them.

Every RCM company should stay ahead of regulatory changes by regularly tracking HBMA regulatory updates. Conduct risk assessments and develop contingency plans for potential regulatory shifts. Automate compliance monitoring, reporting, and documentation. Leverage analytics to anticipate these trends. Invest in systems that can evolve with changing requirements.

Effective stakeholder engagement will help educate clients about the complexities we face. Keep clients informed about regulatory and payor changes and how they are being addressed, so there are no surprises about the impact of new denial reasons and regulatory impacts. Informing clients proactively about changes that affect them will reinforce trust. Consider developing multiple scenarios and action plans to respond quickly to potential changes.

As in the past, with proper planning, RCM companies can enhance their resilience, maintain compliance, and succeed in our complex, highly regulated industry. There is no shortage

of innovative technologies available to improve and streamline the RCM process. Do not let your organization become overwhelmed by every new technology offering. To quote Davinci, "Simplicity is the ultimate sophistication." Your organization has significant institutional knowledge of your clients' workflows, how your systems function, and where automation and AI could make a positive impact.

Let HBMA be a resource for the evaluation of what solutions are available in the marketplace, whether you are addressing automation, staffing, regulatory or other issues. Consider attending HBMA conferences, webinars, and networking as a long-term investment that, over time, will enable your organization to adapt better and thrive. Awareness of the available solutions and your institutional creativity will help you determine your next steps.



– **Kirk Reinitz**

HBMA President | Kirk.Reinitz@advocatercm.com

HBMA Education Calendar

VIRTUAL MEETINGS

REGISTER!

May 1, 2025

**Member Benefit Highlight:
Distance Learning Library**

May 21, 2025

RCM Exchange: Leaders & Managers

June 5, 2025

Member Benefit Highlight: Job Board

June 11, 2025

RCM Executives Connect

June 30, 2025

**Member Benefit Highlight:
Government Relations**

August 20, 2025

RCM Exchange: Leaders & Managers

September 10, 2025

RCM Executives Connect

November 19, 2025

RCM Exchange: Leaders & Managers

December 10, 2025

RCM Executives Connect

HBMA Education Calendar

WEBINARS

REGISTER!

April 16, 2025 | 11am PT / 12pm MT / 1pm CT / 2pm ET
Updates to Telemedicine for Evaluation and Management Services

April 22, 2025 | 9am PT / 10am MT / 11am CT / 12pm ET
Denied But Not Defeated: Fixing Common Denials in Pediatric Billing

May 8, 2025 | 10am PT / 11am MT / 12pm CT / 1pm ET
Sustainable Obesity Care: Balancing Operational Efficiency and Financial Success

May 12, 2025 | 10am PT / 11am MT / 12pm CT / 1pm ET
Cigna for Healthcare Professionals - CHCP Overview (Presented by Cigna)

May 28, 2025 | 10am PT / 11am MT / 12pm CT / 1pm ET
Transition in Equity Ownership - Planning Issues for Medical Billing Companies

June 18, 2025 | 10am PT / 11am MT / 12pm CT / 1pm ET
Medicare Claim Management: Impacts of the Aging Population and Shifting Payor Mixes

June 24, 2025 | 9am PT / 10am MT / 11am CT / 12pm ET
Giving Feedback: Developing Your Feedback Skills to Create More Impactful Relationships

July 15, 2025 | 11am PT / 12pm MT / 1pm CT / 2pm ET
Mastering Difficult Conversations

July 29, 2025 | 11am PT / 12pm MT / 1pm CT / 2pm ET
The CFPB Final Medical Debt Credit Reporting Rule: An Inside Look at the Rule, the Lawsuits to Stop It and What to Expect Next!

August 12, 2025 | 9am PT / 10am MT / 11am CT / 12pm ET
Pairing Challenge with Support to Transform Your Team

August 27, 2025 | 9am PT / 10am MT / 11am CT / 12pm ET
How to Improve Focus, Concentration, and Attention Span of Your Employees

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!

Member Benefits Webinar Series
 2025 Innovation Conference
 2024 Fall Conference
Seeing Burnout Clearly: Protecting Your Most Valuable Talent
AI Solutions Save Time And Reduce Denials With Significant Impact
Checking in on the No Surprises Act
Making the Shift from a Command and Control, to a Trust and Inspire Work Culture

Decoding the 2025 CPT® Code Changes: What You Need to Know
Medical Necessity
Ensuring Clean Claims Submission Modifiers
Performing Providers
Unseen Biases: Understanding Your Role in Decision-Making
Credit Balances
2024 Washington Update

Potential To Impact: How To Unlock Your Highest Potential Through Five Growth Principles
Revolutionizing Medical Coding: An Introduction to Automated Solutions for Clinicians and Hospitals
Navigating Workplace Conflict & Difficult Conversations
Is Your Radiology Revenue at Risk? Avoid These Documentation Pitfalls



SOUND OFF!

TOPIC: 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.

In 2025 there are several indices and metrics requiring constant monitoring to ensure physician practices and hospitals continue to succeed.

As the healthcare landscape continues to evolve and shift, patient engagement preferences must be respected. It is no exaggeration in stating that patients expect an “Amazon Type” of experience in both their clinical experience and their financial experience. A poor patient financial experience will cause a public relations nightmare for the clinician and her/his hospital and physician practice. Patient preferences can include texts, email discovery and follow up, phone calls, portals, payment plan options, and even paper statements. Very importantly, these preferences can change, which is precisely why these metrics must be closely monitored.

The payor mixes of both physician practices and hospitals will change as the year unfolds. It remains to be seen what will happen, particularly with Medicare Advantage plans and Medicaid. With Medicare Advantage plans, hospitals continue terminating these plans; with Medicaid there appears to be risk these benefits will be cut back. The latter will potentially mean the incidence of self-pay coverage will increase. These types of changes necessitate data to be available immediately to ensure the financial success of hospitals and physician practices.

The clinical acuity mix also requires close monitoring as these acuities continue to rise. Using the emergency department as just one example, as the acuity mix increases, it impacts on staffing needs on already stressed physicians, nurses and advanced practice providers, as well as worsening both the over-

crowding and burnout issues.

In an environment of reduced reimbursement, these metrics are some of the most critical ones requiring 24/7/365 reporting with predictive analytics capabilities being one of the most important “tools-in-the-toolbox” to leverage daily to stay ahead of the curve.

It goes without saying that the issue of claim denials and requisite appeals require 24/7/365 data and analytics as well. These issues must be recognized immediately, which requires sophisticated technological reporting; manual processes are simply not enough today to keep pace with the changing payor landscape of policies and procedure updates.

All of these changes require technology but also educated and informed hospital and physician practice administrators and executives. The technology and reporting capabilities provide the data, while the administrative staff must be poised to swiftly recognize, interpret and step into action every day.

It is a both a challenging time, and an exciting time today in healthcare, as well.

- John Holstein, Zotec Partners

Machine learning and automation with healthcare data analytics.

- Karan, AmeriHealth LLC

As we step into 2025, CrystalVox remains committed to excellence in Revenue Cycle Management (RCM) by embracing innovation, optimizing workflows, and ensuring compliance

with ever-evolving regulations. Our strategic vision for the year revolves around enhancing efficiency, expanding service offerings, leveraging AI and automation, and strengthening client relationships to maximize revenue recovery and reduce administrative burdens for healthcare providers.

Business Resolutions for 2025:

Enhance Automation & AI Integration

- Implement AI-powered claims scrubbing tools to reduce denials
- Expand the use of automated eligibility verification to ensure proper reimbursement
- Improve predictive analytics to anticipate revenue trends and optimize cash flow
- Develop chatbot-assisted customer service for real-time provider inquiries

Strengthen Compliance & Data Security

- Conduct quarterly compliance audits to ensure adherence to HIPAA, Medicare, and Medicaid guidelines
- Enhance cybersecurity protocols to safeguard patient data
- Train staff on the latest regulatory updates and fraud detection measures

Expand Service Offerings

- Introduce specialized RCM services for telehealth, behavioral health, and urgent care centers
- Develop end-to-end credentialing solutions to streamline provider onboarding
- Expand payor contract negotiation services to maximize reimbursements

Improve Client Engagement & Retention

- Offer customized reporting dashboards for real-time revenue insights
- Provide dedicated account managers to enhance personalized service
- Launch a client education series on optimizing RCM strategies

Strengthen Workforce & Culture

- Invest in RCM-specific training programs to upskill employees

- Foster a culture of continuous improvement through feedback and innovation
- Enhance employee well-being programs to boost productivity and retention

Strategic Analysis: SWOT Assessment

Strengths

- 15+ years of RCM expertise, with a proven track record of maximizing reimbursements
- Strong first-pass claims acceptance rate leading to reduced denials
- A robust client portfolio spanning multi-specialty clinics, hospitals, and private practices
- Agile technology adoption, including AI-driven claims processing and automation
- A highly skilled team of certified medical coders and billing specialists

Weaknesses

- Dependency on payor policies and regulatory changes that can impact revenue cycles
- Limited brand visibility in new healthcare sectors (e.g., behavioral health, home care)
- Growing competition from AI-driven RCM startups that offer low-cost automated solutions
- The need for continuous investment in staff training and technology upgrades

Opportunities

- Expansion into underserved markets such as rural healthcare facilities and federally qualified health centers (FQHCs)
- The rise of value-based care models, opening new revenue streams in population health analytics
- Increased demand for outsourced medical billing services due to provider burnout
- Collaboration with EHR vendors and telemedicine platforms for integrated billing solutions
- The potential for government contracts to provide billing services for public health initiatives

Threats

- Regulatory uncertainties, including potential reim-

bursement cuts from Medicare/Medicaid

- Data security risks with the increasing threat of cyberattacks on healthcare institutions
- Economic fluctuations affecting providers' ability to outsource RCM services
- Growing competition from large-scale RCM firms offering aggressive pricing models

Action Plan for 2025

Technology & Innovation

- Invest in AI-powered billing automation to improve claim accuracy and processing speed
- Implement blockchain technology to enhance transparency and security in medical transactions
- Develop machine learning models to predict denial patterns and optimize claims submissions

Client Acquisition & Market Expansion

- Target independent physician groups and specialty practices that lack dedicated billing resources
- Leverage digital marketing (SEO, LinkedIn, and webinars) to improve lead generation
- Establish strategic partnerships with EHR vendors to offer integrated RCM solutions

Compliance & Risk Mitigation

- Stay ahead of regulatory changes by maintaining a dedicated compliance task force
- Enhance staff training programs to ensure adherence to new CMS policies
- Conduct cybersecurity drills to mitigate risks of data breaches and fraud

Talent Development & Culture

- Launch an RCM training academy to develop in-house expertise
- Offer performance-based incentives to retain top billing professionals
- Foster a culture of innovation by encouraging staff-driven process improvements

Measuring Success: Key Performance Indicators (KPIs)

- Claim Acceptance Rate: Targeting a 95%+ first-pass approval rate

- Revenue Growth: Aiming for a 20% increase in collections across all clients
- Client Retention: Maintaining a 90%+ client retention rate
- Compliance Accuracy: Reducing billing errors to less than 1%
- Employee Satisfaction: Targeting a 15% improvement in staff engagement scores

Conclusion

With a clear roadmap for 2025, CrystalVoxx is positioned to drive efficiency, innovation, and compliance excellence in RCM. By leveraging technology, expanding service offerings, and maintaining a client-centric approach, we are confident in achieving sustained growth while delivering exceptional value to healthcare providers.

As we embark on this journey, we remain committed to being a trusted RCM partner, ensuring seamless revenue cycle operations for medical practices nationwide. Here's to a successful and transformative 2025!

– S.S. Steven, Crystalvoxx Global

Our billing operations will continue to look for solutions to help us address erroneous denials and underpayments from the health insurance plans. Requirements include cost-effectiveness, efficiencies gained, and powerful results obtained.

– Andrea Halpern Bryan, Elite Billing LLC

As a small operator (10 employees), I will be focusing on cutting costs and looking for duplication of services, for example, to be more streamlined and efficient.

– Linda Thomas, Ambulance Billing Co., LLC

Our 2025 Initiatives are:

- Implement a CRM system
- Implement Microsoft BI Dashboards
- Rollout MedAcademy (our AAPC certification training prep courses)
- Rollout our Audit Services line

Incorporate as much AI as possible into our RCM process.

One of the resolutions for 2025 was to cut costs while making processes more efficient. The first step we took was to identify our vendors and what services they provide to us. While doing that, we located the monthly fees we were paying. Then we shopped around and compared prices. In addition, we were looking for vendors that provide various services to combine them. For instance, we found a credit card vendor that offered us lower fees than our current vendor. In addition, the same vendor can process our statements for a lesser cost than we pay our current statement vendor. Finally, that vendor offers integration and a patient portal free of charges since we have statements with them. Having the same vendor for payment processing and statements decreased patient call volumes because patients can now see all their charges and balances on the portal. Not only that, we saved a lot of money by choosing this vendor and combining items, and our staff also has more time now to focus on other projects.

– Adela Berberovic, Retina & Vitreous Consultants of WI

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

Tell us whether your staff work in-house, remotely, or in a hybrid model and if you plan to make any changes.

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

SUBMIT YOUR RESPONSE ONLINE HERE

WELCOME NEW HBMA MEMBERS ■ ■ ■ ■

Revenue Cycle Management Companies

- Boomerang Global
- Core One Med LLC
- Evolve Business Solutions
- Healthcare Partners Consulting and Billing
- Hummingbird Medical Billing Specialists, LLC
- InlandRCM
- MedCycle Solutions
- Moore Support Services, Inc.
- Physican Support Service LLC
- Pinnacle Healthcare Consulting
- Reliant Management
- Revantage Healthcare Business Solutions LLC
- RevNu Medical Management
- SolisRx
- Streamline Health Care Solutions, Inc
- Sustainable Medical Billing, LLC
- VirtuMD The Physicians Genie
- Y&Z Physicians Reimbursement Services, LLC

HBMA is the only organization dedicated to the advancement of healthcare revenue cycle management professionals. For a full list of benefits, [please click here!](#)

Spotlight on the Membership Committee

By Joshua Klinge, Chair



CLICK HERE TO WATCH THE VIDEO!

Enhancing Member Experience

The Healthcare Business Management Association (HBMA) is committed to supporting professionals in the healthcare revenue cycle management (RCM) industry. A key element in this mission is ensuring that its members receive the value, resources, and engagement necessary to thrive in an ever-evolving healthcare space. At the heart of this effort is the Membership Committee, composed of a group of dedicated volunteers focused on continuously improving the HBMA member experience.

Purpose of the Membership Committee

The core purpose of the Membership Committee is clear: to review, enhance, and optimize the value of HBMA membership to all members. Through our work, the committee ensures that every member feels valued, supported, encouraged, and equipped with the tools they need to succeed in the ever-changing RCM industry. By focusing on key areas such as member growth, engagement, involvement, and retention, the committee aims to strengthen the HBMA's membership base and bolster its value proposition.

Member Growth

One of the primary objectives of this committee is to attract new members to the HBMA. Through targeted outreach and promotional efforts, the committee works to raise awareness of the association's offerings and benefits, ensuring that professionals in the healthcare business management and RCM fields recognize the value of joining HBMA. Whether through networking, speaking at industry events, or leveraging digital marketing, the Membership Committee plays a crucial role in expanding the association's reach and welcoming new members into the association. We also welcome new volunteers to the committee who have the same passion for the successes of our peers.

Member Engagement

Engagement is at the core of the HBMA's mission. The Membership Committee is dedicated to creating opportunities for members to interact with each other and the association in meaningful ways. The committee fosters an environment where members can connect, share insights, and learn from

one another through online communities, industry events, webinars, or social media.

Member Involvement

The Membership Committee also focuses on increasing member involvement within the association. Through various volunteer opportunities, committees, and special interest groups, members are encouraged to actively contribute to HBMA's initiatives and events. Becoming involved strengthens the association and provides members with leadership and networking opportunities that can enhance their careers and professional development.

Member Retention

Retaining existing members is as important as attracting new ones. The Membership Committee focuses on identifying strategies and programs that keep members engaged, satisfied, and invested in the HBMA's mission. From providing ongoing professional development resources to offering exclusive access to industry tools, the committee works tirelessly to ensure members see continued value in their membership.

By maintaining strong relationships with members and consistently delivering high-quality services, the Membership Committee ensures that the HBMA's members remain loyal advocates for the association, helping to strengthen the overall community.

Join the Membership Committee

As a volunteer-led organization, HBMA depends on the service and leadership of our members. You can have a direct impact on the future of HBMA and our industry by volunteering for any committee. If you are interested in volunteering your time and expertise, we welcome you to contact HBMA by info@hbma.org or by phone at 877.640.HBMA (4262). The Membership Committee meets monthly via Zoom on the second Tuesday of each month at 10am PT (11am MT, 12pm CT, 1pm ET).

Conclusion

As the HBMA continues to evolve, the Membership Committee will remain at the forefront of ensuring that the association delivers unparalleled value to its members, helping them to succeed and grow in a dynamic and ever-changing industry. ■

Happy Anniversary, RCM Advisor!

By Madelon Berger, MPH, MA, CCS-P, CPC, Editor

2025 marks the 30th anniversary of *RCM Advisor*, HBMA's journal. This publication has gone through a number of iterations, editors, and a name change over the span of three decades.

The journal editor has always been a member of the Publications Committee, which is comprised of HBMA member volunteers who meet monthly on Zoom and discuss topics relevant to RCM companies and potential authors. John Davidson, our graphic designer, has been doing his magic with the journal for 25 years. He designs all the journal graphics, layout, type, and much more, and for all other HBMA publications, ads, and conference signage as well.

HBMA's original name was International Billing Association (IBA), and the journal's name was *Billing*. In 1998, as the billing industry evolved, the association changed the name to HBMA, Healthcare Billing and Management Association, and again in 2016, to Healthcare Business Management Association, reflecting further changes in the healthcare industry.

Billing was originally published as a bi-monthly newsletter, mailed to members and over twenty pages long. K.T. Anders served as one of our early and longest editors. Her last issue was November-December 2009 when she passed away. She was beloved by HBMA, and a wonderful and professional editor. The Publications Committee commissioned the redesign of *Billing* to a journal format beginning with the January-February 2010 issue; this was quickly accomplished by John Davidson during this difficult time. A new editor was brought on during the transition.

In 2011, Brad Lund asked me to step in as editor (as the owner of an RCM company, I was a charter member of HBMA who had been on the board. In 2003, I created a Business Practices Committee and we published a book, *Collected Wisdom – Best Practices for Third Party Healthcare Billing Companies*). Along with the Publications Committee, we expanded the number of departments to include **Software Talk**, **ICD-10**, and continue Dave Jakielo's **From the Road**. We included a quiz which, when completed, provided HBMA CEU credits. We also added **Sound Off!**, which provides a topic and responses from the



For the first 14 years, *Billing* was originally published as a bi-monthly newsletter in 2-color and mailed to members.



In 2010, *Billing* was redesigned into a full-color journal format with more graphics, features, and regular departments covering topics like compliance, coding, ICD-10, and From the Road. The first issue (above) dove into Washington Updates, representing HBMA's growing influence.



membership and are published in the next issue. Our 20th Anniversary issue, published in April 2013, included articles of accomplishments and challenges from every past president, descriptions of awards, and other HBMA membership benefits.

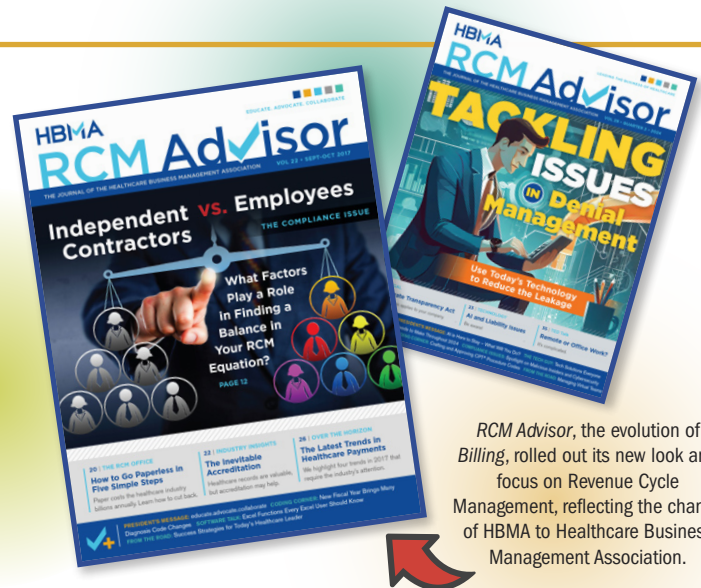
After Smith Bucklin took over management of HBMA, they decided to utilize a staff member to serve as editor; my last issue in this role was June, 2014.

In 2017, the Publications Committee felt it was time to change the name of the journal since the industry had advanced so much, and the September-October 2017 issue was rebranded as *RCM Advisor*. They changed the journal to

section, and relevant topics from four departments: **Compliance Issues**, **The Tech Guy**, **Coding Corner**, and **From the Road**. There is also a **Vendor Member Directory** in every issue. Additionally, we have included podcasts on different topics, along with other articles describing new membership benefits and survey results.

We strive to meet our members' needs, covering issues impacting different aspects of owning and managing an RCM company. We recently added a feature where a member can tap the name of the article on the **Table of Contents**, and it will bring the reader directly to that page. Our latest

We strive to meet our members' needs, covering issues impacting different aspects of owning and managing an RCM company... Our latest improvement in the January issue includes an audio version of the articles, so members can listen instead of reading.



RCM Advisor, the evolution of *Billing*, rolled out its new look and focus on Revenue Cycle Management, reflecting the change of HBMA to Healthcare Business Management Association.

a quarterly publication in 2019 and published their last issue in the first quarter of 2021.

When ISAM returned as HBMA's management company in 2022, Brad asked me to step in as editor again. We published our first issue in the fourth quarter of 2022. Our 30th Anniversary issue (April 2023) was an updated version of our 20th Anniversary issue featuring accomplishments by every past president up to that point. We also included **Sound Off!** responses from past presidents and members on the value of HBMA. We received the largest response of any issue.

Since 2022, we have enhanced *RCM Advisor*, and every issue includes: a **President's Message**, **Committee Spotlight**, five feature articles, including a reprinted article from the AMA, an article by Matt Reiter in our **Government Affairs**

improvement in the January issue includes an audio version of the articles, so members can listen instead of reading.

We are always looking to increase the value of *RCM Advisor* to our membership and would very much appreciate your feedback. We want to learn from you in your responses in **Sound Off!** If you are interested in writing an article or suggesting a topic, please feel free to contact me directly at Madelon.Berger@gmail.com.

Thank you to our great team – the Publications Committee (past and present members), Brad Lund and HBMA staff Haley Popejoy and Shannon Watson, and John Davidson for all your hard work, and to the board and membership for your support. We look forward to many more years of publishing *RCM Advisor!* ■

Thank You!

REGULAR CONTRIBUTORS TO RCM ADVISOR OVER THE YEARS...

K.T. Anders / Editor

Madelon Berger / Editor

Dave Jakielo / From the Road

Melody Mulaik / Coding Corner

Jackie Miller / Coding Corner

Chad Schiffman / Compliance Issues

Burton Kelso / The Tech Guy

Nate Moore / Software Talk

Bill Finerfrock / Washington Update

Matt Reiter / Washington Update

John Davidson / Graphic Designer

AND TO OUR CURRENT PUBLICATIONS COMMITTEE...

Cindy Groux / Chair

Jeffery Hillam / BOD Liaison

Adela Berberovic

Kristin Callaway

Joshua Burd

Ginna Norvell

As well as all our past Publication Committee members, past board members, current and past presidents, and feature contributors who have dedicated their time and energy to serving HBMA members through *Billing* and *RCM Advisor* with their expertise and experience. We are grateful for your contributions!



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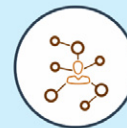
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NAVIGATING Cultural Differences



in the Workplace

By Cristina Amyot and Michael Kairios, MHRM, SHRM-CP

Cultural Differences 文化の違い Diferencias culturales

In a continuously expanding global economy, more U.S. based employees are regularly engaging with colleagues from diverse regions around the globe. Some of the most common partners include India, Mexico, and the United Kingdom, amongst many others, bringing their own distinct cultural values into the workplace.¹ As many companies continue to expand their global reach, employees may collaborate with colleagues from various cultural backgrounds, each bringing unique perspectives, work habits, and communication styles to the table.

A merger of cultural differences can enhance or, if not understood, valued, and respected, destroy workplace culture, productivity, and morale. One component of these differences is indicative of the employee's country of origin, which can influence everything from how authority is perceived, to how team collaboration is approached. Navigating these cultural variations is vital for organizations that wish to build innovative, productive, and harmonious teams. Geert Hofstede, a Dutch management researcher known for his work on cross-cultural communication and organizational behavior, becomes particularly relevant in this area. Hofstede focused his research on understanding how workplaces are influenced by cultural differences, eventually leading to the development of Hofstede's cultural dimensions theory, which explores six key dimensions of culture:

- **Power Distance:** Reflects how much a society accepts and expects power to be distributed unequally.
- **Individualism vs. Collectivism:** Looks at whether people prioritize personal freedom and individual rights or emphasize loyalty and responsibilities to the team.
- **Masculinity vs. Femininity:** Contrasts cultures valuing competition and achievement with those prioritizing care and quality of life.
- **Uncertainty Avoidance:** Measures how comfortable a culture is with uncertainty and ambiguity.
- **Long-term vs. Short-term Orientation:** Explores whether a culture focuses more on long-term goals and future rewards or emphasizes quick results and respect for traditions.
- **Indulgence vs. Restraint:** Shows whether a culture encourages the free expression of enjoyment or tends to control and regulate such impulses.



As many companies continue to expand their global reach, employees may collaborate with colleagues from various cultural backgrounds, each bringing unique perspectives, work habits, and communication styles to the table. A merger of cultural differences can enhance or, if not understood, valued, and respected, destroy workplace culture, productivity, and morale.

Kulturelle Unterschiede सांस्कृतिक अंतर Kulturele verskille

Hofstede's model provides insight into how cultural dimensions shape behavior in the workplace and can be used as an essential tool for gaining a deeper understanding of the ways cultural differences influence today's workforce. Within each of these dimensions, the common trait remains the same – people are different. They have different motivators, stressors, goals, and communication styles. When embraced, this diversity can become a source of strength and innovation, leading to better communication and a more collaborative atmosphere. However, significant business challenges can arise when a group of culturally diverse individuals works together; it can cause misunderstandings, miscommunication, tension, and potentially lead to workplace conflicts.

For example, in countries like Japan or India, communication tends to be indirect, and much meaning is conveyed through non-verbal cues, tone, and context. In contrast, cultures like the United States or Germany may value clear, direct, and explicit communication. In these interactions, it is common for the intention behind a message to be misinterpreted. When team members from these contrasting cultures interact, an employee from a culture where communication is characteristically indirect may interpret direct comments as rude or confrontational, while a direct communicator might view indirect communication as evasive or unclear. Similarly, employees can be strongly influenced by cultural dimensions such as individualism vs. collectivism, which help shape how employees approach teamwork, loyalty, and personal goals, for example. In more individualistic cultures, like the United States or the United Kingdom, employees tend to prioritize autonomy and individual achievements, whereas even in teams, employees are more likely to compete with each other for recognition and advancement. In contrast, cultures with a more collectivist approach, like Mexico or China, emphasize the importance of shared responsibilities and loyalty to the team, where the needs of the team are often put ahead of personal ambitions, leading to a different approach towards collaboration.

One pivotal way businesses can harness the power of cultural understanding is by implementing cultural awareness training. Sharing knowledge with employees plays a key role in reducing misunderstandings and potential conflicts that may arise from cultural differences. Teaching employees



As workforces continue to diversify, understanding and respecting cultural differences in the workplace is no longer optional – it is essential. This understanding becomes a key factor in shaping a workplace that is both adaptive and resilient. By recognizing the various cultural dimensions that shape behavior and communication styles, businesses can create a more inclusive, collaborative, and productive work environment and experience.

اختلافات فرهنگی Differences culturelles 文化差異

how to navigate and appreciate diverse perspectives begets a more inclusive workplace, allowing individuals to feel valued and understood. Neal Goodman, President of Global Dynamics Inc., says that in cultural awareness training, organizations “have got to provide the skills necessary to lead in a culturally diverse and geographically diverse workforce, workplace and marketplace. Without the ability to see the same situations from multiple perspectives simultaneously, none of us will ever be successful.”²

To effectively conduct cultural awareness training, the focus should be on providing practical tools that employees can apply in real-world scenarios. This training should include introducing key concepts, such as cultural dimensions, communication styles, and the impact of cultural misunderstandings, to help employees understand how cultural differences can manifest themselves in everyday work situations, enabling them to practice communicating with empathy and respect. It is crucial that this training encourages open dialogue, allowing employees to share their personal experiences, and ask questions without judgment.

Cultural awareness training is not just a one-stop shop. It is important to offer ongoing learning opportunities, such as workshops and webinars, to keep cultural awareness a continuous part of the organizational culture. While cultural misunderstandings can induce irrefutable harm to a company, a focus on creating a safe, supportive learning environment equips businesses with the tools to navigate and appreciate diversity in the workplace, where mutual respect and collaboration drive business objectives forward.

As workforces continue to diversify, understanding and respecting cultural differences in the workplace is no longer optional – it is essential. This understanding becomes a key factor in shaping a workplace that is both adaptive and resilient. By recognizing the various cultural dimensions that shape behavior and communication styles, businesses can create a more inclusive, collaborative, and productive work environment and experience. The ongoing commitment to navigating cultural understanding not only enhances team cohesion but also strengthens the organization's ability to adapt and thrive globally. Ultimately, embracing cultural diversity is not only about avoiding communication mishaps, but is also about leveraging the unique strengths that

different perspectives bring, driving both individual growth and collective success within the workplace. ■



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Michael Kairios is an HR Business Partner with EnformHR. He brings more than 15 years of extensive experience in aligning human resources strategies with organizational goals, training and development, and people management, providing clients a unique perspective on optimizing workplace cultures and improving employee engagement. As a passionate advocate for professional development, Mr. Kairios works closely with clients to design and implement HR strategies to drive performance and enhance team dynamics.

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Going Beyond Chargemaster Rates



By
Steve Rolfes

INNOVATIONS IN HEALTHCARE REVENUE

Historically, healthcare providers have relied heavily on chargemaster rates as a primary method for revenue generation. But in the healthcare industry, one constant remains: the need for financial stability and growth. As this industry faces increasing complexity and scrutiny, it is becoming clear that this traditional approach has its limitations.

Healthcare organizations are rethinking revenue generation strategies, moving beyond chargemaster rates to embrace innovative approaches that align with the value of services provided. This shift represents an important evolution in the

financial strategies that drive healthcare systems, from large hospitals to smaller care providers.

As we delve into this shift, it is crucial to understand the limitations of relying solely on chargemaster rates and explore the diverse approaches that can help healthcare providers optimize their revenue streams.

Limitations of Chargemaster Rates

Chargemaster rates, or the list prices for medical services, have long been the backbone of healthcare billing. Healthcare providers establish these fee-for-service rates to set the price

Instead of relying on a fixed set of charges for a given service, providers are adopting more nuanced strategies. These strategies account for the level of care delivered, along with patient satisfaction, treatment efficacy and long-term health outcomes. By utilizing this model, providers can align billing more closely with the actual value of the service and its impact on patient health.

for each service, from routine office visits to complex surgical procedures. However, there are several inherent issues with this pricing model.

One of the key limitations of this model is the failure to reflect on the true cost and value of care delivered. While chargemaster prices may be consistent within an organization, they do not account for variations in the complexity of care, the resources used, or the outcomes achieved. As a result, charges often fall short in accurately representing the value of care provided to patients.

This discrepancy can lead to undercharging, where services are provided at rates lower than their actual worth, thus resulting in significant revenue loss. In many cases, this practice disproportionately impacts hospitals and healthcare organizations that are required to treat uninsured or underinsured patients, as well as those participating in government-sponsored programs like Medicaid or Medicare. Undercharging is compounded by other issues such as outdated pricing models and a lack of transparency, both of which have been the subject of increasing scrutiny.

The traditional reliance on chargemaster rates does not align well with modern financial demands. The increasing focus on patient-centered care, value-based care, and transparency in healthcare pricing has led many to question whether these fixed rates are sufficient for ensuring financial sustainability in the long term. As healthcare organizations strive to meet the growing expectations of patients, payors, and regulators, the established methods of pricing services are simply not enough.

Analyzing Services Provided and Billing Approaches

To address these challenges, healthcare providers are increasingly turning to more data-driven approaches that assess the full spectrum of services provided. By analyzing a variety of

data sources, including clinical outcomes, patient demographics, and cost-of-care metrics, organizations can gain a clearer understanding of the true value delivered by their services.

This shift toward value-based billing practices marks a significant departure from the older, volume-based models. Instead of relying on a fixed set of charges for a given service, providers are adopting more nuanced strategies. These strategies account for the level of care delivered, along with patient satisfaction, treatment efficacy, and long-term health outcomes. By utilizing this model, providers can align billing more closely with the actual value of the service and its impact on patient health.

One notable approach is the bundling of services, where a healthcare provider charges a single price for a series of related services. This approach, known as bundled payment, is a shift away from the traditional fee-for-service model and is gaining traction in various healthcare settings. Bundled payments aim to reduce unnecessary tests and procedures, promoting a more efficient use of resources while ensuring that patients receive high-quality care.

Data analysis can also help identify inefficiencies and areas of improvement within a healthcare organization's revenue cycle. By assessing billing patterns and identifying common errors or gaps in documentation, healthcare providers can fine-tune their operations, ensuring that they are billing accurately and fully for the services they provide.

Leveraging Data and Technology

Advancements in data analytics and technology offer transformative possibilities for revenue enhancement in healthcare. Predictive analytics, for example, enables proactive identification of revenue optimization opportunities. By analyzing historical data, healthcare organizations can forecast demand, better understand patient needs, and anticipate the costs associated with various treatment options. This allows them to adjust

their approach in real-time, enhancing both operational efficiency and patient care.

Furthermore, AI-powered revenue cycle management tools are revolutionizing the way RCM companies handle their billing processes. These systems can automatically review claims, identify discrepancies, and even predict the likelihood of payment denials, which helps to ensure that payments are collected in a timely and efficient manner. By leveraging these technologies, healthcare providers can minimize the administrative burdens associated with billing and reimbursement, freeing up resources to focus on patient care and other core functions.

The integration of electronic health records (EHR) systems with billing platforms also enhances revenue cycle management. EHRs contain valuable clinical data that can help ensure accurate and complete billing. By confirming that the correct codes are applied, and all services are properly documented, organizations can avoid undercharging and reduce the risk of audits and claim denials.

Data-driven approaches also enable healthcare organizations to analyze payment patterns from different payors, allowing them to optimize their relationships with insurers and government programs. By understanding the payment behaviors and expectations of various payors, RCM companies can better negotiate reimbursement rates and terms that align with the actual costs of care delivery.

Collaborating with Payors for Strategic Reimbursement

Closer collaboration among providers, RCM companies, and payors is essential for developing reimbursement models that prioritize value over volume. The traditional fee-for-service model is increasingly being replaced by value-based reimbursement models that focus on patient outcomes and quality of care.

Value-based reimbursement arrangements offer several advantages over traditional fee-for-service models. In these models, healthcare providers are incentivized to deliver high-quality care at lower costs, as reimbursement rates are tied to specific quality metrics rather than the quantity of services rendered. This approach encourages the reduction of unnecessary tests and procedures while promoting preventive care and the efficient management of chronic conditions.

Successful partnerships between providers and payors



A shift towards value-based care also requires healthcare organizations to invest in new technologies, data infrastructure, and workforce development.

can highlight the potential for aligning incentives and improving financial outcomes. For example, providers that participate in accountable care organizations often share savings with payors if they meet quality benchmarks while reducing costs. These collaborations are particularly advantageous for organizations that treat large populations of patients with chronic conditions, as they offer opportunities to improve outcomes while managing costs.

A shift towards value-based care also requires healthcare organizations to invest in new technologies, data infrastructure, and workforce development. Providers that are equipped to meet the requirements of value-based reimbursement models will be better positioned to succeed in this ever evolving environment.

Implementing Comprehensive Revenue Strategies

To truly thrive today, organizations must adopt a comprehensive approach to revenue generation. This involves a multi-faceted strategy that encompasses billing adjustments, along with investments in staff training, operational efficiency, and patient engagement.

One key element of this strategy is the integration of financial and clinical teams. A collaborative approach between clinical care providers and the RCM company can improve the accuracy of coding and reduce the occurrence of claim denials. Continuous training and education are essential for ensuring that all staff are equipped with the knowledge they need to navigate this changing reimbursement environment.

Additionally, organizations must invest in performance monitoring to track their financial health and identify areas for improvement. This includes regularly reviewing key performance indicators such as collections rates, denial rates, and patient satisfaction scores. With the right data and performance metrics in place, providers and RCM companies can continuously refine their revenue strategies and ensure that they remain financially sustainable.

Finally, healthcare providers must embrace innovation. This includes exploring telemedicine, which can offer additional revenue streams and improve patient access to care. By embracing telemedicine and other innovative technologies, healthcare organizations can expand their reach while maintaining high standards of care.

Embracing the Future of Healthcare Revenue Generation

The days of relying solely on chargemaster rates for revenue generation are behind us. As the healthcare system continues to evolve, providers must embrace innovative approaches that align with the value of services provided. By leveraging data, technology and collaboration, these organizations can optimize their revenue cycle and ensure financial sustainability.

A more flexible and dynamic approach to revenue generation can help providers and RCM companies navigate the challenges of modern healthcare while continuing to deliver exceptional care to patients. Through strategic planning, comprehensive revenue strategies, and ongoing innovation, providers will not

only meet the financial challenges of today but also position themselves for success in the future.

In today's healthcare environment, financial stability and growth are no longer only about maximizing the volume of services rendered. They are about optimizing the value of each interaction with a patient, enhancing operational efficiency, and fostering partnerships that prioritize quality care. By embracing these principles, healthcare providers and RCM companies can ensure that they thrive in an increasingly complex and competitive healthcare environment. ■



Steve Rolfes is the Manager of Continuous Improvement at Savista, an end-to-end revenue cycle services provider serving healthcare organizations for more than 30 years.

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By James Wood

Adopting AI in Healthcare Organizations Can Solve STAFFING CHALLENGES

As a leader of a healthcare organization, you are acutely aware of the staffing challenges that these organizations face. The shortage of qualified professionals, high turnover rates, and mounting administrative burdens can strain your resources and impact the quality of work for your clients. However, there is a transformative solution that can address these issues: Artificial Intelligence (AI). By embracing AI healthcare staffing solutions, you can alleviate staffing pressures while enhancing operational efficiency and patient satisfaction.

The Growing Staffing Crisis in Healthcare Organizations

Healthcare organizations play a crucial role in providing accessible treatment, especially in underserved areas. Unfortunately, you may be grappling with significant staffing shortages as the demand for RCM services continues to outpace the supply of qualified professionals. This imbalance leads to overworked staff, increased administrative burdens, and financial strain

due to overtime pay and recruitment costs. These challenges underscore the need for innovative staffing solutions that can ease the load on your organization.

How AI Can Revolutionize Staffing Solutions

AI offers a promising avenue to address staffing challenges. By automating routine tasks and optimizing workflows, AI can help maximize your existing resources.

AUTOMATING ADMINISTRATIVE TASKS

Administrative duties often consume a significant portion of your staff's time. AI can automate several of these tasks:

- **Scheduling:** Intelligent AI solutions can efficiently manage appointments and staff schedules by automating bookings, optimizing resource allocation, minimizing scheduling conflicts, and adapting to changes in real-time, thus improving operational efficiencies and patient satisfaction.
- **Patient Insurance Card Readers:** Manually collecting



and inputting insurance information can lead to mistakes. AI-powered card readers capture and store patient insurance details accurately, reducing errors associated with manual data entry, and speeding up the registration process.

- **Payor Eligibility and Benefits Verification:** Verifying patient insurance eligibility is time-consuming, but essential. AI-driven systems can automatically check eligibility in real-time, reducing wait times and minimizing errors that lead to claim denials. This frees up staff to focus on responsibilities other than paperwork.
- **Prior Authorization:** Obtaining prior authorizations is often a bottleneck in patient care. AI solutions automate requests, efficiently submit and track the authorizations, reduce delays, and ensure timely patient care by automatically staying current with changing payor requirements.

By adopting these AI tools, you significantly reduce the admin-

istrative burden on your clients' staff, enabling them to dedicate more time to patient care or other administrative functions.

ENHANCING REVENUE CYCLE MANAGEMENT (RCM)

Effective RCM is crucial for the financial health of your organization. AI-driven solutions optimize this process:

- **Charge Capture:** Automates the process of recording charges of rendered medical services by ensuring accurate billing by identifying missed charges and reducing errors which will enhance RCM and compliance in healthcare settings.
- **Medical Coding:** Inbuilt CPT and ICD-10 databases ensure accurate and efficient coding of medical procedures and diagnoses, thereby reducing errors and streamlining the billing process.
- **Denial Management:** Using AI to comprehensively analyze claim denials will identify patterns and root causes, provide actionable recommendations to correct issues, and minimize future denials, thereby enhancing your revenue cycle efficiency.
- **Accounts Receivable Management:** Managing accounts receivable (AR) can be complex and resource intensive. AI analyzes historical data to forecast payment timelines, automate follow-ups for outstanding balances, and accelerate collections, improving cash flow and reducing days in AR.
- **AI Appeals Support:** Dealing with denied claims is frustrating and time-consuming. AI assists by analyzing denial reasons to prevent future occurrences, swiftly generating customized appeal letters, and increasing the likelihood of successful appeals through data-driven insights.
- **Predictive Analytics:** AI provides valuable insights into your revenue cycle by forecasting revenue based on current trends, identifying risks before they impact your bottom line, and optimizing staffing levels with predicted patient volumes.

Implementing AI solutions is not only about improving efficiencies; it is also a sound financial investment. Understanding the Return on Investment (ROI) can help you make informed decisions.

With AI-enhanced RCM, you streamline your financial processes, ensuring that your company remains financially sustainable.

IMPROVING PATIENT ENGAGEMENT

AI is not only about backend efficiency; it also enhances the patient experience. Tools like chatbots and virtual assistants provide patients with 24/7 access to information and support. AI enables personalized communication, tailoring messaging to individual patient needs which improves engagement and adherence. Telehealth integration facilitated by AI expands your clients' reach without additional staff, allowing remote consultations and follow-ups.

By leveraging AI, you improve patient satisfaction while reducing the workload on your team.

Evaluating the ROI of AI Implementation

Implementing AI solutions is not only about improving efficiencies; it is also a sound financial investment. Understanding the Return on Investment (ROI) can help you make informed decisions.

Cost Savings on Administrative Tasks

Manually verifying insurance eligibility can take up to 10 minutes per patient. For a center handling 100 patients per day, this function represents over 16 hours of staff time daily. Assuming an average administrative wage of \$20 per hour, automating this process with AI can save approximately \$320 per day or \$83,200 annually.

Prior authorizations can take 30 minutes to several hours per request. If your clients' staff handles 20 authorizations per week, that's at least 10 hours weekly. Automating this task could save \$200 per week or \$10,400 annually.

Increased Revenue through Improved RCM

The average denial rate in healthcare ranges from 5% to 10% of all claims. If your organization submits \$5 million in claims annually with a 10% denial rate, that is \$500,000 in denied claims. AI can potentially reduce denials by 50%, recovering \$250,000 in revenue.

Reducing Days in Accounts Receivable (DAR) from 60 days to 45 days improves cash flow. On \$500,000 in monthly billing, this acceleration means accessing funds 15 days sooner, saving on financing costs and enhancing financial stability.

ROI Calculation Example

Total Investment in AI Solutions: Let us assume the cost of implementing AI tools, including software licenses and training, is \$150,000 annually.

Total Annual Savings and Additional Revenue:

- Administrative Savings: \$83,200 (eligibility verification) + \$10,400 (prior authorization) = \$93,600.
- Recovered Revenue: \$250,000 from reduced claim denials.
- **Total Benefit:** \$93,600 + \$250,000 = \$343,600.

Net Gain:

- \$343,600 (Total Benefit) - \$150,000 (Investment) = \$193,600.

ROI Percentage:

- $(\$193,600 \text{ Net Gain} / \$150,000 \text{ Investment}) \times 100 =$ Approximately 129% ROI.

This example illustrates that investing in AI yields substantial returns, both in cost savings and increased revenue, making it a financially sound decision for your healthcare organization.

Overcoming Barriers to AI Adoption

You might have reservations about implementing AI due to concerns about cost, complexity, or disruption to existing processes. Here is how to overcome these barriers:

Cost Considerations: Although implementing AI solutions requires a significant initial investment, the long-term benefits far outweigh the cost. AI reduces labor expenses by automating repetitive tasks, minimizing costly errors, and enhancing cash flow by speeding up processes like claims management and prior authorizations, ensuring a positive financial return over time.

Integration with Existing Systems: Modern AI tools are designed to seamlessly integrate with Electronic Health Records (EHR) and other software platforms, ensuring minimal disruption. With user-friendly interfaces and scalable functionality, AI solutions are adaptable to your current workflows and can evolve with your organization's needs, reducing the learning curve and boosting efficiency.

Staff Acceptance: To ensure smooth AI adoption, it is essential to foster staff acceptance by clearly communicating the benefits of AI, such as reduced workload and improved accuracy. Providing thorough training and involving staff in decision-making can ease concerns about job displacement, highlighting AI as a tool to support them rather than replacing them. Proactively addressing fears and questions can ensure a successful transition to AI-enhanced operations.

Future-Proofing Your RCM Organization

By adopting AI today, you are positioning your RCM organization to adapt to changing demands, enhance quality care, and stay competitive. Investing in AI healthcare staffing solutions is not only about solving today's challenges; rather, it is about securing a sustainable future for your organization.

Taking the Next Step

Embarking on the AI journey might seem daunting, but you do not have to navigate it alone. Here is how to get started:

1. Assess Your Needs:

Begin by evaluating the current staffing shortages, operational inefficiencies, and administrative burdens within your RCM company. Identifying these challenges will help target AI solutions for maximum impact.

2. Research Solutions:

Explore the wide range of AI technologies available, from automating scheduling to improving revenue cycle management. Focus on solutions specifically designed for RCM companies to address your organization's unique challenges.

3. Engage Stakeholders:

Involve your staff and clients, including administrative and clinical teams, in discussions about adopting AI. Gaining their insight and support early on will foster a smoother transition and ensure team-wide buy-in.

4. Partner with Experts:

Collaborate with technology providers that specialize in healthcare AI. Their expertise will help you select and implement the right tools, ensuring seamless integration and minimal disruption to daily operations.

5. Monitor and Adjust:

Regularly review the effectiveness of the AI solutions that were implemented. Analyze key performance metrics and adjust strategies as needed to ensure continuous improvement in staffing, operations, and patient satisfaction.

By taking these steps, you will be actively working towards a more efficient and effective RCM company.

Conclusion

Staffing challenges in RCM organizations are pressing concerns that require innovative solutions. By adopting AI, you will transform these challenges into opportunities for growth and improvement. AI healthcare staffing solutions offer a pathway to optimize resources, enhance patient care, and ensure financial stability.

As a healthcare leader, you have the power to drive this transformation. Embrace AI and lead your company into a future of efficiency, sustainability, and greater ROI. ■



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.

6 REASONS TO...



By Blake Walker

Rethink Patient Billing Support

...AND UNLOCK A HIDDEN ADVANTAGE

Motivating patients to pay their medical bills is an uphill battle, and it has been that way for decades. This year, providers and RCM companies face another barrier. In January, the Consumer Financial Protection Bureau (CFPB) banned the inclusion of medical bills on credit reports. Then in February, the CFPB was shut down, freezing the ruling, adding to consumer confusion, and reducing the incentive for patients to pay for services rendered. However, on March 28th, a federal judge blocked the dismantling of the CFPB. The status of the CFPB will continue to be updated in the courts.

Uncertainty surrounding medical bills does not support the case to pay. According to a recent survey, 40% of consumers are confused by their medical bills, and patients are not willing to jump through hoops to get the information they need in order to feel confident completing payment.

As patient responsibility continues to represent a larger piece, about 30% of medical practices' revenue, RCM professionals need to embrace innovation in their approach to patient billing support to one that combines modern technology with human interaction as the secret weapon to increasing collections and building trust with providers.

1 Finding the Right Balance of Technology with Human Interaction

Lack of understanding of healthcare bills highlights the need for innovative solutions to bridge the gap between the time when patients receive a bill and when they follow through with their financial responsibilities. The key is to integrate technology with human touchpoints. Data shows that when you combine human interaction with technology, 90% of patients' questions are resolved after the first contact.

As patient responsibility continues to represent a larger piece, about 30% of medical practices' revenue, RCM professionals need to embrace innovation in their approach to patient billing support to one that combines modern technology with human interaction as the secret weapon to increasing collections and building trust with providers.

Many companies are rushing to implement AI in patient billing support and for good reason. AI streamlines billing workflows by automating tasks and freeing human agents to work on more complex inquiries. Chatbots provide instant responses to common questions and gather preliminary information during patient interactions, including account details, specific billing concerns, or insurance related questions. This information is then seamlessly shared with an agent, allowing them to step in with context and resolve the issue faster and more effectively. Data shows that patients prefer a variety of options when it comes to communication methods – 53% of inquiries come through text, chat, and email, while 47% are handled by phone calls.

However, technology cannot do it all. From patients' perspective, frustrations mount when human support to navigate a complicated healthcare system is inaccessible. AI does not replace billing support teams. Instead, it empowers them to provide more efficient and accurate support. Technology gathers pertinent information, but a human agent brings the solution and empathy to patient interactions.

2 Empathy and Expertise Are a Winning Combination

Financial conversations are sensitive and emotionally charged for patients. Half of adults say it is difficult to afford healthcare costs, according to a Kaiser Family Foundation poll.¹ Demonstrating empathy is essential to creating positive outcomes for patients – something a chatbot is unable to provide. To reach a resolution, patients need to feel heard, and support agents must have expertise navigating the U.S. healthcare system. Offering patient-directed payment plans to pay down healthcare costs is one way to demonstrate empathy while ensuring providers get paid. For some healthcare organizations,

up to 10% of patients enroll in payment plans.² The billing company is an extension of the provider, and an empathetic support experience positively reflects on the business.

3 Transparency at Every Touchpoint

Every patient interaction is an opportunity to communicate clearly. Patients often feel overwhelmed by the lack of transparency and understanding around their healthcare costs. The patient support experience begins the moment a statement is received. Statements that clearly show the cost of service, the amount the insurance paid, and the patient responsibility in a clear, concise format give the patient confidence in the accuracy of the bill. When patients do have questions, the statement should prominently indicate where to go for support. Options such as phone, email, text, or live chat make it easier for patients to seek help, foster trust and improve payment compliance.

4 Timing is Everything

When it comes to patient support, timing is essential. Consumers are accustomed to getting support immediately, and they expect the same from their providers or RCM companies, although the experience traditionally falls short. Digital support channels like live chat and text generate responses in less than one minute. These quick response times are critical because data demonstrates a strong correlation between response rates and payment velocity. The faster patients have their questions answered, the sooner they will pay their bills.

5 Alleviate Administrative Burden

Managing patient support, even while utilizing modern communication channels, can still be a time-intensive process.

Many RCM companies do not have the resources or staff to respond to patient inquiries in less than one minute. To provide support that meets patient demand today requires the attention of at least one full-time employee, but that is not always a realistic solution for billing companies. Outsourcing is an option that allows billing companies to redirect their staffs' focus to complex insurance claims and other revenue-generating tasks. Today's technological advancements allow an outsourced team to provide the same level of support as your internal staff – at lower costs. The result saves RCM companies' time and increases patient collections – a win for both you and your providers.

6 Earn Trust with Providers

Practices need to feel confident that their billing professionals' companies will provide a positive payment experience for patients. Fifty percent of patients have left a provider due to a poor billing experience. Patients are your clients' customers, and providers view the patient financial experience as an extension of patient care. We are in an era with fewer incentives for consumers to pay while patient responsibility simultaneously is a larger revenue driver for practices. As an

RCM company, adopting innovation in patient billing support is a differentiator that will support retention and growth goals for years to come. ■



Blake Walker is the co-founder and CEO of Inbox Health, a company dedicated to transforming the patient billing experience in healthcare. He has focused his career on design and innovation in the patient billing space and played a pivotal role in developing technologies that simplify medical billing for patients and healthcare providers alike. Under his leadership, Inbox Health has become a trusted partner for more than 3,000 healthcare practices and more than 2 million patients a year and was recently named to the Inc. 5000 list of fastest-growing private companies in America.

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¹ Americans' Challenges with Health Care Costs
<https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=When%20asked%20specifically%20about%20problems,in%20the%20past%2012%20months>

² Leader in Medical Diagnostics Sees Increase in Revenue
<https://www.inboxhealth.com/leader-in-medical-diagnostics-sees-increase-in-revenue-with-inbox-health/>

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Want Happier Doctors? Restoring Their Practice Autonomy Is a Must

By Georgia Garvey

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A new survey shows a link: when physicians lack control over their work environments, they are more likely to have burnout, quit or cut back on hours.

Over the last several decades, the amount of control that physicians have over their work environments has slowly eroded, a phenomenon that has taken place for a number of reasons.

But irrespective of the cause, the results are clear: autonomy and flexibility are increasingly rare commodities for practicing physicians, and a study published in the *Annals of Internal*

Medicine has found that lack of control can be directly related to physicians' burnout levels and their intent to leave their jobs or reduce hours.

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“With these shifts, physicians often feel treated as a unit

The study’s authors argued that job satisfaction has never just been about money for the vast majority of physicians. They need more to be happy and productive in their jobs, which can be demanding and stressful but also rewarding when the conditions are right.

of productivity to be manipulated and afforded little control over their work environment,” says the study, which was co-written by Christine Sinsky, MD, vice president of professional satisfaction at the AMA.

After surveying more than 2,100 physicians in 2022 and 2023, the study found a relationship between burnout and poor control over patient load, team composition, workload, clinical schedule and matters for which the physician was held accountable. Physicians who reported not having enough control over their patient loads and workloads were also more likely to say that they were going to reduce their hours.

Of the survey respondents, 61.4% said they had enough control over their patient loads, 60.6% said they had enough control over membership of their clinical team and 61.3% said they had enough control over their workloads. Almost half – 49% of the physicians – reported that they had enough control over hiring of staff and 74.6% said they had enough control over their clinical schedules. Of those who answered the survey, 58.3% said they had enough authority or autonomy over the matters for which they were held accountable.

While the authors pointed out that the study could not determine causation, the evidence was strong that there was a relationship between the studied factors.

The study’s authors argued that job satisfaction has never just been about money for the vast majority of physicians. They need more to be happy and productive in their jobs, which can be demanding and stressful but also rewarding when the conditions are right.

“Intrinsic motivators, such as autonomy, mastery and purpose, have been shown to be more powerful for physicians than extrinsic motivators, such as salary, and are associated with higher professional satisfaction and lower burnout,” the study says.

As the leader in physician well-being, the AMA is reducing

physician burnout by removing administrative burdens and providing real-world solutions to help doctors rediscover the *Joy in Medicine*™.

Lack of Autonomy: A Burnout Recipe?

Physician burnout – though down from its historic high in 2021 during the COVID-19 public health emergency – remains an epidemic in the U.S. From the number of physicians leaving their jobs or reducing their hours to patient satisfaction and the care they receive, burnout affects virtually every aspect of health care.

The study’s authors contended that its results show that physician practices and health systems might be able to ameliorate burnout – and hence, its damaging effects – by giving physicians more control over their jobs and workdays, especially over matters for which they ultimately will be held responsible.

“Providing control over these aspects of practice may seem at odds with organizational initiatives to standardize practice operations, including scheduling and workflows,” the study says. “It is imperative, however, that organizations find the right balance between standardization and customization/flexibility.”

Paying Cost of Burnout - and Turnover

The study says the reductions in autonomy and control of physicians over their work “has been driven by many forces including: the move from physician practice ownership to employment, the application of an industrial approach favoring standardization over customization, and cultural changes in the relationship between organizations and their physicians with a shift toward commodification, measurement and culpability.”

Burnout, and the resulting turnover, among physicians can cost organizations significant amounts of money. Depending on a variety of factors, replacing a physician who departs

their job can mean anywhere from \$500,000 to \$1 million or more in lost revenue. The AMA provides a calculator to see just how much it's costing your organization to replace its lost physicians.

While some health system leaders and executives may believe that giving more control to physicians would be expensive, the alternative is even costlier, wrote the study's authors.

Providing work control and influence "may decrease the likelihood of physicians experiencing burnout, reducing clinical work hours or leaving to pursue more control elsewhere, thus preserving access for patients, ensuring continuity of care and reducing recruitment/replacement costs," says the study. "These findings may be critical to organizational and societal efforts to maintain an adequate physician workforce."

But it's not just about giving physicians more autonomy. More must be done to turn the tide on burnout.

"Ensuring adequate control over the clinical work environment should be considered one component of a holistic strategy to reduce burnout and retain physicians," the study's authors wrote. "Reductions in burnout and turnover, in turn, have the potential to ensure adequate access to care and foster continuity and quality."

AMA STEPS Forward® open-access toolkits offer innovative strategies that allow physicians and their staff to thrive in the new health care environment. These resources can help you prevent burnout, create the organizational foundation for joy in medicine and improve practice efficiency. ■



Georgia Garvey is a Contributing News Writer to the American Medical Association.

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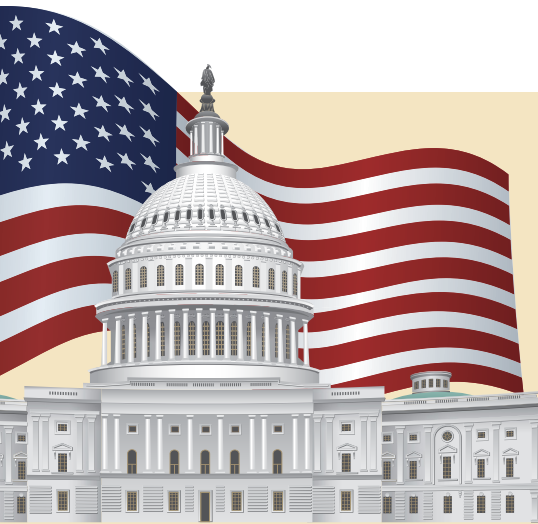
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Understanding the State of Medicare Telehealth Coverage

By Matt Reiter

Rahm Emanuel, former White House Chief of Staff to President Obama and Ambassador to Japan under President Biden, once said, “Never let a serious crisis go to waste. And what I mean by that it’s an opportunity to do things you think you could not do before.” A crisis often forces innovations that outlast the crisis itself. This saying was proven true in many ways throughout the COVID-19 pandemic. One particularly noteworthy example was the Medicare telehealth policy.

Prior to the COVID-19 pandemic, Medicare used an outdated coverage framework for telehealth that did not reflect the modern realities of how people expected to receive this service. This all changed during the pandemic when telehealth became the only way to provide many types of healthcare services.

The Centers for Medicare and Medicaid Services (CMS) used the special authority it received under the COVID-19 Public Health Emergency (PHE) declaration to waive many restrictive Medicare telehealth coverage requirements. CMS lost the authority to provide this flexibility when the PHE expired. However, Congress has since passed legislation to extend some of the most popular coverage flexibilities.

These extensions, plus other coverage changes CMS has made via the annual Medicare Physician Fee Schedule (PFS) rulemaking, have resulted in a much different Medicare telehealth coverage environment than from the pre-pandemic period. Some of these changes are permanent, while others are temporary. Further, many physicians are easily confused by which changes are permanent, and those which Congress must extend again.

This article summarizes these important telehealth policies

and explains which are permanent and those which will need to be renewed.

Medicare’s Outdated Medicare Coverage Framework

Section 1834 (m) of the Social Security Act (SSA) dictates how Medicare covers telehealth. Under this statute, Medicare telehealth coverage is limited to patients located in rural areas and excludes many Medicare beneficiaries who live outside of rural areas. It also requires the patient to travel to an “originating site,” such as a physician’s office or rural health clinic (RHC), to connect to the telehealth provider located at a “distant site.” This framework is completely antiquated, when compared to how patients expect to receive telehealth from the convenience of their home, office, or other place of their choice.

The geographic and originating site/distant site policies were waived during the PHE, essentially allowing patients to connect to any telehealth provider from anywhere they wanted.

Additionally, many types of practitioners, such as physical and occupational therapists, gained the ability to bill Medicare for telehealth services through the PHE when there was more leniency. Under the current flexibilities, any provider who can independently bill Medicare for their professional services may furnish telehealth services.

Other temporary changes to policies, such as virtual supervision and in-person mental health service requirements, are summarized in this [CMS telehealth FAQ](#).

Congress has passed multiple extensions of these flexibilities since the PHE ended. The most recent extension was passed as part of a continuing resolution (CR) that funds the federal government through September. In this

Congress has passed multiple extensions of these flexibilities since the PHE ended. The most recent extension was passed as part of a continuing resolution (CR) that funds the federal government through September. In this legislation, Congress extended these telehealth flexibilities through September 30, 2025.

legislation, Congress extended these telehealth flexibilities through September 30, 2025. **If Congress fails to extend these policies again, Medicare telehealth coverage will revert to the pre-pandemic regulatory framework as articulated in Section 1834 (m), including the geographic and originating site/distant site requirements.**

Medicare is the only major payor that includes such restrictive telehealth coverage policies. However, CMS does not have the authority to change these requirements. Only Congress can change Section 1834 (m). Congress is widely expected to pass at least another temporary extension while considering a permanent policy change.

Telehealth Coding Updates

CMS also plays an important role in setting Medicare coverage policies. While Congress determines how Medicare covers telehealth, CMS decides which telehealth services Medicare will cover. Updates to the [list of telehealth services](#) that Medicare will cover are updated annually in the Medicare PFS rule. These coverage determinations are permanent unless changed by CMS in future PFS rules.

CMS often does not align its coverage policies with those of other payors, nor does it always cover every AMA CPT code.

While Medicare is often a market leader for coverage policies, when it comes to telehealth, it is very much the opposite. It is essential to understand the telehealth coverage policies in each state and for every payor. Policies related to Medicaid, licensure, supervision, audio-only, and documentation often vary from state to state and from payor to payor.

Place of Service Code Matters

Medicare telehealth payment rates vary based on the place of service (POS) code on the claim. Medicare pays two different rates for telehealth services: 1) the facility rate and 2) the non-facility rate. The facility rate is lower because the overhead component of that service is reimbursed separately, directly to the facility. The non-facility rate is higher because it includes an overhead component.

Currently, telehealth services billed to Medicare using POS Code 10 (telehealth provided in the patient's home) are *typically* reimbursed at a higher non-facility rate. Telehealth services billed to Medicare using POS code 02 (telehealth provided other than in a patient's home) are *typically* paid at the facility rate.

Audio-Only Telehealth

In addition to those updates, the 2025 PFS makes it easier for clinicians to bill for telehealth services that only provide an audio (and no visual) connection **if** the physician can use an audio-video telecommunications system, but the patient is unable or does not consent to use video. This policy applies to any covered Medicare telehealth service. Previously, Medicare restricted audio-only telehealth coverage to certain services.

As part of this change, audio-only CPT codes 99441-99443 are no longer available.

Provider Enrollment

For 2025, CMS will continue to permit distant site providers to use their currently enrolled practice locations instead of their home addresses when providing services from their homes. This comes in response to privacy concerns from telehealth providers about having to enroll their home as a practice location.

Outlook on Permanent Changes

Annual updates to Medicare coverage policies made via the PFS are difficult to predict. Typically, the PFS is mainly used to update the list of covered telehealth services. But it also sets important policies such as allowing virtual direct supervision and establishing frequency limitations for certain in-patient services.

Congress has the responsibility to permanently modernize Medicare telehealth policies.

Congress has a deadline to extend the COVID flexibilities – either temporarily or permanently – by the end of September. There is strong bipartisan interest in Congress to permanently remove these requirements. According to the Congressional Budget Office (CBO), doing so is projected to increase

Medicare spending by around \$2.4 billion annually. Telehealth increases access to healthcare which therefore increases how much Medicare must spend to cover these services. Identifying a way to offset this cost is the main barrier to a permanent legislative policy change.

Congress does not want to be blamed for allowing these Medicare telehealth coverage flexibilities to expire. Therefore, Congress is expected to continue passing short-term extensions of these policies until it can pass a permanent solution. ■



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.

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HIPAA or State Laws – Which One Holds the Gavel?

By Chad Schiffman

On December 23, 2024, all covered entities and business associates were required to comply with the applicable requirements under a Final Rule to modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to support Reproductive Health Care privacy issued by The Department of Health and Human Services (HHS). The Final Rule strengthened the Privacy Rule regarding acceptable and unacceptable disclosures of protected health information (PHI) that involves reproductive health. Many providers and healthcare organizations have been scrambling to determine how this applies to them. One point of confusion is how PHI can be disclosed without a person’s permission when HIPAA has strict language against doing this. The fact is that HIPAA does not protect PHI in every circumstance. There are several exceptions, and these exceptions are what have caused confusion between following federal laws vs. state laws. First, let us look at the federal level.

HIPAA – Federal Act

The HIPAA Privacy Rule states that in most circumstances, an individual must authorize disclosures of their medical records. This disclosure will ensure that the individual’s privacy will help patients seek medical care without fear and that they feel comfortable enough to share information with their healthcare providers. HIPAA also states that disclosures can be made without permission when PHI is needed for law enforcement or public health reporting. Examples of how law enforcement might use medical records include investigations of a crime, proving a person’s health status in a case, and medical negligence cases. Public health reporting might include disease reporting, vital events (births/deaths), suspected child abuse/neglect, and COVID-19 reporting data.

State Laws

Our government is structured so that states can make laws that are often stricter than the federal law or even make allowances that are not permitted at the federal level. Examples of state law regulations include medical marijuana, environmental regulations, minimum wage, and healthcare. The general rule of thumb is that if state laws are more stringent than federal laws, the state laws must be followed if they do not negate the federal law. However, the Supremacy Clause says that even if a state law is contrary to the federal law such as the HIPAA Privacy Rule, the federal law will always take precedence.

Application for Healthcare

Here is where things get confusing. Reproductive health became a hot topic after the Dobbs decision made the legality of abortion a state issue instead of a federal one, since many states enacted abortion restrictions or complete bans. These restrictions and bans caused many women to seek reproductive care outside of their state if certain services were deemed illegal by their state. Regarding HIPAA, the difficulty became who could decide what information can and cannot be disclosed to a government agency, the state where the services were rendered, or the state of residence. A state with a complete abortion ban may surmise that a person seeking an abortion across state lines has committed a crime; therefore, their medical records can be requested under the HIPAA Exception for Law Enforcement. Another state may contend that since the individual received the service in a state that allows abortion, no crime was committed, and the Law Enforcement Exception does not apply. The Final Rule attempts to clarify how states can handle reproductive health information.

The Final Rule stipulates that medical records containing

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reproductive health information cannot be used to prosecute an individual for a crime concerning reproductive health. If an entity of any type requests medical records that contain reproductive health information, they must sign an attestation stating that the information will not be used to prosecute the individual. Since this Federal Act is more stringent than most state laws, it now becomes the authority over these types of medical records.

The Final Rule has been challenged in court. On December 22, 2024, the U.S. District Court for the Northern District of Texas (Kacsmark, J.) issued a preliminary injunction halting the defendants from enforcing the 2024 Final Rule against Dr. Purl and her practice. The court held that the plaintiffs had not only provided "more than sufficient evidence," they would suffer irreparable harm from enforcement of the 2024 Final Rule, and that they had also shown a likelihood of success on the merits. Since then, two other states filed a separate lawsuit against HHS on January 17, 2025.

For the time being, compliance with the Final Rule is required to ensure that privacy protections are in place for medical records and other health information related to

reproductive healthcare. However, under the Trump Administration, there is a possibility that the Final Rule will be updated or rescinded, and there are rumblings that even if the rule remains, it would be enforced. Based on the fact that the OCR's webpage is being updated, and resources are no longer available, we expect updated guidance and changes sooner than later.

Important Takeaways

This topic alone shows how important it is for covered entities and business associates to pay attention to federal and state laws. On top of that, staying up to date on changes is of utmost importance. These laws are constantly being challenged in courts, and one decision could change their precedence and legality.

Having a compliance officer on your team is no longer an option when considering the mountains of regulations dictating healthcare organizations. Most organizations cannot afford to be hit with fines for HIPAA violations. Staying vigilant and compliant will save you time, money, and energy in the long run. Find someone on your team who can champion compliance for your organization. The OIG and the OCR expect healthcare entities to comply with these laws and regulations. ■

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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 Yourself from PayPal Invoice Scams

By Burton Kelso

PayPal invoice scams are the latest growing threat targeting you and your finances. Falling victim to these scams can result in stolen identity and depletion of your bank accounts. But there is good news; with the right knowledge and precautions, you can significantly reduce your risk of becoming a victim in these scams. In this article, I will help you take a closer look at these PayPal scams, share tips on how you can spot them, and provide you with practical advice on how to protect yourself and your financial information. What you need to know is described below.

How PayPal Invoice Scams Work

Most data hacks originate with criminals sending you phishing emails. In the instance of PayPal invoice scams, you will receive an invoice via PayPal in your inbox. It may have a subject header that says something like “Invoice Due” or “Payment Due,” or it will inform you that a payment was accidentally processed on your account. The invoice looks real because it was sent through PayPal’s website or app. The problem is that the invoice is bogus. PayPal’s service allows anyone with an account to send an invoice. Scammers take advantage of this feature and exploit it to send you a legitimate-looking invoice or payment request.

How to Avoid PayPal Invoice Scams

Because PayPal invoice scams occur within the PayPal app, it can be a challenge for many of you to easily avoid these bogus messages. Doing the following can help make your life stress and scam-free:

- **Verify who sent the invoice.** Before paying any invoice that shows up in your inbox, review it for inconsistencies. If a friend or small business normally sends out payment requests that are not from PayPal, then you can be sure it’s a scam.

If someone claims they charged you too much for an order, never give out credit card information. If you made a purchase from PayPal, the person claiming to want to refund you should already have your credit card information.

- **Unfamiliar sender.** Be cautious of invoices from senders you do not recognize, even if they appear to be from a legitimate business. Many times, fake PayPal invoices look like they are from well-known software and hardware companies.
- **Incorrect details.** Check for discrepancies in the invoice like wrong amounts, incorrect item descriptions, or unusual billing addresses.
- **Urgent requests.** Scammers often use pressure tactics by asking for immediate payment with urgent language.
- **Suspicious email addresses.** Verify that the email address sending the invoice is from a legitimate domain associated with the company.
- **Fake “customer service” contact.** Do not trust the



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contact information provided on the invoice; reach out to the company through their verified website or phone number.

- **Contact PayPal.** Report the suspicious invoice through your PayPal account and provide details about the sender and the invoice.
- **Review your PayPal account.** Check your recent activity on PayPal to see if there are any other suspicious invoices or transactions.

How to Protect Yourself Further

Hopefully, these tips will help you stay safe from PayPal invoice scams. If you have any questions, please reach out. I'm 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



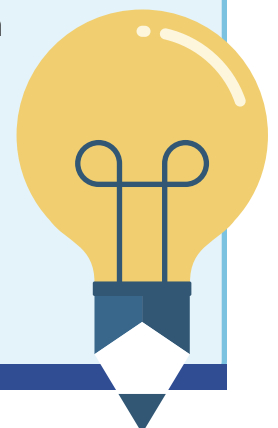
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Is it Really Incident-To?

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

Billing companies face many challenges in terms of educating physicians and providing appropriate and accurate guidance for documentation and billing practices. One such continuing challenge is the appropriate billing for Non-Physician Practitioners (NPPs)/Advanced Practitioner Providers (APPs). For simplicity, for the remainder of this article, they will be referenced as APPs. Many physician groups count on APPs and other personnel to assist them as they take care of patients. It is important to remember the following guidance is specific to billing rules and guidelines. It is not meant to supersede the clinical decisions of the physician or APPs providing direct patient care. Unfortunately, there is and has been incorrect information on how and when a physician may bill for services that they themselves did not personally provide. Medicare has one mechanism that exists for this purpose – “incident to.” Private payors do not consistently follow this Medicare concept, so it is important that individual payor guidelines are reviewed to ensure compliance.

“Incident to” services are rendered or provided by auxiliary personnel (nurses, technicians, therapists, medical assistants, etc.) under the direct supervision of the physician in an office setting (place of service (POS) 11). Note the concept of “incident to” does not apply in the hospital setting (inpatient and outpatient). “Auxiliary personnel” refers to any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician. In addition to the auxiliary personnel listed above, APP services may be covered as “incident to” the physician’s professional service. For an APP service to be considered “incident to,” the following criteria must be met according to Centers for Medicare and Medicaid Services (CMS) MLN Matters Article #SE0441:

“More specifically, these services must be all of the following:

- An integral part of the patient’s treatment course

- Commonly rendered without charge (included in your physician’s bills)
- Of a type commonly furnished in a physician’s office or clinic (not in an institutional setting); and
- An expense to you [physician].”

This document continues: “In your office, qualifying ‘incident to’ services must be provided by a caregiver qualified to provide the service, who you directly supervise, and who represents a direct financial expense to you (such as a ‘W-2’ or leased employee, or an independent contractor).

You do not have to be physically present in the treatment room while the service is being provided, but you must be present in an immediate office suite to render assistance if needed. If you are a solo practitioner, you must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise.”¹

In a hospital setting, professional services provided by an APP are billed under the APP’s name and provider number (NPI); there is no ‘incident to’ in the hospital or skilled nursing facility. Reimbursement is typically at the reduced rate of 85 percent of the assigned physician rate.

Place of Service

The place of service (POS) will dictate whether “incident to” services can be billed under the physician’s name or if the APP must bill for the service performed under their name. In order to support billing for “incident to” services in the physician’s office, the physician must be onsite and available to provide immediate assistance and/or redirection of the service provided by the APP; this would include evaluation and management (E/M) services performed as part of the established treatment plan by the physician. If the patient is being seen for a new problem, the physician must be the one to provide the E/M service to the patient and establish the plan of care; “incident to” would not be applicable in this scenario. The only way the

APP could see the patient for the new problem would be to bill for their services under their own name and NPI. As mentioned previously, “incident to” rules do not apply to auxiliary personnel or APPs employed by a hospital.

An office can be in a freestanding center or represented by space leased from a hospital. The hospital must be credentialed as POS 11, ‘carve out’ space on cost reports, and lease it to the physician or professional group at fair market value. In this situation, the physician would bill globally rather than only for the professional component.

According to the Medicare Benefit Policy Manual, the services of a physician’s nonphysician employee rendered outside of the individual physician’s office or clinic setting (at the patient’s home, bedside in an institution, etc.) can be covered only if the physician accompanies the nonphysician to treat the patient and directly supervises the nonphysician’s services (in the same room).²

Direct Supervision

Direct supervision means the physician must be present in the office suite and immediately available to provide assistance and direction during the time the auxiliary provider is performing the service. However, the physician does not have to be present in the same room with the auxiliary personnel or see the patient during every “incident to” visit or service. In an organized clinic, especially one with departments, direct supervision may be the responsibility of several physicians as opposed to an individual attending physician. The physician ordering a particular service does not need to be the physician who is supervising the service. The NPI reported on the claim should be that of the physician who was present in the office during the service and providing the necessary supervision.

According to Medicare Administrative Contractor (MAC) Noridian Healthcare Solutions: “There are no Medicare laws or regulations that define the term ‘office suite.’ The key factor in ‘incident to’ billing is the physician’s availability to the practitioner performing the service. Noridian uses a general rule that ‘immediately available’ means the supervising physician is able to provide assistance and direction in five minutes or less. The supervising physician must be within the same entity to be considered immediately available. For example, if the patient is being seen in the clinic and the supervising physician is

located in the adjoining hospital, the physician is not considered to be in the ‘office suite.’”

According to CMS: “The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct personal supervision.” This means the physician cannot be several minutes away from the office, attending a meeting in the hospital, etc. If the physician does not provide direct supervision, the service cannot be charged in the name of the physician as provided “incident to.”

In addition, the physician must remain ‘immediately available’ and able to respond without intervals of time to provide direction and assistance to the auxiliary personnel, including the APP, when needed. This means the physician cannot be rendered unavailable by performing a surgical procedure such as a biopsy during the time they are supervising the ‘incident to’ service.

As previously addressed, CMS requires that services such as diagnostic tests, incident to services, pulmonary rehabilitation services, and cardiac and intensive cardiac rehabilitation services require direct supervision. The expectation was that “immediate availability” could not be provided virtually but must be in person. Beginning with the public health emergency (PHE) for COVID-19, CMS began to allow direct supervision to be provided using real-time audio/video capabilities.

In the 2025 Medicare Physician Fee Schedule (MPFS) final rule, CMS did make a few changes to direct supervision in the office setting. CMS will “continue to define direct supervision to permit the presence of “immediate availability” of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.” Medicare noted that audio-only technology cannot be used to provide direct supervision.

Additionally, CMS permanently extended the ability to supervise some services, i.e., those assigned a PC/TC indicator “5” in the MPFS final rule and Current Procedural Terminology (CPT®) code 99211 using real-time audio/video capabilities.

Established Medical Condition

If the APP is providing follow-up care for an established medical condition (initially evaluated by the physician), but the patient reports any new medical problem, the physician must participate in the evaluation of the new problem (to bill incident to,

under the name of the physician). Generally, this participation must include physician documentation in the medical record since treatment of a new medical condition does not meet the “incident to” definition.

If the APP provides evaluation and treatment of a new medical condition (i.e., a condition not previously evaluated by the physician), then the services are reported in the name and NPI of the APP.

Some payor policies state that if during the course of treatment, the APP makes a medical decision and changes the plan of care, the services no longer support billing the services as ‘incident to’ and should be submitted under the APP’s name and NPI. It is recommended that a review of top payors is conducted to ensure compliance.

Documentation

Documentation by the auxiliary personnel in the patient’s medical record should include the physician’s order for services, a notation of all services rendered to the patient by the auxiliary personnel, a statement that verifies they are working under the supervision of the physician, and for some payors, a physician co-signature.

According to CMS: “The progress note must substantiate the service performed and be signed by the person performing it. When the physician is involved with a particular service, their contribution to the care must be documented. This will assist in substantiating their continued involvement in the patient’s care. The extent of physician involvement should reflect the patient’s condition, increasing with instability and uncertainty of the situation. All documentation should support the level of care provided.”

According to First Coast Service Options, the MAC for Florida: “The patient’s medical record must verify that the information on the claim is accurate, and the service is ‘incident to’ services provided by the physician. The contractor must be able to identify who ordered, supervised, and rendered the services. Documentation should include:

- The initial service to which the service is incidental;
- The order and/or plan for the subsequent service;
- Active involvement of the ordering physician in the

treatment of the patient; and

- Evidence that the supervising provider was present and available at the time the service was rendered.”

Not ‘Incident To’

It is always important to verify specific coverage with local insurance payors. Individual payor policies should be reviewed to determine if they follow Medicare guidelines, do or do not recognize “incident to” services, or have other policies. There may be a difference between Medicare and commercial payor credentialing and payment guidelines for APPs.

An APP such as a physician assistant (PA) or a nurse practitioner (NP) may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without physician supervision. In this scenario, the service must be billed as an independent service under the name and identification number (NPI) of the PA or NP, which will generally be reimbursed at a rate lower than the physician allowance. As a result, when an APP supervises chemotherapy, for example, this must be a service that the provider can legally render under the individual state scope of practice.

Summary

Ensuring that incident to services are billed correctly is challenging, but educating and reinforcing correct practices with our physicians is critical. Failure to do so could result in incorrect billing practices in our organizations and expose the physician and the billing company to potential compliance concerns. ■

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Resources

- ¹ <http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0441.pdf>
- ² <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>



The Past is the Past – Decide Your Future

By Dave Jakielo

The origin and evolution of the medical billing industry over the decades is an interesting story and there are some similarities as to how many companies have gotten to where they are today.

Some companies were launched when a practice decided it no longer wanted to bear the total expenses for an in-house billing operation and include their employees in their rich retirement program. So, they asked their business manager to remove the cost from their practice and start their own company, with the promise that they would help them land more clients.

Another birthing process example is when a company's first client was a relative who was understanding and patient while the billing company ascended the learning curve of how to run a successful billing business.

Most of these companies were launched in the days when medical bills that were sent to patients were actually paid. Claim denials were exceedingly rare, preauthorizations did not exist, and many providers were non-participating with most payors.

Companies grew if they provided good service, and their marketing efforts consisted of mostly waiting for the phone to ring because current clients recommended the company to their colleagues. Referrals were the norm as to how you grew your business. Most marketing approaches were reactive, waiting for referrals, versus proactive, making things happen. However, welcome to 2025 and beyond.

Our businesses are under attack and client attrition is rampant in various regions of the country. What has changed? Here are some of the common reasons:

- Older physicians are retiring and the partners taking over may want a billing company of their choice.
- Hospitals have been acquiring medical practices while requiring them to use their central billing operations.
- Clients are choosing price over quality, and even though it is the wrong choice, it can take them 12 to 24 months to admit their mistake. Many are

reluctant to return to their previous billing company – because that would mean they would have to admit they were wrong.

- Some of the new EMR software vendors, when trying to sell their software, inform the client that they no longer need a billing company because the practice management system that is bundled into the EMR is so sophisticated that claims virtually bill and collect themselves.
- Venture capital groups are rolling up practices into larger entities and they usually have an exclusive arrangement to manage their billing needs.

I could go on and on, but you get the idea. So how do you offset the above from adversely affecting your business? The best way is to have a living, proactive sales and marketing plan. You need to move from waiting for the phone to ring to making the phone ring.

Let's get something straight in case you do not have the skills, the time, or the desire to become an expert at sales and marketing – not a problem – but remember to turn out the lights when your last client dies or cancels. At least eBay, Craigslist or Facebook Marketplace will help you receive some money from the sale of your capital equipment.

Okay, okay, enough already. So, what are some of the steps you need to follow to help you become successful at sales and marketing? I'm glad you asked; here are a few ideas:

Knowledge

Learn everything about what is occurring in your region.

- What are the hospital CFOs thinking, which EMR vendors are canvassing your area, what is your competition up to? You need to recognize opportunities. HINT: You can answer any of these questions from behind your desk. The internet, Google Alerts, and various free newsletters such as *Becker's*, *Fierce*, etc., are chock full of information.

**Referrals were the norm as to how you grew your business.
Most marketing approaches were reactive, waiting for referrals, versus proactive, making things happen. However, welcome to 2025 and beyond.**

Associations

Become an active member/vendor in the associations that your clients and prospects are involved with. HINT: Why do people rob banks? Because that is where the money is. Why get involved in an association? Because that is where the prospects are. HINT: You need to focus, focus, focus. You do not have the time or money to chase every specialty. Determine where your strength lies and attack, attack, attack.

Social Networking

Learn about this medium and how to effectively use the tools they provide:

- LinkedIn
- Facebook (it's for businesses also)
- X
- ETC., ETC., ETC.

Top Ten

Develop a list of the top ten prospects you would like to turn into clients and build a strategy to get to know them and for them to learn about you.

Invest

You must invest in marketing and sales efforts if you expect a positive outcome. HINT: Yes, you must spend money to make money.

- Carve out a minimum of twenty percent of your time for marketing, two hours a day, one day a week, or one week a month – your choice. If your business is currently in a tailspin, then you should invest eighty percent of your time. And if you are not actively marketing because you do not have the time, no problem; shortly you will have plenty of time while you decide what to do in your next business.
- Set aside money for your marketing efforts, e.g., website, ezine, and join meetings that your prospects attend.

These are just a few strategies to help get you on the road to a successful sales and marketing plan. There are thousands of resources, books, audio programs, podcasts, and seminars, to help you enhance your skills. Remember, successful salespeople are made, not born, and there is a big difference between knowing what to do and actually doing it. ■

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
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

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

Collectly

44 Montgomery St
San Francisco, CA 94104
408-466-5417
collectly.co

CombineHealth

One Saint Francis Place
San Francisco, CA 94107
415-336-4826
combinehealth.ai

CTECH LLC

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

Data Media Associates, LLC

1295 Old Alpharetta Rd
Alpharetta, GA 30005
770-475-4464
dma.us

eBridge, Inc.

1018 N Ward St.
Tampa, FL 33607
813-387-3870
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

Lawrence, Evans & Co., LLC

88 E Broad St., Ste. 1750
Columbus, OH 43215
614-448-1304

Luminai

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

Matrix Imaging

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



HBMA Vendor Directory

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

NexTrust, Inc.

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

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

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

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

RXNT

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

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

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

Vodera

PMB 1443, 1000 Brickell Ave.
Suite 715
Miami, FL 33131
732-312-6634
vodera.ai

Waystar

9901 Linn Station Rd., Ste. 550
Louisville, KY 40223
844-692-9782
waystar.com

ZOLL

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

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