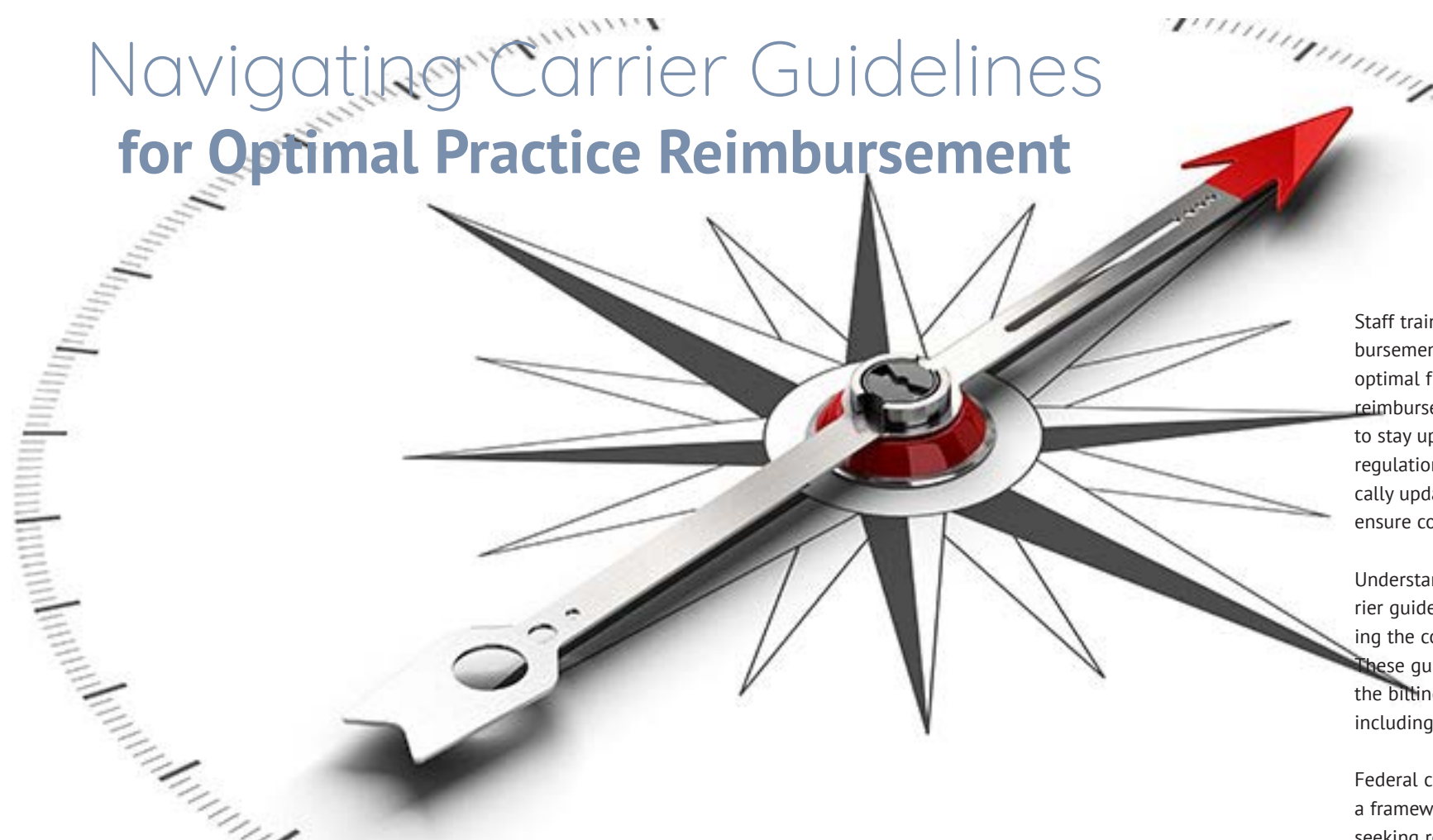


# Navigating Carrier Guidelines for Optimal Practice Reimbursement



When a Medicare patient has multiple sources of insurance coverage, Medicare will only pay for services after the primary payor has processed the claim and made their payment. Medical office staff must always verify the patient's insurance coverage thoroughly— gathering all necessary information from the primary insurance, such as policy numbers, claim submission instructions, and any preauthorization requirements, etc.

**W**orking with patient claims when Medicare is the secondary payor can be a complex process, and everyone on the team should understand current guidelines and procedures for compliant billing and reimbursement. Medicare reviews and updates some guidelines annually, and providers and staff must stay informed and compliant. Attention to detail, thorough documentation, and adherence to current Medicare guidelines will ensure proper reimbursement.

Medicare's payment as a secondary payor is based

on its own fee schedule and reimbursement rules. Reimbursements may be limited to the Medicare-approved amount, and any remaining balance, after the primary payor's payment, is the patient's responsibility. Medicare's guidelines for submitting claims as a secondary payor include accurate and complete documentation to support the claims submitted to Medicare, properly coding the services provided, and indicating the primary insurance information on the claim form. Failure to accurately follow these guidelines may result in claim denials or delays in reimbursement.

Staff training is an essential part of proper billing and reimbursement where all types of claims are involved, to ensure optimal financial outcomes for the patients and physicians. The reimbursement team must work together with their providers to stay up to date on any changes in Medicare's policies and regulations regarding secondary payor claims. Medicare periodically updates its guidelines, and providers must stay informed to ensure compliance and proper reimbursements.

Understanding and complying with federal and commercial carrier guidelines is crucial for healthcare providers when navigating the complexities of insurance coverage and reimbursement. These guidelines outline the rules and regulations that govern the billing and payment processes for various insurance carriers, including Medicare and private insurance companies.

Federal carrier guidelines, such as those set by Medicare, provide a framework for providers to follow when submitting claims and seeking reimbursement for services rendered to Medicare beneficiaries. These guidelines cover a wide range of topics, including eligibility requirements, covered services, documentation requirements, coding guidelines, and reimbursement rates. Providers and billing teams must understand these guidelines to ensure accurate and timely claim submission and maximize reimbursements.

Commercial carrier guidelines, on the other hand, are specific to private insurance companies and may vary from carrier to carrier. These guidelines dictate the rules and requirements for claims submission, preauthorization processes, documentation standards, and reimbursement rates. Avoid claim denials, delays in reimbursement, or underpayments when the team knows these commercial carrier guidelines.

Knowing the intricacies of payor guidelines helps ensure that documentation and claims are submitted correctly to minimize claim denials, optimize reimbursements, and avoid penalties or audits. Regular training and education for billing and administrative staff are crucial to ensure that your team is in sync.

## Nancy Clements

Practice Management Institute® (PMI) trains and certifies administrative professionals working in medical offices: medical office managers and staff working in coding, billing, auditing, and compliance. New and experienced professionals learn current guidelines and best practices to perform more effectively in their role. Providers and consultants involved in the business side of outpatient services also attend to understand the practical application of medical office administration guidelines.

The PMI curriculum includes five opportunities for medical office professionals to earn certification in their area(s) of expertise: Certified Medical Coder (CMC)®, Certified Medical Insurance Specialist (CMIS)®, Certified Medical Office Manager (CMOM)®, Certified Medical Compliance Officer (CMCO)®, and Certified Medical Chart Auditor E/M (CMCA-E/M).

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