

# Resolute Billing Cycle Test Script Template

Charge | Claims | ERA | Denials |  
TechFitFlow.com

<b>Test Cycle:</b>	<input type="checkbox"/> Unit <input type="checkbox"/> Integrated <input type="checkbox"/> BAT <input type="checkbox"/> End-to-End	<b>Billing Type:</b>	<input type="checkbox"/> PB <input type="checkbox"/> HB <input type="checkbox"/> Both
<b>Tester:</b>	_____	<b>Date:</b>	_____
<b>Environment:</b>	_____	<b>Build Version:</b>	_____

## CHARGE CAPTURE AND CDM VALIDATION

ID	Test Description / Steps	Expected Result	Status	Notes / Defect Ref
RC-001	Complete outpatient office visit for established patient. Provider signs note. Verify E/M charge generates with correct CPT code.	E/M charge fires on note sign-off. CPT matches appointment type and documentation level. CDM item correct.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-002	Place and result a CBC lab order. Verify lab technical component charge generates at result-verified status, not at order placement.	Charge fires when result is verified in Beaker. No charge fires at order placement. CDM CPT code matches lab fee schedule.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-003	Document an infusion administration in nursing flowsheet. Verify infusion charge generates at administration-complete, not order signed.	Infusion charge fires on nursing administration documentation. Charge does not fire on order signature alone.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-004	Cancel a lab order after charge trigger status but before completion. Verify charge is reversed or routed to review.	Charge reversal fires or charge routes to charge review queue. No unbilled charge for cancelled service.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-005	Document a procedure using a custom SmartForm. Verify correct procedure charge generates linked to correct CDM item.	Procedure charge fires. CDM item and CPT code match the documented procedure. Charge routes to correct billing type.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-006	Check charge review work queue after charge generation. Verify charges requiring modifier evaluation appear correctly.	Charges needing modifier review appear in charge review queue. Modifier 25 or 59 scenario correctly flagged for coder review.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	

## CLAIM EDIT RULES AND SCRUBBING

ID	Test Description / Steps	Expected Result	Status	Notes / Defect Ref
RC-007	Submit a test claim with an invalid ICD-10-CM diagnosis code (deleted code). Confirm claim edit holds the claim.	Claim held in edit work queue. Error message identifies invalid diagnosis code. Claim does not submit to clearinghouse.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
RC-008	Submit a test claim for a Medicare patient with a service requiring LCD coverage - without a supporting diagnosis. Confirm LCD edit fires.	Claim held for medical necessity edit. LCD/NCD edit fires. Coder review task generated. ABN status checked.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	

RC-009	Submit a test claim with two CCI-bundled CPT codes without a modifier 59. Confirm CCI edit fires and holds claim.	CCI bundling edit holds claim. Edit message identifies code pair. Claim routes to coding queue for modifier review.	[ ] Pass [ ] Fail [ ] N/A	
RC-010	Submit a test claim for a patient with no prior authorization on file for a payer/procedure requiring PA. Confirm auth edit fires.	Authorization edit holds claim. Missing auth number flagged. Claim routes to authorization work queue.	[ ] Pass [ ] Fail [ ] N/A	
RC-011	Submit a test claim approaching the payer timely filing deadline. Confirm timely filing alert fires and claim is prioritized.	Timely filing alert visible on claim. Claim appears in priority work queue. No claim is submitted past deadline.	[ ] Pass [ ] Fail [ ] N/A	
RC-012	Submit a test 837P professional claim to clearinghouse sandbox for Medicare. Confirm accepted acknowledgment received.	Clearinghouse returns 999 accepted acknowledgment. No functional errors. Claim proceeds to payer adjudication.	[ ] Pass [ ] Fail [ ] N/A	

### HIPAA TRANSACTIONS: 837, 835 ERA POSTING

ID	Test Description / Steps	Expected Result	Status	Notes / Defect Ref
RC-013	Submit 837I institutional test claim for inpatient stay to clearinghouse sandbox. Confirm accepted with correct DRG data.	Clearinghouse accepts 837I. DRG code present in claim data. Revenue codes populated for all billed services.	[ ] Pass [ ] Fail [ ] N/A	
RC-014	Load test 835 ERA file from Medicare sandbox. Confirm payment posts to correct claim with correct allowed amount.	Payment posts to correct claim. Allowed amount matches ERA. Patient responsibility calculated and posted.	[ ] Pass [ ] Fail [ ] N/A	
RC-015	Load 835 ERA with CARC code 197 (no authorization). Confirm denial reason records correctly in Resolute denial catalog.	CARC 197 maps to "No Authorization on File" denial reason. Claim routes to authorization denial work queue.	[ ] Pass [ ] Fail [ ] N/A	
RC-016	Load 835 ERA with unmapped CARC code. Confirm system behavior - payment posts but denial reason flags for review.	Payment posts. Unmapped CARC flagged in system. Alert generated for revenue cycle team to add mapping.	[ ] Pass [ ] Fail [ ] N/A	
RC-017	Test COB scenario: Medicare primary, supplement secondary. Submit primary claim, receive ERA, confirm secondary claim generates with EOB data.	Primary claim adjudicates. Secondary claim generates with correct COB data from primary ERA. Secondary routes to supplement	[ ] Pass [ ] Fail [ ] N/A	
RC-018	Submit 270 eligibility inquiry for test patient to Medicare sandbox. Confirm 271 response populates coverage in patient account.	271 received. Coverage details populate in Epic patient account. Effective date and benefit information visible to scheduler.	[ ] Pass [ ] Fail [ ] N/A	

### DENIAL MANAGEMENT AND AR WORKFLOW

ID	Test Description / Steps	Expected Result	Status	Notes / Defect Ref
RC-019	Simulate a claim denial for missing authorization (CARC 197). Confirm claim routes to authorization denial work queue.	Denied claim appears in auth denial queue. Denial reason visible. Appeal deadline calculated and displayed.	[ ] Pass [ ] Fail [ ] N/A	

<b>RC-020</b>	Simulate a claim denial for ICD-10 code issue (CARC 16). Confirm claim routes to coding review work queue.	Denied claim appears in coding queue. ICD-10 denial reason recorded. Coder can correct and resubmit from queue.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-021</b>	Simulate a claim denial for eligibility issue (RARC N30). Confirm claim routes to front-end registration queue.	Denied claim routes to eligibility/registration queue. Denial reason recorded. Registration staff can update coverage and resubmit.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-022</b>	Verify AR aging report shows correct days-in-AR for accounts approaching timely filing deadline.	Aging report shows correct age. Accounts within 14 days of timely filing deadline flagged with priority indicator.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-023</b>	Verify denial analytics report shows top 5 denial reasons by volume and dollar for Medicare and commercial payers.	Reporting Workbench denial report runs without error. Top denial reasons visible by payer. Dollar amounts accurate.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	

**PROFESSIONAL VS HOSPITAL BILLING AND COMPLIANCE**

ID	Test Description / Steps	Expected Result	Status	Notes / Defect Ref
<b>RC-024</b>	Book and complete a new patient office visit. Verify E/M charge generates 99205 for professional billing with individual NPI on 837P.	99205 charge generated. Individual rendering provider NPI on 837P claim. Group billing NPI in correct loop. Tax ID correct.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-025</b>	Complete an inpatient hospital admission. Verify DRG grouper assigns correct DRG based on principal diagnosis and procedure codes.	DRG assigned by grouper. DRG code visible on claim preview. Revenue codes present for all hospital services on 837I.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-026</b>	Document a same-day E/M visit and minor procedure. Verify modifier 25 applies to E/M charge and both charges submit on same claim.	Modifier 25 appears on E/M charge. Procedure charge on same claim without modifier 25. Both charges route to correct payer.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	
<b>RC-027</b>	Submit 837P to Blue Cross with individual NPI. Verify clearinghouse accepts and NPI matches payer enrollment records.	Clearinghouse accepts. Individual NPI in loop 2310B matches Blue Cross provider enrollment. No NPI-related rejection.	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	

<b>Revenue Cycle Lead Sign-off:</b>	<b>Compliance Sign-off:</b>	<b>Date:</b> _____	<b>Cycle #:</b> _____
_____	_____		