

A FIELD GUIDE FOR PRACTICE LEADERS

2027 Medicare Plan Switch Guide

Get your billing workflow ready for your patients' Medicare plan changes.

Understand the payer changes and coverage checks your office needs to handle. RxRev can support that work with AI and automation.

OPEN ENROLLMENT

Oct 15-Dec 7, 2026

CHANGES GENERALLY TAKE EFFECT

January 1, 2027

RxRev support throughout the revenue cycle.

Prepare your Medicare transition with RxRev.

Choose focused billing support or a broader RCM scope that fits your practice.

[Click here](#)

Request a walkthrough

Navigate the Medicare transition and your support options.

Click a section to jump to it. Use the case workflow as an example, then choose the services that fit your office.

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Find the right support for your practice.

Bring the workflow or backlog that needs attention. Discuss a focused project or broader services.

Click here →

Request a walkthrough

A Medicare plan switch can change how the next visit is billed.

Prepare for the 2027 transition before returning patients arrive with different coverage.

October 15-December 7, 2026

During Medicare Open Enrollment, patients can change Medicare Advantage plans or switch between Original Medicare and Medicare Advantage. Those enrollment changes generally take effect January 1, 2027. A patient may remain entitled to Medicare while the plan responsible for the next visit changes. [3]

What staff need to verify

Confirm the coverage path, payer, member details and effective date for the encounter. For Medicare Advantage, check the relevant provider, location and service requirements with the plan. Review any pending authorization or previous approval before relying on it for the new coverage.

What a missed switch can cause

If the billing system carries forward the old plan, the claim may reach the wrong payer. Staff then investigate coverage, update records, review authorization and correct or follow up on the account while payment waits. Future appointments may repeat the same mistake if the new details are not recorded.

Where RxRev can support the office

RxRev offers eligibility and benefits, authorization coordination, claim and denial support, payment posting, patient financial workflows and broader RCM services. AI-assisted preparation and automation can organize the agreed steps and route unresolved questions to staff. Choose one function or connected support that fits your practice. [14], [16]

One practical starting example

You can start with a denial queue your team already knows. The case and starter-project sections show how the service could work. You can also choose another function or a broader RCM assignment.

Prepare your billing workflow for Medicare plan switches.

Discuss eligibility, authorizations, denied claims or broader RCM support for the 2027 transition.

[Click here](#) →

[Discuss practice support](#)

Sources: [3], [14], [16]. Verify the actual plan and service-date requirements; eligibility does not guarantee payment.

THE BUSINESS PROBLEM

04

Missed coverage changes create extra work for your billing team.

A returning Medicare patient may have a different payer and billing requirements in January.

A familiar visit can create an unfamiliar claim

A returning Medicare patient arrives with the card already on file. The visit is completed and the claim goes out. Weeks later, the payer says the patient changed plans or the service needed different authorization information. Your team reopens work it thought was finished. Confirming coverage for the service date helps staff detect the change earlier.

One error creates several jobs

Staff must research eligibility for the service date, find the payer, update the account and check authorization. They may also need to correct or appeal the claim and explain the delay. Current claims still need submission, new visits need verification and unpaid accounts need follow-up. The same staff now have more work.

Payment delay is only part of the problem

The office may also face missed filing deadlines, inaccurate patient statements, refund reviews and complaints from patients who believed their visit was covered. When an error affects a payer or provider, the billing manager needs to find and review the other affected accounts.

How RxRev can help

RxRev combines revenue-cycle support with AI and automation for the work you assign. It aims to reduce repeated checks, information gathering and coordination, with results and unresolved questions available for staff review. You can discuss eligibility, authorizations, denials or aging accounts receivable (A/R), and see how the proposed workflow would fit your office. [14], [16]

Give your team help with the work that keeps coming back.

Tell us which task consumes the most time. Discuss a starting workload alongside your staff.

[Click here →](#)

Discuss practice support

Office scenarios illustrate potential consequences; they are not RxRev client case studies.

Start with the problem already costing your office time.

Choose the support your practice needs: one workflow, several connected functions or broader revenue-cycle management.

Start with the Medicare transition

Read the Medicare plan-switch section and RxRev's AI and automation approach. The denial case and starter-project plan show how a focused assignment could work. The service map covers the other functions available for discussion.

If eligibility denials keep returning

Review the Medicaid changes and Medicare verification sections. Compare your actual verification steps with what is needed for the service date. Look for missing results, old member IDs and failures that staff have been treating as completed checks.

If authorizations delay appointments

Read the prior authorization and service-specific sections. Identify where requests wait for documents, where a plan change invalidates an assumption, and who follows up when the payer requests more information. A request needs a responsible person and a follow-up date.

If balances keep aging

Use the denial, filing-deadline and A/R sections to separate correctable billing problems from clinical, contractual or coverage decisions. Review the labor calculator before treating every dollar of old A/R as equally collectible.

If payer notices sit unread

Use the steps in "Keeping current" to turn a relevant bulletin into a staff instruction or billing check. Choose the work you want RxRev to handle and agree on which future payer updates it will review for that assignment.

Bring a recurring billing problem to the assessment so you can discuss the accounts, steps and support involved.

RxRev builds AI and automation around your billing workload.

Give your team a service that combines administrative support with technology built for the steps that repeat.

Start with the work that keeps coming back

Reading a coverage result, sorting a denial, requesting a missing document and recording status all take staff time. The work grows with the appointment list. RxRev builds AI and automation for the revenue-cycle tasks you assign, using a process that fits your practice and systems.

Use AI to organize the information

AI-assisted document extraction, summaries, prioritization and draft preparation can help staff review information with less repeated reading and re-entry. Staff still need the account details, any missing information and a next action to review.

Use automation to keep the work moving

Supported interfaces and structured imports can move information between the agreed steps. Rule-based validation, routing, matching and status updates handle repeatable work and send exceptions to the responsible person. Your manager can see which items need a decision.

Keep the service easy for the office

Your staff should receive an organized question with the context needed to answer it. RxRev coordinates the assigned administrative work and builds the supporting workflow. Important billing and clinical decisions remain with authorized people. Technology choices and access are confirmed for your systems. [16]

Ask to see it on a familiar task

Choose a task your team wants help with. In the walkthrough, follow how RxRev would receive and organize the information, check it and handle the next action. Use that example to decide whether the proposed support fits.

See what RxRev could automate for your practice.

Bring one repetitive billing task. Ask for a walkthrough of the AI assistance, automation and staff handoff.

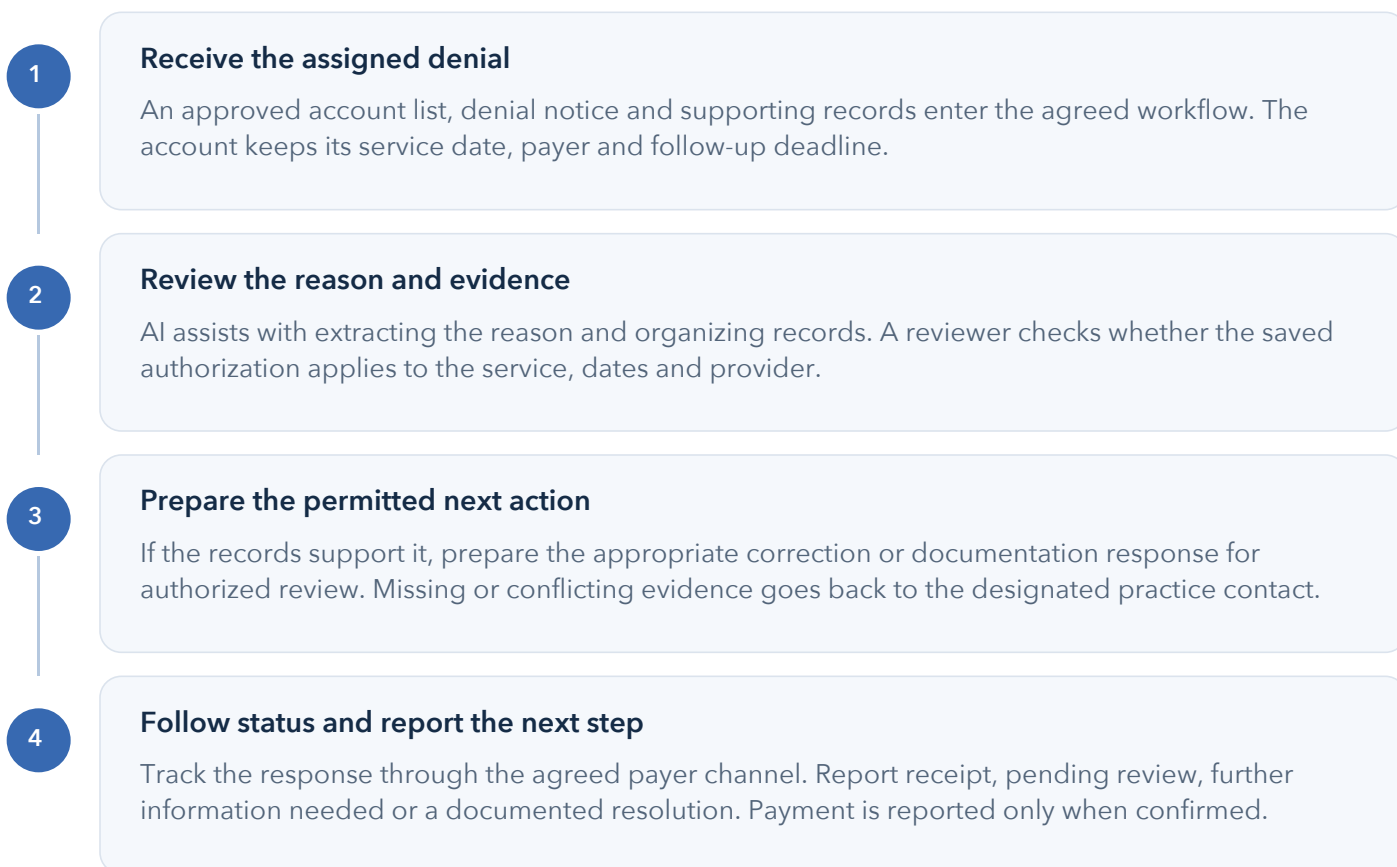
[Click here](#) →

Request a walkthrough

Source: [16]. Technology and access are selected for the agreed workflow.

Case example: how RxRev could follow up on a denied claim.

This illustrative denial concerns missing authorization details. It shows one service process; you can choose other RxRev functions or broader RCM support.



Start with a denial queue if that is where your team needs help.

Choose one denial type and see the process. Other starting points can be scoped around your practice.

Click here →

Discuss denial follow-up

Illustrative denial workflow; no live patient data or recovered-payment claim. Sources: [14], [16].

One way to begin: a denial-follow-up project.

Use a small, defined assignment to understand the service. The same setup approach can support other agreed workflows.

1 / Define the first queue

Choose a payer, denial category or fixed account list. Record the starting account count, relevant balances and known filing or appeal deadlines. Identify the practice contact, exclusions and actions RxRev may perform. Keep general scope information separate from sensitive account records.

2 / Prepare records and access

Agree on how claim records, remittances, denial notices and supporting documents will be shared. Confirm required agreements, approved access and who authorizes consequential actions. Map the status labels and prevent duplicate follow-up by assigning each account to one team.

3 / Configure and test the workflow

Set up AI-assisted preparation and repeatable task routing for the agreed work. Walk through a small authorized sample or synthetic example. Check reason extraction, supporting records, due dates, exception handling and the report your manager receives.

4 / Begin follow-up and review progress

Work the assigned list and review progress on an agreed schedule. Show actions completed, payer responses, missing information and next follow-up dates. Compare the report with the starting inventory. Use documented results to decide whether to extend the queue or adjust the process. [14], [16]

Apply the approach to the work you need

An eligibility workload, authorization list, enrollment project or another agreed function can use the same sequence: define the scope, prepare access and records, test the handoff and review progress. Choose the starting point with RxRev based on your office's needs.

Choose a starting project that fits your practice.

Denial follow-up is one option. Tell us which workflow or backlog needs attention and discuss the first assignment.

[Click here →](#)[Request a walkthrough](#)

Illustrative starter project; timing and scope depend on the work chosen. Sources: [14], [16].

Send staff the account details with each question.

AI and automation should make the service simpler to use, with less information to chase.

Replace scattered information with an organized work item

Include the issue, payer response, missing document, responsible person and due date in the handoff. AI-assisted extraction and draft preparation can organize the material for review. Staff confirm the information before using it.

Keep the next step attached to the task

Automation can route work according to agreed rules and update its status. Your staff should be able to identify whether the account is waiting on the payer, a document or a practice decision. The manager receives the context needed to act.

Let RxRev coordinate the assigned workload

Eligibility, authorization, denial follow-up and older accounts often depend on one another. RxRev supports those administrative steps within the work you assign. Your team keeps current claims moving and receives questions that need its authority or clinical input.

Review the handoffs

Review whether the handoff reached the responsible person with the information needed to act. Check that staff requested the missing document and recorded the next step. Consider those observations alongside payment and workload evidence when evaluating the service. [14], [16]

Bring one recurring handoff problem. Ask RxRev how the workflow would make that task easier for your staff.

Source: [16]. Technology and access are selected for the agreed workflow.

Bring your billing workflow. RxRev builds support around it.

Start with the systems and work your practice already uses.

Choose a familiar starting point

One payer, appointment window, authorization list or denial category gives both teams a practical place to begin. RxRev reviews how the work moves today and identifies the repeatable steps, source information and questions that need a person.

Fit the technology to the task

Supported APIs, healthcare transactions, structured imports and approved portals are possible parts of the workflow. RxRev confirms the suitable method for your systems and access. AI assistance and automation are selected for the job, with a clear path for missing information or an unexpected response.

Build the handoff your staff will use

Agree on how results reach the office, which questions need a response and what your manager receives in the report. You can start with one function alongside your team and review that assignment before adding more work.

Get a useful demonstration

Use synthetic or properly authorized information for the walkthrough. Follow an item from receipt through review, assignment and status update, including what happens when information is incomplete. Your billing manager should be able to explain the process to staff. [14], [16]

Find a starting point in the systems you already use.

Tell us your billing platform and the task that needs help. Discuss a suitable workflow and access.

Click here →
Request a walkthrough

Source: [16]. Technology and access are selected for the agreed workflow.

COST OF REWORK

11

Include staff time when you count the cost of claim corrections.

Count the staff time and payment delay, even when the payer eventually pays.

Count every return to the account

A correction often involves more than changing an insurance field. A biller may call the payer, review the service date, request documentation, revise the claim and check the next response. A manager may become involved when the same problem appears on several accounts. Those minutes rarely show up in a denial-rate report.

Estimate the labor with your own numbers

Illustrative calculation: 100 affected accounts per month, with three follow-up touches averaging 12 minutes each, require 60 staff hours. At an assumed loaded labor cost of \$30 per hour, that is \$1,800 a month or \$21,600 a year. Replace these assumptions with your own account count, touches, minutes and labor cost. This is not an industry benchmark or an RxRev savings claim.

Separate delayed cash from lost revenue

If those 100 accounts each have an expected collectible payer balance of \$150, \$15,000 is tied up pending resolution. That amount is not automatically a write-off, and it should not be added to the labor estimate as if both were realized losses. Some accounts will pay, some need a different action and some may be uncollectible.

Review where the time goes

Review which checks could have caught the problem before billing and where staff spend time on repeated corrections. RxRev can help with a defined verification or follow-up workload. Use the account evidence to assess that work and whether older accounts are still falling behind. [14]

Record staff cost, delayed balances and actual write-offs separately.

EVIDENCE OF WORKLOAD

12

Busy offices already spend hours chasing authorization.

The research gives a reason to review staffing. Your own account data determines what help the office needs.

The latest AMA survey

The American Medical Association (AMA) released its 2025 Prior Authorization Physician Survey in May 2026. Respondents averaged 40 requests per physician per week and 13 hours of physician and staff time. Forty percent employed staff dedicated exclusively to authorization work. The survey included 1,000 practicing physicians. These are self-reported findings, not an audit of your practice. [10]

Some denials deserve a closer review

The HHS Office of Inspector General (OIG) reviewed 250 authorization denials and 250 payment denials from 15 large Medicare Advantage (MA) organizations. The denials covered one week in June 2019. It estimated that 18% of payment denials met Medicare coverage and plan billing rules. The report was published in 2022. The percentage describes denied requests in that study, not all MA claims or today's national denial rate. [11]

What these findings mean for a billing manager

Record the denial reason and an appropriate next action for each account. A busy team may lack time to review some denials. Repeated resubmission can also consume time without resolving the cause.

Make support measurable

Choose a specific authorization or denial list for RxRev. Review the missing documents, payer responses, deadlines and corrected submissions, along with items needing your staff's decision. Evaluate payments and the evidence supporting a clinical response, contract review or account closure. [14]

Use the published findings to review your workload, then use your account data to choose the support needed.

Sources: [10], [11], [14]. Historical findings and survey results are labeled to avoid overstating their reach.

Put the effective date on the billing checklist.

A published rule is useful only when the right staff know when it applies.

Already in effect in 2026

Enrollment requirements for the Medicare eligibility system, HETS, changed on May 11, 2026. Non-drug prior-authorization process requirements under CMS-0057-F generally began January 1, 2026. Check whether the relevant systems and payer procedures are working now. [5], [8]

October 15-December 7, 2026

Medicare Open Enrollment gives patients an opportunity to change coverage for January 1. Ask returning patients about changes and verify the plan for the visit. The national plan information helps with preparation; an individual eligibility check identifies the patient's current coverage. [3], [15]

Affected renewals and applications in 2027

Most Medicaid expansion adults move to six-month renewals beginning with renewals scheduled on or after January 1, 2027. Adult-group applications from that date have a shorter retroactive eligibility window. Applicable adults also face community-engagement checks, subject to exemptions and state implementation. [1], [2]

Other 2027 preparation

Certain Dual Eligible Special Needs Plans (D-SNPs) face new-enrollment alignment restrictions. Most electronic interface requirements under CMS-0057-F have compliance dates generally beginning January 1, 2027. Exact dates vary by payer type. Confirm which requirements apply to the payer, system and account you are reviewing. [7], [8]

For each relevant date, record the patients affected, the staff action and the person responsible.

Sources: [1]-[3], [5], [7], [8], [15]. Review other policy changes relevant to your patients and services as well.

Prepare for more frequent Medicaid expansion renewals.

For practices treating adults covered through Medicaid expansion.

The federal change

CMS guidance requires most expansion adults to move to renewals every six months, starting with renewals scheduled on or after January 1, 2027. Specified exemptions and state transition details matter. Other Medicaid eligibility groups do not automatically follow the same schedule. [1]

How the problem reaches your office

An established patient returns after a renewal or coverage change. Staff see the same card and use the prior eligibility record. If current coverage differs, the claim may be rejected or denied. The office must then establish the service-date eligibility and determine whether another payer, a corrected claim or another permitted action is appropriate.

What to check before service

Save the current state or plan response, effective dates and verification time. Keep unavailable results on the unresolved list. Review an inactive result and avoid substituting the previous visit's result. Tell the scheduling or clinical lead when coverage remains unclear.

Organize verification and follow-up

RxRev can handle assigned verification work, organize results and track follow-up on unclear coverage. Your team receives a completed check or a question with the information needed to resolve it. Agree on the appointment window, payer sources and review time, including how missing results are handled. [14], [16]

Get help with eligibility before it becomes a denial.

Describe your appointment volume and payers. Discuss verification support and follow-up on unclear results.

[Click here](#)

Discuss practice support

Sources: [1], [14]. More renewal checkpoints create potential exposure; they do not establish a forecast of coverage losses.

Give staff a clear response to Medicaid coverage questions.

The requirement applies to certain working-age Medicaid adults. Exemptions and hardship provisions matter.

Understand who is affected

CMS's June 2026 rule describes applicable non-pregnant adults ages 19-64 who are not entitled to or enrolled in Medicare and are covered through the adult group or specified demonstrations. States generally implement by January 1, 2027, with an earlier start possible. Exemptions and hardship provisions apply. It is not a new Medicare eligibility requirement. [2]

Confirm the current eligibility result

Confirm eligibility before drawing conclusions about a patient's work requirement, coverage loss or reported change. Incorrect assumptions can lead to wrong estimates, unnecessary calls and inconsistent scheduling decisions. The state or plan determines eligibility. Your office needs the current result and a recorded next step.

Use a consistent handoff

When a patient brings a renewal notice or raises a coverage concern, record it and check eligibility through the approved channel. Identify who can explain the state process. Practice staff responsible for care decide clinical urgency and care questions; the billing checklist records the administrative information.

What RxRev can take off the desk

RxRev can help with eligibility coordination, registration, approved non-clinical communication and reporting of unresolved results. Give your team the issue and proposed next action, with enough detail to continue the conversation. Confirm the communication and escalation rules before work starts. [14]

Give reception staff an approved script and an escalation contact for coverage questions.

Sources: [2], [14]. Use state-specific guidance for individual eligibility and exemption questions.

Check Medicaid application timing before relying on retroactive coverage.

Check the service date and application timing before assuming Medicaid will pay an older balance.

What changes for the adult group

For applications made on or after January 1, 2027, the Medicaid adult group is limited to a maximum of one month of retroactive eligibility before the application month. CMS describes this in its renewal guidance. Eligibility and coverage of any particular service remain subject to the applicable requirements. [1]

An illustrative timing problem

An adult-group patient applies in April 2027 after a February visit. Under the maximum one-month retroactive window, February falls outside the ordinary lookback before April. Other coverage or case-specific rules may affect the result. Confirm the applicable dates before promising the patient that a later Medicaid application will cover the visit.

Delay can multiply the work

If the office waits for a denial before asking about enrollment, it may need to find another payer, review patient liability under applicable rules and revisit prior estimates. A later application should not be treated as a guaranteed payment plan for an older encounter. The clinical team also needs timely information about unresolved coverage without being asked to make a billing determination.

Use support earlier

RxRev can identify inactive results, record the service-date questions and work assigned coverage-related denials or older accounts. Agree on when a pending application or inactive result needs practice review. Recovery depends on the account facts and applicable rules. [14]

Put unresolved coverage on a follow-up list now. Waiting for an aged balance leaves fewer useful options.

Sources: [1], [14]. Illustrative example; individual eligibility, payer rules and other coverage may change the outcome.

Follow up when a Medicare eligibility request fails.

Confirm access to Medicare eligibility checks, then verify Medicare Advantage coverage with the plan.

Use the right verification source

CMS says its HIPAA Eligibility Transaction System (HETS) may not be used to verify Medicare Advantage Part C or Part D coverage. For Part C, send the eligibility inquiry to the plan. A generic "Medicare verified" label does not tell a biller which coverage was confirmed or which payer should receive the claim. [4]

Check the 2026 enrollment change

Since May 11, 2026, each National Provider Identifier (NPI) submitted to HETS requires valid electronic data interchange (EDI) enrollment. CMS says requests are rejected without active enrollment. Providers must identify vendor relationships and acknowledge the rules; a vendor cannot simply enroll the provider on its behalf. [5]

How a technical problem becomes a billing problem

When an eligibility request fails, staff may reuse old information or assume the patient is inactive. Either choice can produce avoidable correction work. Capture the failure, distinguish a system or enrollment problem from an eligibility result, and use an approved alternative or escalation process.

What to ask your support team

Check the NPI used, vendor relationship, returned result and source of the plan information. RxRev can coordinate verification and escalate missing information. The authorized provider and vendor keep their enrollment responsibilities. Agree on who receives technical failures and how they are resolved. [14]

Keep a failed request on the unresolved list until staff obtain a valid eligibility result.

Sources: [4], [5], [14]. HETS = HIPAA Eligibility Transaction System; EDI = electronic data interchange.

Check both coverage records before sending the secondary claim.

Medicare and Medicaid information can change on different schedules.

The current policy context

Qualifying integrated D-SNPs can use a monthly Integrated Care Special Enrollment Period for full-benefit dual-eligible people, subject to alignment conditions. Starting in 2027, certain D-SNPs restrict new enrollment to people enrolled in, or enrolling in, an affiliated Medicaid managed care organization; exceptions apply. Existing unaligned members can have a transition through 2030. [6], [7]

Why your billers need both records

A current Medicare plan does not by itself establish Medicaid status, the correct secondary payer or what cost sharing may be collected. If staff rely on an old secondary record, they may send the claim to the wrong destination, wait for a response and reopen an account that could have been checked before billing.

Review one account as a whole

Record both plans, identifiers and effective dates, then confirm the secondary billing instructions. Check QMB status separately from D-SNP enrollment. Assign conflicting records to someone who can resolve them before the routine patient statement is generated.

Where RxRev supports the office

Secondary verification, benefit review and denial follow-up are connected jobs. RxRev can help with those administrative steps and report the accounts that still need your staff's decision. You can start with dual-coverage accounts for one provider or payer to see what information repeatedly goes missing. [14]

Record current primary and secondary coverage, along with whether patient cost-sharing restrictions apply.

Sources: [6], [7], [14]. D-SNP = Dual Eligible Special Needs Plan; QMB = Qualified Medicare Beneficiary.

Check QMB status before collecting Medicare cost sharing.

The wrong patient statement creates work for billing, management and the patient.

The billing restriction

Federal law prohibits Medicare providers and suppliers from billing Qualified Medicare Beneficiary (QMB) patients for Medicare Part A or Part B cost sharing for Medicare-covered services. The protection applies to Original Medicare and Medicare Advantage. A payer's unpaid amount is not automatically a collectible patient balance. [9]

A statement can turn one error into several

When the patient disputes the bill, staff must review the account and eligibility record, stop improper collection and correct the balance. Review any cost sharing already collected improperly for the applicable correction or refund. Another incorrect bill can undermine the explanation the patient received.

Check more than the statement batch

Review copay collection, estimates, payment plans, collection referrals and any rule that converts payer responsibility into patient responsibility. Confirm QMB status for the service date. Keep the QMB flag visible to registration, payment posting and statement staff.

How RxRev can help

RxRev's patient financial workflow and payment-posting services can support account review, approved statement procedures, variance reporting and routing of questions. Agree on the QMB checks, suppression rules and practice reviewer. Your compliance lead should decide how disputed balances and prior collections are corrected. [14]

Check patient-billing restrictions before sending statements or collecting cost sharing.

Sources: [9], [14]. This restriction concerns Medicare-covered Part A/B cost sharing, not every possible charge.

Give every pending authorization a person and a follow-up date.

An active plan is only one part of preparing a service for billing.

The 2026 process requirements

CMS-0057-F generally requires affected payers to decide expedited non-drug requests within 72 hours and standard requests within seven calendar days. Qualified health plan issuers on federally facilitated Exchanges are excluded from these decision deadlines. Specific denial reasons are required. Most API compliance dates generally begin in 2027 and vary by payer type. [8]

The preventable office mistake

Staff may submit a request without tracking the response, or use an approval for the wrong provider, location, dates or units. Confirm the approved details before treating a reference number as a completed authorization.

What a useful status report contains

Show the service, payer, submission date, approved scope, expiration, visit or unit limits, missing documents and next follow-up. Separate approved, pending, denied and additional-information requests. A payer's missed deadline does not establish approval. Clinical urgency must go to the appropriate clinical staff.

Combine coordination with AI-assisted preparation

RxRev can coordinate requirements, documents, permitted submissions and payer follow-up. AI can help organize documents and draft work notes. Automation can route missing items and status changes under agreed rules. Clinical staff approve medical-necessity content and make care decisions. Agree on who receives their questions and supporting records. [14], [16]

Get support for the authorization work waiting on your desk.

Choose a payer, service or pending-request list. Discuss document coordination, status tracking and follow-up.

[Click here](#) →

Discuss practice support

Sources: [8], [14]. The described federal framework concerns non-drug items and services.

Prepare staff for electronic authorization before the system changes.

Plan for the document requests and staff handoffs that remain after electronic submission.

What to verify with the payer and vendor

CMS-0057-F requires application programming interfaces (APIs) for electronic prior authorization, with compliance dates generally beginning in 2027. Ask which of your payers is covered, when the connection will be available, which services it supports and how your software returns a denial or additional-information request. [8]

Keep responsibility attached to the response

Assign someone to review the electronic response. Requests for records go to the appropriate clinician, denials need reason-specific review and approved details must reach scheduling and billing staff. Faster transmission alone does not complete those steps.

Test the whole administrative sequence

Choose a permitted test or controlled workflow with your vendor. Confirm requirement lookup, submission acknowledgment, status retrieval, document requests and final disposition. Keep an approved fallback for outages. Record who handles technical errors separately from payer coverage decisions.

Agree on implementation responsibilities

RxRev can support the agreed administrative process, from organizing documents to following status and reporting practice decisions. For a payer or technology change, define the instructions RxRev maintains and the testing or vendor work your practice handles. Confirm those responsibilities when agreeing on the connection. [14]

Include response handling in your implementation plan. Electronic submission alone is not a completed authorization.

Sources: [8], [14]. Confirm API availability and applicable payer requirements before using the proposed workflow.

Protect filing deadlines while you investigate the wrong payer.

An account can become harder to recover while everyone waits for a response.

The Original Medicare filing deadline

CMS says Original Medicare fee-for-service (FFS) claims must reach the correct Medicare Administrative Contractor within one calendar year of service. Check CMS guidance for filing exceptions. CMS also notes that a late-filing denial is not an initial determination and is not subject to appeal. This is not a universal deadline for every MA, Medicaid or commercial payer. [12]

Why a coverage problem needs urgency

A claim sent to the wrong payer can spend weeks in a worklist before someone identifies the actual coverage. Repeated follow-up may consume the remaining time for the correct submission or another required action. An account's dollar value does not show how close it is to a deadline.

Keep distinct dates

Record the original service date, initial submission, acknowledgment, denial notice, corrected-claim cutoff and appeal deadline as applicable. Confirm each from the relevant payer rules or contract. Do not assume correcting the insurance field resets the clock or that a pending call protects timely filing.

RxRev's role in a defined backlog

RxRev can help investigate denial causes, prepare allowed corrections or appeal support, follow payer status and document escalations. Start with accounts needing time-sensitive review. Your practice should confirm the governing deadlines and any exceptions; RxRev can organize the work so those decisions are requested before the date passes. [14]

Sort the worklist by deadline as well as age and balance. A small claim near its cutoff may need action before a larger newer claim.

Sources: [12], [14]. Filing, corrected-claim and appeal time limits are separate and payer-specific.

Keep provider enrollment problems out of the claim queue.

A correctly verified patient can still have a claim problem tied to the provider record.

Check the provider side

For a new provider, location, payer enrollment or revalidation, confirm the provider, group, payer product, location and effective date that apply. Record approval evidence before relying on a submitted application for billing.

Revalidation deserves a tracked task

CMS warns that late revalidation can cause a payment hold or deactivation of billing privileges. Medicare will not reimburse services during a deactivated period. Verify due dates and the current enrollment record through the authorized process. Do not assume a vendor or another department is handling the request unless someone can show the status. [13]

How the office loses time

When billing discovers an enrollment issue through a denial, staff may have to separate provider eligibility from patient eligibility, locate missing documents and review other claims for the same provider. The original problem may have been a notice or application waiting for a signature.

Use specialized administrative support

RxRev offers credentialing and payer-enrollment support, including application management, supporting-document coordination, payer follow-up, revalidation and demographic updates. Agree on who supplies documents, who signs, who may submit and what approval evidence the billing team needs before relying on an effective date. [14]

Give billers verified enrollment status and effective dates before they rely on the provider record.

Sources: [13], [14]. Participation, enrollment and contracting depend on the specific provider, payer and product.

Recurring visits can repeat the same error across several claims.

Use the service and appointment pattern to decide what staff must track.

Behavioral health and recurring treatment

Track the payer, covered provider, authorization dates and applicable visit or unit limits. After a plan change, check whether the pending request or previous approval remains valid. A mistake in the first session can be copied into several later accounts before the payer returns a denial.

Procedures and imaging

Verify the planned service, rendering provider, site and approved scope. A scheduling change may require another payer check. Make the authorization record available to the person entering charges as well as the coordinator who obtained it.

Urgent care and same-day appointments

A short registration window needs a defined process for checking coverage and documenting unavailable results. Staff should know who receives unresolved questions and how clinical urgency is handled. Administrative uncertainty should not turn into an improvised clinical decision.

Geriatrics and primary care

Returning patients with Medicare and Medicaid may need both plans checked, with a separate QMB review before cost-sharing collection. Keep the new plan details visible across future appointments and secondary billing.

Choose relevant RxRev support

RxRev can help with verification, authorization coordination, selected front-office work and denial follow-up. Start with the service line producing repeat corrections. Agree on the exact payer requirements to check; the examples here are not universal coverage rules. [14]

Review repeat errors by service, provider and appointment pattern to decide which checks need attention.

Source: [14]. Scenarios illustrate administrative risks; actual coverage and documentation rules vary.

An incorrect bill makes patients call your busiest staff.

The patient sees one office, even when the error crossed several departments.

What the patient experiences

A patient told the visit was covered may receive a statement months later. The front desk sends the call to billing, which needs another eligibility check. If staff cannot explain the change, the patient may hear contradictory answers or believe the practice has charged twice.

What staff need before calling

Confirm the service date, coverage information, payer response, reason for the proposed balance and any QMB or other billing restrictions. Separate an estimate from a final determination. Use approved language for pending coverage and avoid promising a payer will approve or pay.

Tell the patient who will follow up

Explain which administrative question is being checked and when the office expects to follow up. Record the conversation for the next staff member. Send clinical, compliance or financial decisions to the authorized practice contact.

Where RxRev can add capacity

RxRev can support approved non-clinical communication, statement inquiries, benefit questions and policy-based escalation through its front-office and patient financial services. Define the scripts, actions and practice reviewer. Review whether handoffs are complete and account information is usable against your own workload. [14]

Review patient calls about insurance and statements as billing evidence. Repeated questions may point to a missing check.

Source: [14]. Communication recommendations must be adapted to practice policy and applicable billing rules.

Give denied claims a reason-specific next action.

Repeated resubmission can leave the original problem untouched.

Separate the causes

An inactive policy, wrong member ID, missing authorization, enrollment problem and medical-necessity denial call for different work. Use the payer response and account evidence to identify the cause. A broad "insurance denial" label makes it difficult to fix either the account or the underlying process.

Document what will change the result

Record the field or document needed for a corrected claim. For an appeal, identify the evidence and deadline. Assign missing clinical material to the practice contact. Keep the remittance and contract information for payment questions, and support the account notes with evidence.

Review the related accounts

Check for similar errors involving the payer, provider, service or date range. Correcting one denial may still leave ten others to work. Share recurring errors with registration, authorization, posting or enrollment staff.

Give follow-up an organized starting point

RxRev can categorize denials, review causes, prepare corrected claims or appeal support and follow payer responses. AI-assisted extraction and work prioritization can help organize the material for review. Automation can route work and status updates where the rules are clear. Agree on the accounts assigned and ask to see how the next action and practice decisions will be reported. [14], [16]

Give repeat denials a dedicated follow-up process.

Bring a denial category or payer. Discuss review, permitted corrections and follow-up alongside your team.

[Click here](#) →

Discuss practice support

Source: [14]. Recovery depends on account facts, payer rules, deadlines and permitted actions.

Older accounts need attention while current claims keep moving.

A busy team can have valid priorities and still leave a recoverable backlog untouched.

Review what each balance needs

Review the cause and next action as well as account age. An account may be waiting on a payer response, a correction, an authorization check or a clinical decision. Others need documented closure. This helps staff identify urgent unresolved work instead of repeatedly returning to familiar accounts.

Choose a countable project

Select a payer, age range, provider, location or fixed account list. Document the number of accounts and expected collectible balances where supportable. Exclude accounts outside the agreed work and identify deadline-sensitive cases. Avoid two teams calling the same payer about the same claim.

Keep progress and payment separate

Track accounts reviewed, corrections submitted, appeals pending, payer responses, practice decisions requested and final resolutions. Report collected payments using a defined attribution rule. A claim under review is not recovered revenue, and an adjustment is not cash.

Work the backlog with a repeatable process

RxRev can work an agreed aging A/R list while your staff handle current claims. AI can help organize documents and prioritize review. Automation can handle suitable matching, routing and status updates. Authorized staff review consequential decisions. Use a defined account list to evaluate the completed work and handoffs. [14], [16]

Put older accounts on a worklist someone owns.

Choose a payer or age range. Discuss a focused A/R assignment while your staff handle current claims.

[Click here](#) →

Discuss practice support

Source: [14]. Set recovery expectations from the account evidence; results and payment depend on the assigned balances.

Turn the payer update into a task staff can complete.

Translate the applicable payer requirement into a checklist or staff instruction.

Record exactly what applies

Keep the official source, publication and effective dates, payer product, state, service and affected patients or providers. Identify whether the update is final guidance, a proposal or a clarification. Confirm its scope before changing the workflow.

Write the staff action

Name the checklist, field, submission step or follow-up process that changes. Assign responsibility and tell the staff who use the instruction. Record unresolved questions, such as a payer effective date or vendor capability, for follow-up.

Check that the change works

Use a suitable sample to see whether staff are capturing the right details and routing unresolved cases. Compare related errors after implementation. Keep the previous instruction and effective date available so an older service date can be reviewed under the correct rules.

Build the change into the work your team receives

Ask RxRev how a relevant payer update would change the instructions, checks and routing for your assigned workload. AI can assist with organizing the material, while authorized review establishes the applicable rule. Automation can then support clear, repeatable steps. Agree on the update sources and review frequency so your office knows which changes the engagement covers. [14], [16]

Ask which patients or services are affected, what staff must change and when. Keep the official source with the instruction.

Source: [14]. Agree on the update sources, review frequency and responsibilities for the work assigned.

Choose support across the full revenue cycle.

RxRev can work alongside your staff on one function, connect several services or support broader revenue-cycle management.

Coordinate the cycle

Revenue Cycle Management connects patient access, claim preparation, payer responses, payment posting and account review. Agree on the functions RxRev handles, the decisions your practice keeps and the updates your manager receives.

Prepare the visit

Eligibility & Benefits checks coverage and benefit details. **Prior Authorization** coordinates requirements, records and payer status. **Front Office Support** adds help with selected registration, scheduling, referrals and patient-access tasks.

Work the claim and payment

Denial Management identifies reasons and organizes permitted corrections, appeal support and follow-up. **Aging A/R Recovery** addresses agreed older accounts. **Payment Posting & Reconciliation** records payments and flags mismatches for review.

Support providers and patients

Credentialing & Payer Enrollment supports applications, revalidation and payer follow-up. **Patient Financial Workflows** supports approved estimates, benefit questions, statements and payment-option administration.

Find recurring problems and improve the work

Billing Audit & Reporting reviews an agreed sample or workflow and organizes corrective actions. AI assistance and automation can support preparation, routing, matching and status updates across suitable steps. Choose the services, systems and responsibilities that fit the practice. [14], [16]

Choose the workflow your office needs help completing. Denial follow-up is one example; the service scope can cover other functions or broader RCM.

Sources: [14], [16]. Exact services, access, technology and reporting are agreed with your practice.

Give your billing team AI, automation and added administrative support.

Start alongside current staff, with a service built around the work your office needs.

Start with one backlog or recurring function

Examples include eligibility for the next appointment window, one payer's denials, pending authorizations for a service line or older accounts for a provider. A defined starting point lets both teams understand the work and recognize when it is complete.

Agree on responsibilities before access

List the systems and roles required. Identify actions RxRev may take, approvals your practice retains and questions that need clinical or compliance review. Assign one practice contact and a backup. Establish which team owns each account to prevent duplicate submissions and calls.

Make reporting useful to a busy manager

Agree on status labels and the reporting schedule. Show the next action, responsible person and due date for unresolved items. Identify payer delays separately from missing practice information, and call out decisions the manager needs to make.

Review before expanding

Compare the work completed with the starting inventory. Review corrected claims, payer responses, unresolved decisions and payment evidence. Discuss which repeat errors need a process change. If the office needs steady capacity, extend the agreed function; if the problem is resolved, close the project.

Confirm how the service will work

You can choose a focused task or ongoing function, with AI and automation built for suitable steps. During the walkthrough, see how RxRev receives information and sends results or questions to your staff. Agree on those handoffs before assigning the work. [14], [16]

Add support to the billing team you already have.

Start with one workload. Agree on who handles it, what your staff receive and how results are reviewed.

[Click here](#) →

Discuss practice support

Source: [14]. Timing, access, safeguards and commercial terms are confirmed before work begins.

PRACTICE WORKSHEET

31

Check the billing steps that prevent repeat work.

Use Yes, No or Needs review. A Yes should be backed by a real process your staff can show.

Before service

1. Do staff check current eligibility for each encounter?
2. Is the Medicare or MA verification source recorded?
3. Are secondary coverage and effective dates captured?
4. Are QMB restrictions checked before collection?
5. Does authorization match the service, provider, site, dates and limits?

When something is unresolved

6. Is each missing result assigned to a person and due date?
7. Can staff distinguish a system error from inactive coverage?
8. Are filing, correction and appeal deadlines tracked separately?
9. Does the clinical team receive time-sensitive decisions?
10. Are related accounts reviewed after a repeat error is confirmed?

After a policy or payer change

11. Is the official source and effective date saved?
12. Are affected payers, services and patients identified?
13. Is the checklist or billing instruction revised?
14. Has someone checked that staff use the new step?
15. Do reports identify decisions management needs to make as well as activity counts?

Choose the first task to fix

Missing step: _____
Accounts or appointments affected: _____
Responsible person: _____
First action and due date: _____
Support to discuss with RxRev: _____

This worksheet is a process checklist, not a validated risk score. Review patient-billing restrictions promptly.

Use alongside current payer requirements and practice policy.

COST WORKSHEET

32

Calculate what repeat billing work costs your office.

Use one recent month. Separate delayed payments from actual losses.

1 / Count affected accounts

Affected accounts: _____ Touches per account: _____

Minutes per touch: _____

Staff hours = accounts x touches x minutes / 60

Include repeated payer calls, documentation requests and account corrections. Use a sample if your system does not track time.

2 / Estimate staff cost

Loaded hourly labor cost, including relevant employer costs: \$_____

Monthly rework cost = staff hours x loaded hourly cost

This is a labor estimate. It does not establish that every hour can be eliminated or that hiring outside support will cost less.

3 / Measure the payment delay

Expected collectible unresolved balances: \$_____

Days to resolution: _____ Actual write-offs: \$_____

Do not count gross billed charges as collectible revenue. Do not describe delayed balances as permanent losses.

4 / Compare the support proposal

Define the workload RxRev would handle, the fee, access needed and reporting. Compare the proposal with the time your staff spend and the decisions that remain with the practice. Establish a starting inventory so you can judge the result using the same accounts and definitions.

Use the result to make a staffing decision

Use the estimate to decide whether added support would protect staff time, address the backlog or improve consistency. Compare the proposed work and fee with the workload estimate. Both teams can review the results against the same starting accounts.

Bring the account count and workload estimate to your assessment. You do not need to send patient details through the website.

Illustrative method only. Use your own accounting definitions and verify inputs.

REQUEST AN ASSESSMENT

33

Ask RxRev to show how AI and automation fit your billing work.

Bring your repetitive task, backlog or handoff problem. See what support could look like for your office.

Bring a problem your team recognizes

Tell RxRev where the work is accumulating. It may be eligibility denials for one payer, authorization follow-up or older A/R that current billing keeps displacing. Describe the task, approximate volume, systems and staff responsibility in general business terms.

Ask for a concrete starting scope

Confirm which accounts or appointments RxRev would handle, the information needed and permitted actions. Name the decisions your practice keeps, the status report you expect and the payer changes that will be reviewed for the assignment.

See the technology in the service

RxRev builds AI and automation around revenue-cycle work and offers support across eligibility, authorizations, denials, aging A/R and account review. Ask for a walkthrough of a task your team recognizes. Follow the information, the next action and the exception path so you can evaluate how the service would work for your staff. [14], [16]

Start with one workload alongside your team

Choose an appointment window, payer, service line or account list. Ask RxRev to explain the information needed, proposed support and staff handoff. Your office can discuss a focused starting point and expand the work after reviewing how the first assignment operates.

Request a revenue assessment

Describe your practice, systems and the billing task that needs attention. Ask how RxRev would combine service, AI assistance and automation for that work. RxRev will review your request and suggest an assessment or scope discussion. Keep patient and claim details out of the website inquiry.

See what RxRev could take off your team's desk.

Describe the task, systems and approximate volume. RxRev will review your inquiry and suggest an assessment or scope discussion.

[Click here →](#)
Request a walkthrough

Source: [14]. Scope, fees, timing and access are confirmed in the engagement; no payment or savings guarantee is implied.

The evidence behind the guidance.

Policy and research sources retain their dates. Medicare enrollment timing was rechecked October 1, 2026; the prior evidence review was September 30.

- 01 Medicaid renewals and retroactive eligibility** [Read →](#)
CMS SMD 26-001, March 6, 2026. Six-month renewals; footnote 16 addresses the adult-group retroactive window.
- 02 Medicaid community engagement** [Read →](#)
CMS-2454-IFC fact sheet, June 1, 2026. Affected adults, Medicare exclusion, exemptions and implementation.
- 03 Medicare Open Enrollment** [Read →](#)
Medicare.gov. Annual election period and January 1 effective dates.
- 04 HETS Rules of Behavior** [Read →](#)
CMS bulletin, June 13, 2023. FFS eligibility versus Part C and Part D inquiries.
- 05 HETS enrollment requirements** [Read →](#)
CMS HETS EDI: How to Enroll. May 11, 2026 NPI enrollment requirement and rejected requests.
- 06 Integrated D-SNPs and monthly enrollment** [Read →](#)
CMS D-SNP integration resources. Integrated Care SEP and alignment conditions.
- 07 2027 D-SNP alignment** [Read →](#)
CMS FAQ for 42 CFR 422.514(h), April 13, 2026. New enrollment and existing-member transition.
- 08 Non-drug prior authorization** [Read →](#)
CMS-0057-F fact sheet. Decision deadlines, specific denial reasons and API compliance dates.

The evidence behind the guidance.

Policy and research sources retain their dates. Medicare enrollment timing was rechecked October 1, 2026; the prior evidence review was September 30.

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| 09 | QMB patient-billing protections
CMS QMB Program resources. Medicare Part A/B cost-sharing restrictions. | Read → |
| 10 | 2025 AMA Prior Authorization Physician Survey
AMA release, May 13, 2026. Survey of 1,000 physicians; 40 requests and 13 hours weekly on average. Self-reported findings. | Read → |
| 11 | Medicare Advantage denial review
HHS OIG, April 2022, OEI-09-18-00260. Sampled denials from June 1-7, 2019; not a current national denial rate. | Read → |
| 12 | Medicare FFS timely filing
CMS Medicare Billing training. Correct MAC, one-calendar-year rule and late-filing denial treatment. | Read → |
| 13 | Medicare revalidation
CMS Revalidations (Renewing Your Enrollment). Requirements and payment consequences. | Read → |
| 14 | RxRev service model
RxRev revenue-cycle services and engagement options. | Read → |
| 15 | 2027 Medicare landscape
CMS state-by-state fact sheets, September 28, 2026. Plan-year context and enrollment dates. | Read → |
| 16 | RxRev technology and automation
RxRev technology approach: AI assistance, repeatable-step automation, supported interfaces and authorized review. | Read → |

Examples and calculations are illustrative. Services, systems, access and review responsibilities are confirmed for each engagement.