

Billing Process Checklist

1. Always verify the insurance information is correct and current prior to providing services (preferably at time of scheduling). **Be sure patients expect to pay deductibles and co-pays at the time of service.**
2. All patients must receive a receipt for payments made by cash or check with a duplicate copy kept on file by the office. Persons accepting payments should not be the persons posting payments or preparing practice deposits.
3. Have an established process for reconciling patient visits with charges billed (e.g., charge ticket numbers, comparison of daily sign-in log to daily charge entry report).
4. Send patient statements out daily using a 28-day payment period. Personalize statements containing past due balances to request either payment in full or a reasonable payment plan be made.
5. If an outside collection agent is used, fully review accounts prior to turning to the agent to be sure that all internal work has been properly performed and that account balance is accurate.
6. Track lag time between patient encounter and time of billing for services and set goals for completion of documentation, entry of charges, and claims submission.
7. It is best to enter charges and send claims on a daily basis. When submitting electronically, be sure to review claims acknowledgement and acceptance reports provided by the electronic claims clearinghouse. Any claims not found on the report should be immediately investigated for transmission errors. Claims errors on the report should be immediately corrected and set to re-bill in the next cycle.
8. Check the status of unpaid electronic claims if they are 20 days old or older and make account notes on the status. Follow up with sending any additional information needed or contact the patient if the payer needs information from them. Follow-up weekly until paid. **Work old claims first, most payers have timely filing limitations which could result in lost revenue!**
9. Check the status of unpaid paper claims if they are 30 days old or older and make account notes on the status. Follow up with sending any additional information needed or contact the patient if the payer needs information from them. Follow-up weekly until paid. **Work old claims first, most payers have timely filing limitations which could result in lost revenue!**
10. Follow-up on unpaid claims by payer (e.g., work all past due Medicare on one day). This saves time as you can check the status of several claims with one contact and allows for easy identification of patterns (e.g., all Medicare for a certain code remain unpaid).

11. Know the timely filing periods within the physician's payer contracts (don't agree to less than 90 days, this is one of the most negotiable items in the contract) and make sure that the payer shows receipt of the claims within that time period even if the claim is delayed for further development.
12. Work all claims denials promptly. There is a tendency to let these pile up and become lost revenue often over minor claims filing errors. Failure to work denials also leads to repeated mistakes and more denials.
13. Create cheat sheets which help you remember coding and billing rules from your most common payers.
14. Use the internet or electronic inquiries where possible to verify eligibility, claims status, payer policies, and to sign up for electronic newsletters from your common payers.
15. Attend local chapter meetings of billing or coding organizations and presentations provided by Medicare Contractors or other payers. These are a quick and inexpensive way to keep up-to-date and learn new information.
16. Use the most authoritative information sources that you can find (eg, CMS or the local contractor for Medicare billing and coding information, the payer web site or provider representative for private payer information).
17. Get all billing instructions in writing and keep a file. If customer service at a payers claim office says to submit a claim with a different code, place of service or anything out of the ordinary, ask them to fax or e-mail that instruction for your records. This could be important in the event of an audit.
18. Respond promptly when a payer requests records. Be sure to include all related records for the date of service (eg, medication lists, test results and records from other sources which are referenced in the note, history forms completed by the patient). Review the information with the physician prior to sending it.
19. Don't ignore the problems. Some payers are notorious for slow claim payment and are difficult to contact regarding claims status. While it is tempting to focus on money more easily collected, these are the claims to work continuously so that revenue is not lost and you can file grievances with supporting documentation. This is especially important when claims are processed by contracted vendors whose contracts may be discontinued if their service standards are too low.
20. There is no free time for a biller. There are always claims which need the status checked, patient balances that require follow-up, or payment/billing related materials to read.