- **1.** Providers of all types verify patient insurance eligibility with the health plan, either prior to or during the admission or visit. Medical offices collect and post copays at the visit.
- **2.** The patient is treated and discharged or checked out.
- **3.** As you learned in Chapter 9, the provider usually needs to bill a third party, the insurance plan, in order to receive payment. The insurance bill is called a *claim*. The first step in preparing the claim is to assign procedure codes for the services rendered and the supplies used and diagnosis codes representing the disease or medical condition.
- **4.** Using these codes and the patient registration information, a computer program generates a paper or electronic claim to be sent to the insurance plan. Before the claim is sent to the insurance plan, an insurance or claim specialist reviews the claim to make sure there are no errors. Because of the volume of claims, a computer program is used to examine the claim data and identify problems. Once the claim is correct, it is sent to the insurance plan (usually electronically).
- **5.** When the claim is received by the insurance plan, it is adjudicated. If the claim is correct, a payment is sent to the provider; this is called the *remittance*. A paper or electronic document is generated that explains the amounts that were paid. This is called the *remittance advice* or *explanation of benefits* (EOB).
- **6.** When the remittance is received by the provider, the payment amount is recorded in the patient accounts system. Frequently, the amount billed does not equal the amount paid. This may be the result of a contractual agreement that stipulates that the provider will accept a discounted payment and/or that a portion of the charges is the patient's obligation. An accounting entry called a *write-down adjustment* is posted to adjust the charge.
- **7.** If the patient has a secondary insurance plan, a claim is next sent to the second plan. In certain cases the first plan will automatically forward the claim to the second plan. This is called a "piggyback" claim or *coordination of benefit* (COB) claim. For example, when a Medicare patient has a supplemental insurance policy with the fiscal intermediary who processes the Medicare claims, the company will sometimes process the secondary claim automatically. This eliminates the need for the provider to file a second claim. These are also known as crossover claims.
- **8.** Most health plans require the patient to pay a portion of the medical bill. These payments are referred to as the copay, coinsurance, and deductible amounts. The copay amount is usually stated on the patient's insurance card and collected during the patient visit. The coinsurance amount is usually a percentage of the allowed amount and is not known until the claim has been adjudicated. The EOB tells the provider what amount is the patient's responsibility. When all the patient's insurance plans have responded with remittance advice, a bill or statement is sent to the patient for any amounts due that are the patient's responsibility. The patient statement should clearly show the amounts paid or denied by the insurance plans, any adjustments to the charges required by the plan contract, and the amount due from the patient.
- **9.** When patient payments are received by the medical office or hospital, they are posted to the patient's account. When the account balance is zero, no further statements will be sent.

FIGURE 10-1 Billing workflow.