INTEGRATED CARE

Billing Manager Training Manual

Commercial Insurance Medicare Nebraska Medicaid Workers Compensation
Streamline One Call

Training owner	Assigned employee	Primary systems	Version
Eric Washkuhn	Abril Escalante	Practice Fusion and payer portals	September 2026

Purpose. This manual trains the Billing Manager to create clean claims, route each account to the correct payer, document follow-up, resolve denials, post payments, and escalate risks. It is an operational guide, not a substitute for a payer contract, current payer manual, coding guidance, or legal advice.

Completion standard. Abril completes each module, processes supervised examples, passes the competency review, and demonstrates that every open account has an owner, next action, and documented follow-up date.

How to Use This Training

Complete the modules in order. Each payer type uses the same core revenue-cycle controls, but the payer identification, authorization, filing route, documentation, payment rules, and appeal rights differ. When a payer contract or referral instruction conflicts with this manual, stop and confirm the controlling requirement before billing.

Phase	Target	Evidence of completion
1 Foundations	Days 1–3	System access verified; claim-field exercise complete
2 Payer modules	Days 4–10	One supervised claim from each applicable payer type
3 Follow-up and denials	Days 11–15	A/R worklist updated; three denial scenarios resolved
4 Independent processing	Days 16–25	Five consecutive clean claims with no material corrections
5 Sign-off	Days 26–30	Audit score at least 90 percent and manager approval

Nonnegotiable Billing Controls

- Verify the payer, plan, member or claim number, network status, eligibility, benefits, referral, and authorization before treatment whenever possible.
- Match the patient name, date of birth, subscriber relationship, provider, location, dates of service, diagnosis, procedure, units, modifiers, and charge to the chart and authorization.
- Never copy a prior authorization number, claim number, diagnosis, or payer address without verifying that it belongs to the current episode.
- Submit electronically when accepted, retain the acceptance or rejection record, and correct clearinghouse rejections promptly.
- Do not bill the patient for workers compensation balances unless liability has been formally denied and management approves the transfer after reviewing applicable law and contract terms.
- Do not routinely waive copays or deductibles. Post contractual adjustments only from an ERA, EOB, remittance, fee schedule, or documented contract rule.
- Record every call, portal check, corrected claim, appeal, and resubmission in the account notes with date, contact, reference number, result, and next action.
- Protect PHI: use approved systems, minimum necessary access, secure attachments, and verified destinations.

Core Claim Workflow

Step	Billing Manager action	Stop condition
1 Identify payer	Determine whether the account is commercial, Medicare, Medicaid, workers compensation, or a contracted network referral. Confirm primary and secondary order.	Payer or order is unclear
2 Validate registration	Match legal name, DOB, address, member ID, group, subscriber, injury date, employer, claim number, adjuster, and authorization.	Identifiers conflict
3 Validate coverage	Check eligibility and benefits for the exact date of service. Record source, date, copay, deductible, coinsurance, limitations, and	Inactive or benefit excluded

	authorization rules.	
4 Validate documentation	Confirm signed note, medical necessity, diagnosis linkage, plan of care, units, time, provider credentials, and required reports.	Chart is incomplete
5 Build claim	Enter CPT or HCPCS, ICD-10-CM, units, modifiers, POS, rendering and billing NPI, taxonomy when required, charge, authorization, and accident data.	Data does not match source
6 Scrub and submit	Run claim edits, confirm payer ID and address, submit through the approved route, and save proof.	Rejected or no confirmation
7 Reconcile	Confirm payer acceptance, adjudication, payment, contractual adjustment, patient responsibility, and secondary crossover or billing.	Variance is unexplained
8 Follow up	Work by filing deadline and aging. Document the next action until paid, formally denied, adjusted, appealed, or approved for write-off.	No owner or next date

Clean Claim Quality Check

☐ Correct patient and subscriber

☐ Correct payer and electronic payer ID

☐ Eligibility verified for date of service

☐ Referral or authorization covers provider, service, date, and units

☐ Signed and complete clinical documentation

☐ Diagnosis supports the billed service and is linked correctly

☐ CPT or HCPCS, modifiers, units, and timed minutes are correct

☐ Billing and rendering provider data are correct

☐ Place of service and accident indicators are correct

☐ Claim or authorization number appears in the required field

☐ Attachments included through the payer-approved method

☐ No duplicate or previously paid line

☐ Charge matches the approved fee schedule or contract

☐ Submission confirmation retained

Module 1 Commercial Insurance

Commercial insurance includes employer-sponsored, individual, exchange, and commercial managed-care plans. The card logo does not by itself identify the responsible payer or network. Verify the exact product and the claims destination.

Before the First Visit

- Scan both sides of the card and verify demographics.

- Confirm active coverage for the date of service, network status for the clinic and rendering provider, PT or chiropractic benefit, deductible, remaining deductible, copay or coinsurance, visit or dollar limits, referral requirements, authorization requirements, and telehealth rules if relevant.
- Ask whether another payer is primary because of employment injury, auto accident, Medicare eligibility, or other coverage.
- Document the portal transaction or representative name, call reference number, date, and limitations. State that verification is not a guarantee of payment.

Claim and Follow Up

Control	Required action
Claim route	Use the payer-specific electronic payer ID through Practice Fusion or the clearinghouse. Use paper only when required or when an electronic route is unavailable.
Authorization	Match the authorization to discipline, provider or facility, CPT range when specified, date span, body part, and units or visits. Track remaining visits.
Coding	Use current CPT, ICD-10-CM, NCCI edits, payer modifier rules, correct units, and diagnosis pointers. Do not infer codes from a charge description alone.
Secondary claims	Wait for the primary adjudication unless coordination rules permit otherwise. Send primary EOB or crossover data as required.
Patient responsibility	Post only the amount assigned by the payer after confirming it agrees with benefits and contract. Send statements under clinic policy.
Denials	Classify: registration, eligibility, authorization, coding, documentation, bundling, timely filing, COB, medical necessity, duplicate, or payer error. Correct or appeal with evidence.

Common Commercial Denials

Denial	First review	Usual response
No authorization	Verification notes, auth dates and units, portal history	Correct number; request retro authorization if allowed; appeal only with supporting evidence
COB or other payer	Eligibility response and patient coverage	Update COB with patient or payer; bill correct primary; attach primary EOB
Bundled or modifier	NCCI edit and payer policy	Correct coding only if documentation supports it; appeal payer misapplication
Medical necessity	Policy, chart, plan of care, progress	Submit targeted appeal with records and concise clinical rationale
Timely filing	Original acceptance report and contract limit	Appeal with proof of timely submission; never change date of service

Module 2 Medicare

First distinguish Original Medicare from Medicare Advantage. Original Medicare follows CMS and the Medicare Administrative Contractor. Medicare Advantage claims, authorization, network, and appeal rules come from the plan; do not send those claims to Original Medicare unless directed.

Original Medicare Workflow

- Verify Medicare Beneficiary Identifier, Part B entitlement, Medicare Secondary Payer status, and other insurance. Never use the Social Security number as the claim identifier.
- Confirm the provider is properly enrolled and the rendering discipline may bill the service. Apply Medicare coverage and documentation rules for the specific provider type.
- Submit professional claims electronically as 837P. CMS-1500 paper claims are generally reserved for an approved exception to the electronic-submission requirement.
- File within one calendar year after the date of service unless a recognized exception applies. Track a shorter internal deadline.
- For outpatient therapy, maintain a certified plan of care and documentation supporting medical necessity, skilled care, timed units, progress, and continued need.
- For 2026, apply the KX modifier when medically necessary PT and SLP expenses combined exceed the $2,480 threshold. The targeted medical-review threshold remains $3,000. Confirm the beneficiary accumulation and current CMS guidance before applying KX.
- Apply therapy discipline modifiers and assistant modifiers when required. Medicare payment is reduced for services furnished in whole or in part by a PTA or OTA under the applicable CMS rule; confirm CQ or CO use from the service record.
- Use an ABN only when Medicare ABN rules apply and it is completed before the service. An ABN does not cure missing medical necessity or permit blanket notices.
- Post Medicare allowance, payment, sequestration or other remittance adjustments, deductible, and coinsurance exactly from the ERA. Bill secondary coverage or the patient only as permitted.

Medicare Claim Review

Area	Check
Beneficiary	MBI, eligibility, MSP questionnaire or status, primary order
Provider	Enrollment, reassignment, rendering NPI, discipline, supervision
Therapy record	Evaluation, plan of care, certification, goals, progress, timed minutes, discharge
Claim	ICD-10-CM, CPT, GP or other discipline modifier, CQ if applicable, KX when threshold and documentation requirements are met
Outcome	ERA reason codes, deductible or coinsurance, secondary crossover, reopening or appeal deadline

Module 3 Nebraska Medicaid

Nebraska Medicaid includes fee-for-service and Heritage Health managed-care plans. Verify the member's eligibility and assigned plan on every applicable date. The state manual establishes general requirements; each managed-care organization may add claims, authorization, network, and appeal procedures.

- Confirm Nebraska Medicaid enrollment for the billing entity, service location, rendering provider, taxonomy, and specialty before billing.

- Verify member eligibility, managed-care assignment, primary insurance, benefit coverage, referral, authorization, and service limitations for each date of service.
- Bill third-party liability first when Medicaid is secondary unless an exception applies. Retain the primary remittance and submit required COB data.
- Use the state or plan portal and the correct payer ID. Follow the current Nebraska Medicaid Provider Manual, provider bulletins, fee schedule, and the member's MCO manual.
- Do not collect amounts from a Medicaid member unless the charge is legally permitted and all notice or agreement requirements have been satisfied. Escalate before billing a member.
- Check claim status and remittance codes promptly. Correct registration or coding errors; appeal coverage or medical-necessity decisions using the plan's process and deadline.
- Revalidate enrollment and monitor bulletins. A technically correct claim can deny if a provider, location, or taxonomy is not active on the date of service.

Medicaid Stop and Escalate

☐ Member appears eligible but no plan can be identified

☐ Commercial coverage may be primary

☐ Provider enrollment or taxonomy is inactive

☐ Service is not clearly covered for the discipline

☐ Authorization is missing or exhausted

☐ Portal and Practice Fusion show different payer information

☐ A patient balance is proposed

Module 4 Nebraska Workers Compensation

Workers compensation billing follows the injury claim, not the patient's health-plan member ID. The key controls are employer, carrier or self-insured employer, adjuster or TPA, claim number, injury date, accepted body part, authorization, and the correct billing destination.

Set Up the Injury Account

- Obtain the employer name and contact, injury date, injury description and body part, carrier or self-insured employer, adjuster or TPA, claim number, billing address or electronic payer ID, phone, fax or portal, authorization, and referral source.
- Confirm whether the claim and body part are accepted. If the claim number is pending, obtain written direction for care and billing and track until assigned.
- Separate unrelated diagnoses and non-work services. Never move a work injury to commercial insurance merely because the workers compensation payer is slow or has not issued a number.
- Check whether a contracted network, repricer, or scheduling company such as Streamline or One Call controls authorization, documentation, or invoicing.

Claim Requirements

Field or document	Workers compensation standard

Patient and injury	Legal name, DOB, employer, date of injury, accepted body part
Payer	Carrier, self-insured employer, TPA or network; exact claim destination
Identifiers	Claim number, authorization or referral number, adjuster and contact
Claim form	CMS-1500 or approved electronic format with work-related accident indicator and injury date in the correct fields
Clinical support	Initial report, work status, treatment notes, plan of care, progress, discharge, and requested records
Charges	Current CPT and ICD-10-CM; Nebraska Rule 26 fee schedule or controlling contract; lower of billed charge or applicable scheduled amount when Rule 26 applies
Submission proof	Portal confirmation, clearinghouse acceptance, fax confirmation, or tracked mail evidence

Nebraska Rule 26 effective January 1, 2026 adopts the medical fee schedule and requires CPT and NCCI-consistent coding. Contracted services may be paid under the contract. Do not unbundle. Do not accept an unexplained repricing or coding change without reviewing the remittance, Rule 26, contract, and documentation.

Workers Compensation Follow Up

- Check acceptance within 7–10 business days after submission.
- At 30 days, verify receipt, status, missing information, and expected payment date; use a shorter interval when a contract requires it.
- If records are requested, send only the requested relevant records securely and document the transmission.
- Appeal or dispute under the applicable carrier, contract, or Nebraska process. Preserve original submission proof and the unaltered claim history.
- Do not transfer the balance to the injured worker without a formal liability decision and management review.

Module 5 Streamline and One Call

Streamline and One Call are workers compensation service networks or coordination companies. The referral or authorization controls which services, dates, body part, frequency, reporting, and billing route are approved. Their instructions may replace the carrier's ordinary billing address. Treat each referral as a contract-controlled episode.

Control	Streamline	One Call
Access	Use Provider Connect and the clinic's approved account. Request access or help through the portal support channel.	Use the One Call provider portal and the clinic's approved provider account.
Referral intake	Save referral, authorization, claim information, approved service, body part, dates, frequency, and contacts.	Save referral or order, authorization, claim information, approved service, body part, dates, frequency, and contacts.
Before care	Confirm the clinic location and rendering discipline are approved; resolve missing or conflicting limits.	Confirm location, discipline, service, dates, and visits; request extension before limits expire.
During care	Track visits and required notes or reports against the referral.	Track visits and required status reports against the authorization.
Billing	Use the portal or destination specified in the referral. Include referral or authorization and claim identifiers exactly as instructed.	Use the portal or billing route specified by One Call. Include the required order or authorization and claim identifiers.

Payment	Reconcile network rate, carrier payment, repricing, remit, and any portal status.	Reconcile contracted rate, remittance, portal status, and any separate payment or explanation.
Exception	Stop when authorization, body part, dates, service, or destination is unclear.	Stop when order, authorization, visit limit, dates, or billing path is unclear.

Network Referral Checklist

- ☐ Referral or order saved to the account
- ☐ Injured worker and employer verified
- ☐ Carrier or TPA and claim number verified
- ☐ Date of injury and authorized body part verified
- ☐ Authorized discipline and services verified
- ☐ Date range, frequency, visits, and units verified
- ☐ Clinic location and rendering provider accepted
- ☐ Required evaluation, progress, work-status, and discharge reports calendared
- ☐ Portal or billing destination verified
- ☐ Contracted rate or repricing terms identified
- ☐ Extension requested before authorization expires
- ☐ Final report and final bill submitted
- ☐ Portal status and remittance reconciled

Important: Do not assume that a carrier's verbal authorization automatically satisfies Streamline or One Call requirements, or that the network will accept a bill sent directly to the carrier. Confirm the episode-specific referral instructions.

Denial and Rejection Playbook

Status	Meaning	Action
Clearinghouse rejection	Claim was not accepted by payer	Correct data or payer route immediately; resubmit; retain both reports
Payer front-end rejection	Payer received but did not accept for adjudication	Correct enrollment, identifiers, format, or duplicate issue; resubmit within filing limit
Denial	Payer adjudicated without payment for line or claim	Read CARC, RARC, explanation, contract, and policy; correct or appeal
Underpayment	Payment is below expected allowance	Compare charge, units, modifier, fee schedule, contract, and remit; appeal variance
Medical records request	Payer requires support	Send targeted, legible, signed records securely and keep proof
No response	No usable status after acceptance	Confirm receipt by claim number or trace; escalate by age and filing risk

Account Note Standard

Every follow-up note should answer: What was checked? Who or what source provided the answer? What reference number or evidence exists? What is the result? What exact next action is required, by whom, and on what date?

Example: 09/18/2026 — One Call portal shows claim received 09/12, status pending clinical review, reference OC-12345. Evaluation and plan of care already attached. Recheck 09/25; if unchanged, call provider support. — AE

Payment Posting and Reconciliation

- Post by claim and service line from the ERA, EOB, or network remittance; do not post from the deposit amount alone.
- Separate payer payment, patient payment, contractual adjustment, sequestration or other payer adjustment, denial, refund, and recoupment.
- Verify total posted payment equals the bank or payment batch and that every adjustment has a reason.
- For recoupments, locate the original payment and payer notice, confirm the reason and appeal deadline, and obtain approval before refunding outside an automatic offset.
- For workers compensation networks, reconcile the original charge, network contract adjustment, carrier or network payment, and remaining balance. Do not write off unexplained residuals.
- Route credit balances and suspected duplicate payments for review. Do not apply one patient's credit to another account.

Work Queue Standards

Frequency	Billing Manager responsibilities
Daily	Review unsigned or incomplete notes; scrub and submit ready claims; correct rejections; enter authorizations; post ERAs and payments; work urgent filing deadlines; document contacts.
Weekly	Run unbilled and rejection reports; review authorization balances; work A/R by payer and age; reconcile network referrals; review denials and underpayments; report blockers.
Monthly	Reconcile charges to encounters; review 30, 60, 90, and over-120-day A/R; audit adjustments and patient transfers; review top denials; confirm portal and enrollment access; report trends and corrective actions.

Suggested Performance Measures

Measure	Initial target	Definition
First-pass acceptance	At least 95 percent	Claims accepted by payer without front-end rejection
Charge lag	Within 2 business days	Signed encounter to first claim submission
Rejection correction	Within 1 business day	Clearinghouse or payer rejection to corrected submission
A/R follow-up	100 percent scheduled	Every unpaid account has a documented next action date
Payment posting	Within 2 business days	Receipt of ERA or remittance to posted batch
Adjustment support	100 percent	Every adjustment tied to remittance, contract, fee schedule, or approval

Training audit	At least 90 percent	Clean-claim and documentation audit score

Management should revise targets after establishing a 60–90 day baseline. Accuracy and compliance take priority over raw claim volume.

Thirty Day Training Plan for Abril

Timing	Module	Assignment	Completion evidence
Days 1–2	Access and foundations	Verify Practice Fusion, clearinghouse, Medicare, Medicaid and MCO, carrier, Streamline, and One Call access. Review PHI, claim lifecycle, and account-note standards.	Access checklist and field-mapping exercise
Day 3	Clean claim controls	Audit five prior claims against the clean-claim checklist.	Five scored audits
Days 4–5	Commercial insurance	Verify benefits and prepare two supervised commercial claims; resolve one sample denial.	Two claims and one denial note
Days 6–7	Medicare	Review Original Medicare versus MA; complete therapy claim, modifier, MSP, and remittance exercises.	Two claim reviews and one ERA posting
Days 8–9	Nebraska Medicaid	Verify eligibility and MCO; complete one primary and one secondary scenario.	Two eligibility and claim worksheets
Days 10–12	Workers compensation	Set up injury accounts, confirm claim routing, submit required reports and bills, and calculate expected payment under the applicable rule or contract.	Two complete injury episodes
Days 13–14	Streamline and One Call	Process one referral workflow for each network from intake through final-bill checklist.	Two network episode checklists
Days 15–18	Denials and A/R	Work rejections, denials, underpayments, records requests, and no-response claims.	Ten documented account actions
Days 19–25	Independent work	Process daily work with manager spot-checks.	Five consecutive clean claims
Days 26–30	Final audit and sign-off	Complete knowledge review, live account audit, and improvement plan.	Score at least 90 percent and approval

Competency Sign Off

☐ Identifies correct payer and billing route

☐ Verifies eligibility, benefits, network, and authorization

☐ Builds a clean professional claim from the chart

☐ Distinguishes rejection, denial, and underpayment

☐ Processes commercial claims and secondary billing

☐ Applies Medicare operational controls and recognizes issues requiring escalation

☐ Processes Nebraska Medicaid and MCO claims

☐ Creates and follows a Nebraska workers compensation account

☐ Processes Streamline and One Call referrals according to the episode instructions

☐ Posts payments and adjustments with source support

☐ Maintains complete follow-up notes and work queues

☐ Protects PHI and escalates compliance concerns

Employee: _____ Date: _____

Manager: _____ Date: _____

Final score: _____ Approved for independent billing: ☐ Yes ☐ No

Odoo Project Setup

Create one project named Billing Manager Training and assign the tasks below to Abril Escalante. Use stages Not Started, In Training, Supervised Practice, Needs Review, and Complete. Attach this manual to the project and require evidence in the task chatter before completion.

Task	Milestone	Hours	Dependency
Verify billing system and portal access	Foundation	2	None
Complete core revenue-cycle training	Foundation	3	Access
Complete clean-claim audit exercise	Foundation	2	Core training
Complete commercial insurance module	Payer training	4	Clean-claim exercise
Complete Medicare module	Payer training	5	Clean-claim exercise
Complete Nebraska Medicaid module	Payer training	4	Clean-claim exercise
Complete Nebraska workers compensation module	Payer training	5	Clean-claim exercise
Complete Streamline referral workflow	Network training	3	Workers compensation
Complete One Call referral workflow	Network training	3	Workers compensation
Complete denials and A/R exercises	Revenue-cycle control	5	Payer modules
Complete payment-posting reconciliation	Revenue-cycle control	3	Payer modules
Process five consecutive clean claims	Supervised practice	6	All training modules
Complete final competency audit	Sign-off	2	Supervised practice
Manager approval for independent billing	Sign-off	1	Final audit

Source and Update Register

Billing rules change. The Billing Manager should check payer portals and these primary sources at least annually and whenever a denial, bulletin, contract amendment, or system edit indicates a change.

CMS professional claims and CMS-1500: https://www.cms.gov/medicare/billing/electronicbillingeditrans/1500

CMS Medicare Billing CMS-1500 and 837P: https://www.cms.gov/files/document/mln006976-medicare-billing-cms-1500-837p.pdf

CMS 2026 outpatient therapy KX thresholds: https://www.cms.gov/files/document/R13437CP.pdf

Nebraska Medicaid Provider Manual: https://dhhs.ne.gov/Documents/Medicaid%20Provider%20Manual.pdf

Nebraska Medicaid Provider Bulletins: https://dhhs.ne.gov/Pages/Medicaid-Provider-Bulletins.aspx

Nebraska Workers Compensation Court Rule 26: https://www.newcc.gov/resources/court-forms-and-publications/rules-of-procedure/rule-26

Streamline Provider Connect: https://providerconnect.streamlineworkcomp.com/login

One Call portals: https://onecallcm.com/portals/

Version control: Record the review date, reviewer, material change, and affected section whenever this manual is updated. Keep payer-specific contract terms and portal credentials outside this document in the clinic's approved secure location.