RCMAXIS HEALTH SERVICES

Physician & Trainee Guide: RCM & Credentialing 101

A Clinic-Focused Training Manual | Rev. v2.0 | Aug 2026 | Confidential

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RCMAXIS-GUIDE-001	2.0	August 2026	Confidential	RCM Clinical Ops

1. CREDENTIALING & WHY IT CONTROLS PRACTICE REVENUE

In healthcare, treating a patient is only half the equation — **getting paid** is the other half. A State Medical License allows a physician to legally treat patients. But **payer credentialing** is what allows the clinic to submit claims and receive in-network reimbursement. Without active enrollment, every claim submitted for that provider will be denied.

The New Associate Revenue Risk: When a clinic hires a new physician, PA, or NP, they cannot generate in-network insurance revenue until each payer officially enrolls them. Claims submitted before enrollment is active will be denied as CO-24 ("Provider not covered by contract"). **Important nuance:** some payers offer retroactive billing privileges — typically 30–90 days back from the enrollment approval date — if the application was submitted within the payer's window. Always request retroactive billing in writing at application submission.

The 60–120 Day Pipeline: Commercial payer enrollment takes 60–120 days per payer on average. Medicare enrollment through PECOS (855I) can take 60–90 days. State Medicaid enrollment is a separate, independent process (45–90 days). Begin applications before a new provider's start date — not on it.

2. THE 10 REVENUE CYCLE DIAGNOSTIC AREAS EXPLAINED

#	RCM Area	Real Clinic Workflow	Credentialing & Enrollment Impact
01	**Eligibility & Benefits (RTV)**	Front desk verifies patient plan is active, logs copay/deductible 48h before the visit.	If the rendering physician is not paneled with that payer network, the visit bills as out-of-network. Verify NPI-payer linkage before the patient is seen.
02	**Prior Authorization**	Obtain pre-approval for MRIs, surgeries, biologic infusions.	Payers auto-reject prior auth requests if the requesting physician's NPI is not enrolled. Verify enrollment status before submitting auth.
03	**Charge Capture & Coding**	CPT and ICD-10 codes documented within 24–48h of service.	Claims must specify Rendering NPI (Type 1 — individual) and Billing NPI (Type 2 — group). Mismatch causes immediate clearinghouse rejection.
04	**Clean Claim Rate (CCR)**	Electronic claims submitted through clearinghouses (≥98% clean).	Clearinghouses kick claims if the provider's taxonomy code or billing address doesn't match payer enrollment records.
05	**Timely Filing Limits**	Submit claims before payer deadlines (90 days commercial; 365 days Medicare).	If enrollment takes 90–120 days and claims are held pending approval, the practice risks losing 100% of held revenue to timely filing expiration. Request retroactive billing privileges in writing.

#	RCM Area	Real Clinic Workflow	Credentialing & Enrollment Impact
06	**Payment Posting & ERA**	Match 835 remittances to bank deposits daily.	Confirms payer reimburses at the enrolled fee schedule, not out-of-network rates. Enrollment gaps cause silent underpayments.
07	**Days in A/R**	Average days for claims to convert to cash. Benchmark is specialty-specific (see note below).	Claims >90 days are frequently stalled by missing enrollment links or CAQH re-attestation lapses. Pull aged A/R by rendering NPI to isolate.
08	**Denial Management**	Work unpaid claims within 48h; appeal wrongful denials.	Denial code CO-24 ("Provider not covered by contract") is a direct credentialing breakdown signal. Appeal window: 90–180 days depending on payer.
09	**Patient Financials**	Collect copays at check-in; send post-adjudication statements.	Reduces bad debt write-offs. Accurate pre-visit benefit specificity only possible when the provider is enrolled and the correct in-network rate applies.
10	**Compliance & Audit KPIs**	Quarterly chart audits (25–50 charts per clinician) for coding compliance.	Ensures CAQH profiles, state licenses, DEA certificates, and malpractice coverages are re-attested on schedule. Lapsed CAQH (every 120 days) triggers credentialing holds mid-panel.

Days in A/R Benchmark Note: The standard benchmark of ≤28–32 days applies to primary care and general internal medicine. Specialty benchmarks differ significantly: Cardiology 32–38 days, Orthopedics / Spine Surgery 38–45 days, Neurosurgery 40–50 days, Radiology 20–28 days. Apply the benchmark appropriate to your specialty — do not use a primary care target to evaluate a surgical practice.

3. HOW TRAINEES USE THE 10-POINT EXCEL HEALTH CHECK TRACKER

The companion Excel workbook (RCMAXIS-TOOL-001) provides a 28-diagnostic-item scored audit across the 10 RCM categories above. It contains three tabs: **How to Use**, **RCM Health Check & Audit**, and **Executive Dashboard**. Complete it quarterly per rendering provider.

Step	Where	What to Do
1	**Tab 1, Header Rows**	Enter Practice Name, Assessor, Specialty, Audit Date, EHR Platform, Monthly Billing Volume.
2	**Tab 1, Column D**	For each of 28 items: select PASS (workflow active & measured) or GAP (broken or causing denials). Column E auto-scores: Pass=1, Gap=0. Max score = 28.
3	**Tab 1, Cols F–I**	For every GAP: assign Owner (Col F), Target Date (Col G), remediation fix (Col H), status (Col I): In Progress / Pending Review / Completed.
4	**Tab 2 — Dashboard**	Auto-populates. Shows Overall Health Score, phase-wise compliance rates, and open action item count.
5	**Archive**	Save as: RCM_HealthCheck_Q[N]_[YYYY]_[PracticeName].xlsx. Run quarterly per rendering provider.

Score	Rating	What It Means
25–28 Points (≥89%)	**OPTIMIZED**	High clean claim rate (>98%), denial rate <5%, A/R at benchmark. Revenue leakage is minimal.
20–24 Points (71–88%)	**MODERATE LEAKAGE**	Front-end or back-end friction — auth gaps, COB errors, charge lag. Remediate within 30 days.
< 20 Points (<71%)	**HIGH RISK**	Critical gaps in eligibility, timely filing, or denial follow-up. Losing est. 8–15% of collectible revenue.

4. CORE CREDENTIALING & ENROLLMENT VOCABULARY

Term	Definition
Type 1 NPI	Individual 10-digit identifier for the physician or mid-level provider. Required on every CMS-1500 (837P) claim as the Rendering Provider. Issued by CMS via NPPES.
Type 2 NPI	Organizational identifier for the clinic or group practice. Required as the Billing Provider on claims. Both NPIs must be linked within each payer's enrollment record for claims to process.
CAQH ProView	National universal credentialing database where credentials are stored and shared with payers. Must be re-attested every 120 days without fail. Lapsed CAQH is among the most common causes of mid-panel credentialing holds.
CMS-855I	Medicare Part B individual provider enrollment form. Required for each physician to bill Medicare. Submitted via PECOS. Processing time: 60–120 days.
CMS-855B	Medicare group/organization enrollment form. Required for the clinic entity (Type 2 NPI) to bill Medicare. Must be approved before individual 855I applications can be linked to the group.
CMS-855R	Reassignment of Benefits form. Required when a physician employed by a group wants Medicare payments directed to the group. Without it, Medicare pays the individual provider — creating reconciliation failures.
PECOS	Provider Enrollment, Chain and Ownership System — the CMS portal for submitting all Medicare enrollment applications (855I, 855B, 855R). All Medicare enrollment must flow through PECOS.
Payer Enrollment / Panel	The formal process of adding a provider to an insurance company's in-network list. Typically takes 60–120 days. Billing before the Effective Date causes immediate CO-24 denials.
State Medicaid Enrollment	Entirely separate from commercial and Medicare enrollment. Each state runs its own Medicaid program with its own portal and timeline (45–90 days). Medicaid MCO enrollment is separate again.
Effective Date vs. Approval Date	The Effective Date is when billing can legally begin — often 30–60 days after the Approval Date. Billing claims before the Effective Date results in automatic CO-24 denials.
Re-Credentialing	Mandatory cycle (typically every 2–3 years) where insurers re-verify active license, malpractice history, and board certification. Missed deadlines result in panel termination without prior notice.
CO-24 Denial Code	CARC 24 — "Charges are covered under a capitation agreement / provider not covered." In practice: the rendering NPI is not enrolled with the payer or enrollment has lapsed. Requires credentialing resolution, not a simple refile.
CAQH Re-Attestation	Every 120 days, the physician must log into CAQH ProView and re-attest all credential information is current. Lapsed re-attestation triggers payer credentialing holds — pausing claims processing without notifying the practice.

5. MEDICARE ENROLLMENT FORMS — WHAT EACH ONE DOES

Medicare enrollment involves three distinct CMS forms. Failing to complete all that apply to a given provider-group relationship will result in payment routing failures or outright non-payment, even when enrollment is technically "approved."

CMS-855I — Individual Provider Enrollment

Required for each physician or mid-level to bill Medicare Part B. Submitted via PECOS. Processing time: 60–90 days. Revalidation required every 5 years.

CMS-855B — Group / Organization Enrollment

Required for the clinic entity (Type 2 NPI) to bill Medicare as a group. Must be completed and approved before individual 855I applications can be linked. Revalidation: every 5 years.

CMS-855R — Reassignment of Benefits

Required when a physician employed by a group wants Medicare payments directed to the group practice. Without an active 855R, CMS will not pay the group for that physician's services — even if both 855I and 855B are approved. Among the most frequently missed forms in new provider onboarding.

PECOS — Provider Enrollment, Chain and Ownership System

The CMS web portal for submitting and tracking all three forms above. All Medicare enrollment must flow through PECOS — paper 855 forms are no longer accepted for most enrollment types.

State Medicaid Enrollment

Each state runs its own Medicaid program with its own portal and timeline (45–90 days). Medicaid Managed Care Organization (MCO) enrollment is separate again — a provider enrolled with state Medicaid fee-for-service is NOT automatically in-network with Medicaid MCOs.
