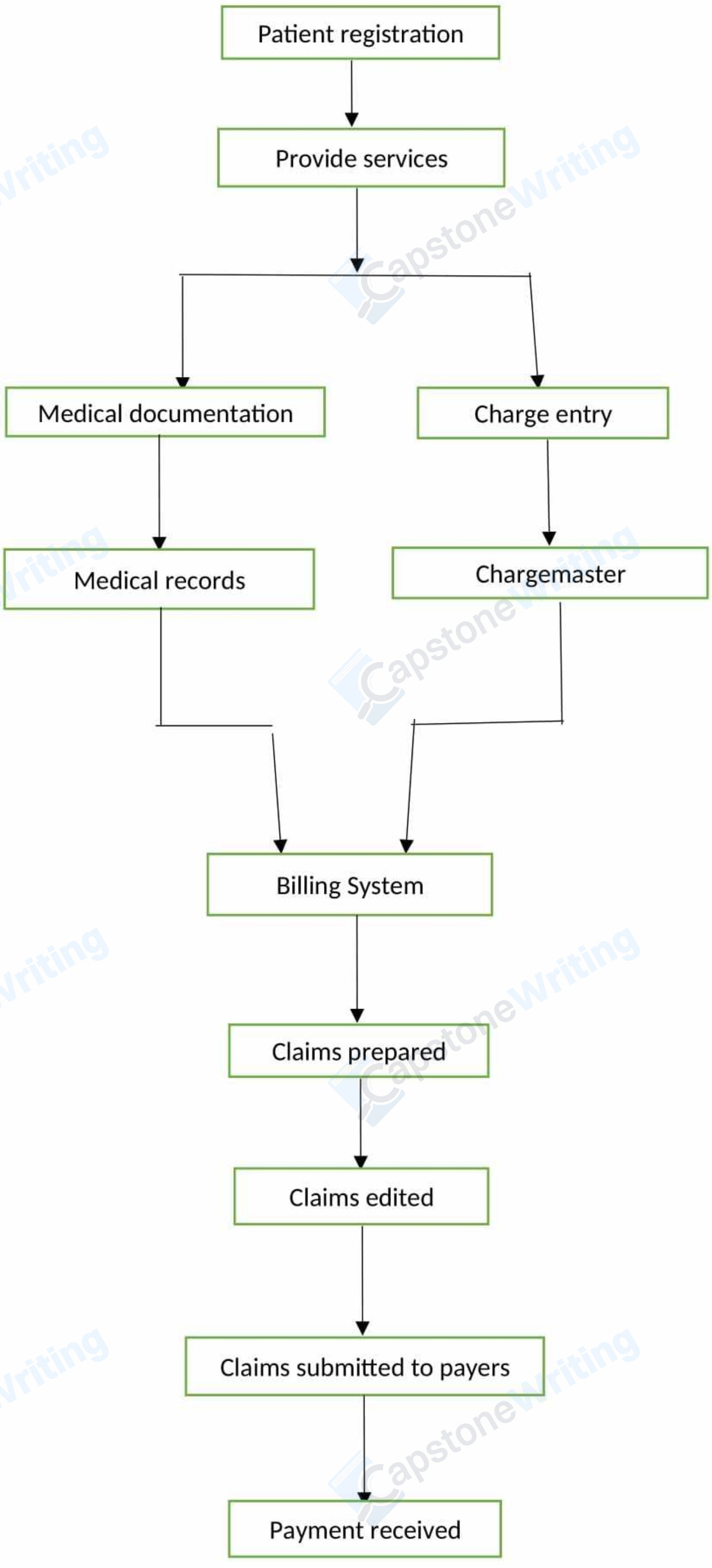
Revenue Cycle for an Inpatient Medicare

Student's name

Institutional affiliation


Patient registration
Provide services
Medical documentation
Charge entry
Medical records
Chargemaster
Billing System
Claims prepared
Claims edited
Claims submitted to payers
Payment received

The billing process covers three major categories, and these are, hospital administrative costs, insurance-related costs, and physician administrative costs. The chart gives comprehensive coverage of the billing process. The billing process starts with the patient registration. During the patient registration, crucial information is taken which are past illness, any outgoing treatment and patient's insurance among others. The billing department then verifies the insurance eligibility. The patient is informed of any changes concerning the insurance during the consultation or treatment. The next stage is the service provision. This is when the medical billing and coding processes start to be considered. In order to settle the patients, claim effectively, the diagnosis, medical procedures and treatment are recorded using the appropriate CPT and HCPCS code modifiers (Rauscher & Wheeler, 2010).

According to Cleverley et al. (2011), if there are queries to the health plan, they can be evaluated to check whether they authenticate the type of coverage offered which can, in turn, determine the patient's eligibility for an applied medical claim. After that, the claims submission follows a pre-determined process. During claims submission, the bills are sent to insurance company. If the claim adheres to that particular insurance company format guidelines, then the payment is made. In case the claim does not adhere to the format guidelines of the insurance company, the payment request is rejected, and the process of submitting a claim is repeated. After the reimbursement of the bills by the insurance company, the patient is served with the payment information and any other expenses that the patient will have to pay. The Medical billing must correspond to the HCC (Hierarchical Condition Categories) model implemented by the CMS (Center for Medicare and Medicaid). The main component of medical billing is the creating and processing billing claims. The billing professionals are supposed to know the billing accepted by the insurance companies to help them in determining the good bills from the bad

bills. The medical biller is expected to be in connection with the patients, insurance payers, and other bodies associated with the reimbursement process regularly (Casto & Forrestal, 2013).

Reference

Casto, A. B., & Forrestal, E. (2013). *The principles of healthcare reimbursement*. American Health Information Management Association.

Cleverley, W. O., Cleverley, J. O., & Song, P. H. (2011). *Essentials of health care finance*. Sudbury, Mass: Jones & Bartlett Learning.

Rauscher, S., & Wheeler, J. R. (2010). Hospital revenue cycle management and payer mix: Do Medicare and Medicaid undermine hospitals' ability to generate and collect patient care revenue. *Editorial Board*, *37*(2), 90-104.