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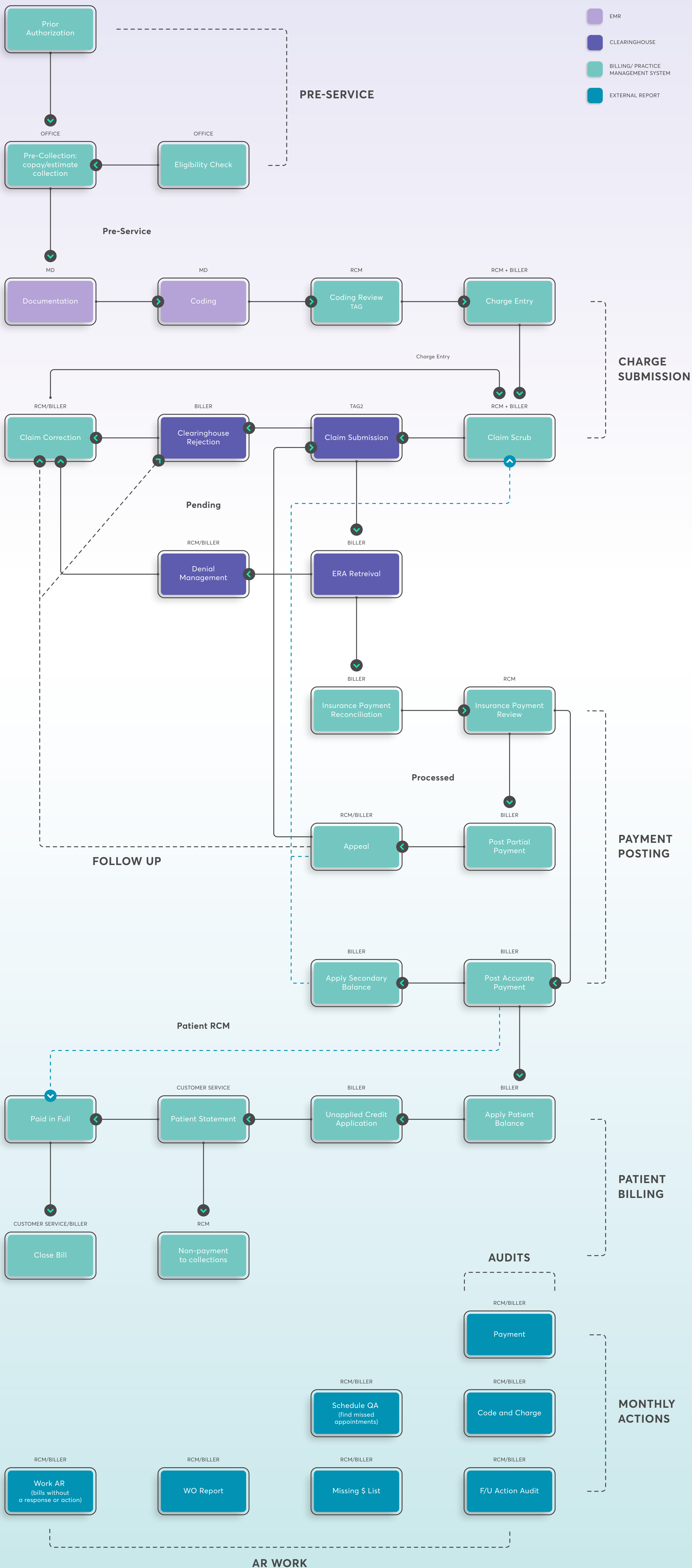
# Billing Workflow Map

Click the box to navigate automatically to the explanation

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# Billing Workflow Document

## Pre-Service

**ELIGIBILITY CHECK** – Before the patient is seen by the practice, ensuring that the patient has active coverage with their insurance plan AND that the provider accepts that insurance plan. This is the first line of defense against non-payment. If the patient is out-of-network (OON) with the provider or does not have active coverage, the claim may not be paid.

IF the provider is not contracted, or is OON with all payers by design, this step can of course be overlooked.

- **Who usually does this?** The office typically. Front desk for office visits/procedures versus surgical scheduling for major procedures. The patient shouldn't be in front of the physician without eligibility being verified per visit. Don't just check once; check before every visit. Many practices check 2-5 days ahead of each visit.
- **How is this done?** Most practice management (PM)/electronic medical record (EMR)/Billing Systems have an integrated solution with the Clearinghouse they partner with. In this way, the practice can run a batch/bulk check based on all the appointments for a day or date range, to get all responses back with a single click. Eligibility checks can also happen directly in the Clearinghouse, on payer portals such as Availity/Optum/Cigna4HCP and/or there are a number of third party systems built for exclusively eligibility checks.
- **How often?** We recommend checking at point of booking/scheduling if feasible as well as daily looking out at least two days. For example, check eligibility today for the patients coming in day after tomorrow so you give yourself enough time to problem solve.

**PRIOR AUTHORIZATION** – Check out our Auths Guide for more info, but essentially Auths are required for major surgical procedures to ensure medical necessity as defined by the payer. Think of this as a box to check before surgery can happen.

- **Who usually does this?** Often in-house Medical Billers, surgery schedulers or even patient care coordinators get stuck with this job, when their time could better be spent on their primary job functions. The Auctus Group offers an Auths Service Line to offload the pain and suffering from our clients.
- **How is this done?** Check out our Auths Guide. Waaaay too much to type. Long story short, using the PM/EMR + payer portals + spreadsheets + follow up notes somewhere…all sorts of fun.
- **How often?** Depends how busy you are Doc! Auths should be submitted as soon as the patient leaves the office if they're a potential buyer so you can get them on the schedule. Volume is going to be dependent on how busy you are of course.

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**PRE-COLLECTION** – If a patient is coming in office for a visit, be sure to collect that copay. It is also wise to check the patient ledger to see if they have an open balance from previous visits. Remember not to collect a copay for post-operative global visits usually within 10, 30, 90 days of a procedure depending on the type.

For office procedures or surgeries may carry larger balances than copays due to deductible and coinsurance, which are extremely common on most insurance plans these days. By using the expected billable CPT codes and an eligibility check, one can estimate what the patient MAY owe after surgery and educate the patient to avoid surprises as well as collect the balance up front to avoid chasing on the back end.

- **Who usually does this?** Copays land at the front desk/check-in. This should be the second step after verifying that the patient has coverage. Copay gets collected as the patient checks in for their visit or it will likely have to be invoiced after insurance processing on the back end, prolonging or even eliminating the payment altogether if that patient ignores the statement(s).

  Benefit Estimations are more commonly carried out by the billing department and/or authorizations representative. Collecting the balance is often best received at the pre-operative visit, when a practice representative can sit down with the patient and answer billing questions/discuss process as well as educate and collect…so it doesn't feel like a shakedown.

  The Auctus Group provides Benefit Estimations as a part of our Auths Service Line. Every Auth comes with a Benny Estimate so the practice can leverage pre-collections and avoid patient statements, which often go unpaid.

- **How is this done?** Copays are easy to collect and post into your PM/EMR. Same with the posting of the Benefit Estimation amounts. Collect the payment. Post it to the PM. Leave it unapplied as a credit until the insurance bill/claim processes. Now, how to get at that benefit estimation is a whole other process and really where the time suck comes in. In short, CPT allowable minus patient benefits equals what to collect. There's a whole lot more math involved than that. Ask your friendly local Auctus Rep for more info.

- **How often?** This should be done for all major surgical cases in an OR or Office Based Surgi-suite. SOME practices will attempt to run this process down for EVERY visit, which can prove a challenge without embedded technology. To pre-collect, you need the codes (AKA what services are being rendered) and the benefits. Part 2 is easy. Part 1 requires knowing what your MD is doing in the room with a patient…not always easy if it isn't a major surgical case (so don't beat yourself up about calculating a 99213 vs a 99214 allowable to collect on the way out the door at check out).

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## Charge Submission

**DOCUMENTATION** – The most necessary of evils. No documentation, no billing. Sorry folks. This is a regulatory requirement for billing and a requirement for you MDs out there for other obvious reasons. This is the baseline and basis for billing, so be sure you document well. If it isn't written down, we can't bill for it…even if the procedure was conducted.

- **Who usually does this?** Really? You really need to ask?
- **How is this done?** In your EMR, unless you're still on paper…please tell me you're not still on paper.
- **How often?** Daily. You do document every day right?

**CODING** – This is the first make/break moment in billing folks. We have minimized the practice of medicine to a series of five digit CPT codes. Yeah, yeah, yeah, we have ICD-10s and modifiers as well, which are certainly important, but using the science of CPTs with a bit of the art of coding is where a Medical Biller pulls their weight. Maximize the CPTs and leverage the proper techniques without bending/breaking rules or blurring lines and you can make your providers more money!

- **Who usually does this?** The provider is ultimately responsible for their coding no matter who does it. Often times they actually take on the initial coding. Sometimes they leave it for their Medical Biller or coder. There is a fair amount of variability here. That said, we consider "best practice" to be collaboration between provider and Medical Biller/coder. Dialogue builds trust and understanding. We want to be sure we are coding to maximize revenue, within the level of comfort of our provider(s). We also want to be sure to let our providers know if something is "over the line."
- **How is this done?** With coding tools like AAPC books and/or their electronic tool Codify as well as the Auctus Aesthetico App! Once you've landed on the right codes, they are typically entered into the PM/EMR and/or on the operative note if the procedure is carried out at a hospital or Ambulatory Surgery Center (ASC) and documentation is required in their system. In these cases the data is manually transferred to the PM/EMR at point of Charge Entry.
- **How often?** Of course volume will drive this decision, but should be 24-48 hours from time of charge submission/coding at Auctus. If you send a batch of 50 op notes, might take a bit more. If you only see a few cases a month, might be weekly.

**CODING REVIEW** – Just as pivotal as coding and even more so if the provider is not fully engaged on coding to begin with. For the record we're not complaining! It is just of course pivotal to review coding when the coding may not be as accurate on the front end. This involves reviewing primarily CPTs as well as ICD-10s and appending modifiers as appropriate.

- **Who usually does this?** The Medical Biller/coder of course if not your friendly neighborhood Auctus Revenue Cycle Manager (RCM)!
- **How is this done?** In EMR/PM or alternatively on .pdf for documentation provided on paper.
- **How often?** As above.

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**CHARGE ENTRY** – So services have been rendered, documented, are coded properly…now to get it entered into a system so you can generate a charge/bill. If it were the early 90s, we'd be talking about filling out a HCFA 1500 form or a UB. Given we are in the age of computers, nearly all providers are on EMR/PM systems, most often a single integrated system, although sometimes they can be split. At the Auctus Group, we always prefer to work in our clients' system(s) so they own the data, have full transparency, and ultimately control. Charge entry involves ensuring that all patient demographics, insurance information, codes, coding information such as Place of Service (POS) codes, referring providers, NPI/Tax ID Number (TIN) identifiers, taxonomy codes, addresses and so on are properly loaded into the charge. Other specialty services such as facility bills require revenue codes, or anesthesia services require Base Units, and/or even drug codes (J Codes) require National Drug Codes or NDCs. Charge entry is really about ensuring that the claim is ready to go out the door with the most important part being that they have the appropriate fees/coding and are ready to be paid as quickly/cleanly as possible.

- **Who usually does this?** Medical Billers are responsible for entering and validating charges once they've been coded. There is coding involved here in that you need to understand coding fully to successfully enter charges, but because notes are not being coded at this step a Medical Biller rather than an RCM may often enter charges.
- **How is this done?** In the EMR/PM system of the provider's choosing/use. These systems have a charge entry workflow and module for specifically this process, which ties to the patient ledger so at any point in time one can run reports and/or view the charges for a given patient to see where the claim is at (e.g., has it been entered and/or submitted). Any errors are reported, which can be immediately corrected within platform to ensure a clean claim is submitted to payers.
- **How often?** Should be 24-48 hours from receipt of charge from the MD with Auctus. Make sure you're AT LEAST getting your claims out weekly please. Probably best to do it daily if you can. Think about it this way. Money will follow the Charge Entry Flow. You skip a few weeks…no problem…expect a break in revenue in 2-3 weeks for however long you skipped on charge entry for. Just don't complain about it when it happens!

**CLAIM SCRUBBING** – This step involves system specific edits that "scrub" claims for missing data fields and/or data mismatches. Think of this as an automated system tool to run behind the human eyes at Charge Entry and ensure the proper information is on the claim to process. This DOES NOT scrub for coding or more complex billing idiosyncrasies, more system setup and field mapping as well as data completion.

- **Who usually does this?** The Medical Biller will complete this task utilizing the EMR/PM tools at hand. RCMs do also submit claim batches occasionally in which case they would be responsible. Essentially this step MUST be completed as the part of entering any charge batch. The batch is not considered complete until it is coded, entered, scrubbed and submitted.
- **How is this done?** Same place as the last step. EMR/PM of the provider's choosing/use. Typically, once charges are entered, they are pushed to a scrubbing queue. Typically systems will require a system scrub PRIOR to allowing submission and/or the Medical Biller must override the warning/reminder to scrub. Natural scrubbing is of course done at charge entry, but this is a more systemized/system driven process. Click the button, get back the errors, fix the errors, send again…all at once…don't submit, get errors and wait 'til tomorrow…that would be a waste of time. Common errors include name mismatches, missing insurance ID or group number, missing DOB, NCCI edits (if programed) and so on…the simple stuff.
- **How often?** Per charge entry batch. This happens after you enter charges – every time.

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**CLAIM SUBMISSION** – This is where the magic happens! The claims actually get sent OUT of the EMR/PM and to the payers via the clearinghouse (think electronic USPS or pipe to the payers that your encrypted claims data runs through).

- **Who usually does this?** We have the same person who enters the charges, scrub and submit them… because why split the workflow. This is typically a Medical Biller, but could also be an RCM.
- **How is this done?** Typically it is no more than the click of a button. SOME systems (more old-school) will have you download and upload files from your PM/EMR to the clearinghouse manually, but this is rare these days. So click the button and off we go!
- **How often?** As above.

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# Follow Up

**CLEARINGHOUSE REJECTION** – Rejections are different from denials. They typically result from missing data points, clerical errors, eligibility issues, payer ID issues (AKA you sent this to the wrong place). These rejections occur BEFORE the payer receives the claim, at the clearinghouse level. Clearinghouse rejections are a sign of a front of house (e.g., front desk) and/or claim scrubbing issue.

- **Who usually does this?** The Medical Biller will typically address rejections at the clearinghouse level as these are simple, clean, easy to fix.
- **How is this done?** #magic. Not really, but the automated scrubbers at the clearinghouses process at least every day and send the rejections back to their own queue as well as the PM/EMR system if the integration is strong. Be sure to know if your rejections show back up in your PM/EMR, otherwise you may have a pile stacking at the clearinghouse!
- **How often?** As often as you submit really. These are typically received w/in a day of submitting the claim.

**CLAIM CORRECTION** – This is the process of addressing rejections to fix them and ensure the claim gets back out the door.

- **Who usually does this?** The Medical Biller will typically address rejections at the clearinghouse level as these are simple, clean, easy to fix.
- **How is this done?** Depends on the error. A lot of rejections are addressed with typographical changes to update the rejected fields or flipping the insurance or searching for the right card. So it really depends on the rejection. 99% of the work happens in the PM/EMR system. Some clearinghouses DO allow corrections at the clearinghouse level, but we strongly recommend making them in the source system (EMR/PM). Why have data in two spots? Everything you do in the EMR/PM is going to flow to the clearinghouse anyways. If you start fixing in two places, how do you know where to look to figure out what happened, when, by whom etc.? Once the claim is fixed, the claim is put back into the scrubbing queue to be resubmitted for payment, hopefully.
- **How often?** We recommend checking daily and have a 24-48 hour TAT. Again, your volume may dictate frequency here, but don't let these stack…not everyone's favorite part of the day and there's a tendency to let them stack…

**ERA RETRIEVAL** – Once you get that claim out the door to the payer cleanly (clean claims are the name of the game folks), it will process and the payer will send an Electronic Remittance Advice file. Think Explanation of Benefits (EOB) AKA the thing you get in the mail as a consumer, with way more explicit information…although still lacking severely in clarity.

- **Who usually does this?** Typically, the Medical Biller is responsible for ensuring the files/documents are being received/made ready for posting. Occassionally the RCM may jump in to assist depending on the escalation level of the claim(s) processed on the ERA/EOB and/or more commonly so in Out-Of-Network (OON) processing because the lack of a contract rate means the payment must be heavily scrutinized to ensure it is at an acceptable level.

- **How is this done?** This is either automatically submitted from the clearinghouse to the EMR/PM, manually downloaded/uploaded (again for the older-school), or potentially may be sent on paper in the form of a bulk EOB.
- **How often?** Again, this is going to be volume and process consistently driven. Submit a lot of claims all the time, you'll get a lot of ERAs/EOBs. Send few claims or inconsistently/weekly…it will be less common.

**DENIAL MANAGEMENT** – Denials are rejections from the payers for lack of a better term. These claims have made it to the payer who has declined payment for one reason or another. This is where medical billing gets tricky. There are countless permutations of denial causes and probably 50% of them, if not more, are BS block/tackle games from the payers. Denial management is the process of addressing denials to resubmit claims and ensure they get paid rather than denied!

- **Who usually does this?** Typically both the Medical Biller and the RCM are involved in this process. Denials can be for simple things like bad patient ID, coordination of benefits not received, global period, etc. Alternatively, they can be more complex NCCI/bundling denials. Also, they can be indiscernible from the denial information and require a phone call and/or appeal. Generally speaking, the Medical Biller will knock out the simpler items and escalate toe the RCM for more complex issues depending on comfort level as well as the size of the claim and age. Generally speaking, at Auctus, 2x denials and/or 2K+ size of claim means the RCM is getting involved.
- **How is this done?** Wide variability. A change can be made in the EMR/PM system to correct something. An appeal letter may be warranted. A call to the payer to send the claim for reprocessing. All of the above may be needed. This is really one of those spots in medical billing where a biller carries their weight. Taking the right action here means payment…the wrong means another denial…the right move may also mean another denial though sadly as we're dealing with insurance companies here and their job is to not pay you…
- **How often?** Same as rejection processing…depends on volume of claims and clean claims percentage. We aim to address denials within 24-48 hours. They are checked and worked daily. Another key, is that you CAN receive denials within payment batches. We instruct our team to work the denial while posting the payment batch…not set it to the side to be addressed later or by another team.

**APPEAL** – Appealing denied claims is again one of those places a biller makes their pay. Assessing what happened with the claim and arguing to get it paid make up the bones of an appeal.

- **Who usually does this?** Often times this is the RCM, but can also be the Medical Biller…whoever is working the denials/rejections. Typically if a claim requires appeal, it needs to be argued and thus needs some escalated skillsets/eyes. Many Medical Billers handle appeals quite well though!
- **How is this done?** For many, this is an old-school process. Pull up your Microsoft Word doc or Adobe and get to typing. Print it out, add your medical records, add your claim form, staple it together and mail it out. Gosh we hope you're not doing it that way though. We leverage Appealio, which is an appeals automation tool that automatically reads the denials and tees the appropriate appeal letter up to be faxed, submitted by online payer portal, and/or print to mail with all appended documents. Super slick huh? If you're not leveraging this type of technology, thing portal > fax > mail…they like to lose things on the payer end.
- **How often?** As above. Don't let these sit…the payers will sit for 30-45 business days for you. No time to waste.

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# Payment Posting

**INSURANCE PAYMENT RECONCILIATION** – When an insurance company pays a claim, they often send batch payments for multiple claims and include denials occasionally. Payment Reconciliation is the process of applying/allocating the payment to the proper patients/dates of service so the sum of the distributions adds up to the check total.

- **Who usually does this?** The Medical Biller will often allocate/apply payments. RCMs can assist/jump in as needed of course!
- **How is this done?** Generally speaking, the ERA is allocated using a specific module within the EMR/PM, which allows line item posting of payments, adjustments and liability shifts (from insurance to patient for things like deductible/coinsurance/copay). EOBs can be manually added as "checks" to the system and allocated in the same fashion. Review of the ERA/EOB/claim/payment/any denied lines should be inherent to the process. The Medical Biller should be ensuring the payment matches contract rates or at least eyeballing it. Same thing with adjustments. Same thing with CARC/RARC (denial codes w/ explanations. Most importantly, if the adjustment isn't valid or the liability shift not 100% accurate…don't adjust and don't shift…address the bogus denial/processing right then/there. If bad adjustments get posted, money is lost because it "disappears."
- **How often?** Getting tired of this answer? Volume dependent. Check daily. 24-48 hour turn around.

**INSURANCE PAYMENT REVIEW** – Although inherent in the reconciliation/posting process, additional review is warranted, especially for high value claims. Ensuring the claim is paid appropriately and per contract is pivotal, especially for OON claims where there is no contract.

- **Who usually does this?** This is the RCM's responsibility. Basically a double check behind the Medical Biller.
- **How is this done?** Manual review. Human eyes. Compare the payment received + patient allowable against the contract rate. Or, for OON, compare it against the Usual & Customary rate for the geographic region/CPT and accept or fight the claim depending on the client specifications.
- **How often?** Should be per batch, so daily if data is received.

**POST PARTIAL PAYMENT** – Sometimes checks/EFTs will come back with claims partially paid, meaning X of Y line items are paid, but not all. Posting partial payments is alluded to above and is the process of posting the properly processed lines, while leaving the denied lines at insurance responsibility to be followed up on for payment.

- **Who usually does this?** This is the Medical Biller or RCM…whoever is posting the batch (more often than not the Medical Biller).
- **How is this done?** As above, via the embedded module in the PM/EMR.
- **How often?** As above.

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**POST ACCURATE PAYMENT** – Similar to posting partial payments…except you just allocate the funds without any denials management and correction!

- **Who usually does this?** Typically the Medical Biller, although the RCM may assist at times especially with OON payments.
- **How is this done?** As with the Partial Payments, right within the payment module in the EMR/PM. The full funds of the bulk payment are distributed to the relevant patient(s) and DOS(s). Correct adjustments are posted. Liability is dropped to the patient if relevant.
- **How often?** Getting sick of the answer? Daily, 24-49, depends on volume.

**DROP SECONDARY BALANCE** – This is essentially the same as submitting a claim, you're just submitting it to the secondary insurance if relevant. This way they can pick up the remainder per their plan guidelines.

- **Who usually does this?** This is a Medical Biller task.
- **How is this done?** Once the balance is dropped to secondary via the payment posting process, the claim is set to submit back to the payer, typically on paper so the primary insurance EOB can be included with the document. This way the secondary payer can SEE what the primary did and process appropriately. If the primary EOB is not included, this can lead to the secondary denying their claim and requesting the documentation. CAVEAT – when a payer is secondary to Medicare (80% of the time probably), you DO NOT need to submit the claim or include primary processing because Medicare "crosses over" the claim to the secondary payer automatically. This saves time and money. That said, this is not consistent at 100%. So…if a secondary plan has a balance for longer than 30 days, it is best to submit the claim with the Medicare EOB to get things moving and fix their gap problem with Medicare (e.g., not crossing the claim over). No point in crying over spilt milk or figuring out the "why" – just get the claim out the door to get payment.
- **How often?** Again, volume dependent. Ideally this is happening weekly. WORST case, if you have very low volume, monthly. We aim for weekly on secondary claims to get all claims out the door in batches. We review secondary claims daily and submit paper batches with documentation at least weekly depending on volume and applicability.

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## Patient Billing

**DROP BALANCE TO PATIENT** – It is important to drop the patient liability, or amount they owe, once insurance has accurately processed the balance. This may be a copay, coinsurance, deductible etc. depending on the situation. Even if you pre-collected, the patient may still owe! In fact, that pre-collection estimate may have resulted in a patient credit! Dropping the balance allows the team to reconcile the account and bill the patient if relevant so it is a pivotal step – otherwise the balance looks like the insurance still owes it, which is inaccurate and will clog up your Aged Receivables (AR)! It is also possible that a patient may have a balance dropped for lack of responsiveness to their insurance company for coordination of benefits (COB) or Injury Forms. These documents are sent from the insurance company, to the member multiple times and if the patient doesn't respond, the insurance stops paying and applies all balances to patient responsibility. Less common, but important to be aware of!

- **Who usually does this?** Whoever is posting payments (e.g., Medical Biller or RCM).
- **How is this done?** Typically, most of the time, this is accomplished during payment posting as a part of the process so it is not a unique process. Occasionally, while working the AR, a Medical Biller (or RCM) may find a balance that was errantly, NOT dropped, so they will manually shift the balance throughout the month as the AR is worked. This is done by adjusting the balance within the EMR/PM.
- **How often?** Manual shifts should be rare because mistakes ideally don't happen. Automated shifts as part of payment processing will be on many EOB/ERAs so as frequently as those are posted, which is ideally daily w/ 24-48 hour turn around!

**UNAPPLIED CREDIT APPLICATION** – This is the process of allocated pre-paid payments/credits on a patient financial ledger. Essentially, we look at where money is owed, are there any credits or unallocated payments… and apply them as needed. We DO NOT touch cosmetic deposits or payments…ONLY insurance related patient payments.

- **Who usually does this?** This is everyone. Front of house, back of house, RCM/Biller. It takes a village. The report is run by Auctus Customer Service and Medical Billers to apply monthly. General account maintenance is an all day thing.
- **How is this done?** Any time anyone is in any account and sees an unapplied payment, it should be manually applied/allocated. This can be a click/drag or a click, apply, post. Additionally, and most importantly, we run an Unapplied Credit Report, which will display all unapplied credits in the system. This report is then manually reviewed for insurance related patient payments to be applied and cosmetic credits left alone. This is run monthly before statements to ensure they go out 100% accurate.
- **How often?** Everyone is on general account maintainance as they come across accounts. Customer Service at Auctus collaborates with the Medical Biller to get the report run and posted before submitting statements. The RCM may assist depending on the situation.

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**PATIENT STATEMENTS** – This is the process of sending patients bills if they owe anything after insurance processes. Statements are often sent on paper, but electronic methods are becoming more common. We always recommend electronic statements with integrated payments so the patient can click to pay and the payment auto-posts back to the EMR/PM. This functionality will depend on the provider's system. Worst case scenario, you drop the balances to paper statements once per month!

- **Who usually does this?** Typically this is Customer Service with Auctus and/or the RCM. We want statements reviewed with a fine toothed comb to avoid any bogus balances going out.
- **How often?** Typically monthly. Some systems may have functionality to get statements out daily, like Inbox Health, which we utilize. This is less common though.

**PAID IN FULL/CLOSE BILL** – This means the claim is closed and paid by all parties (insurance + patient). This is a cause for celebration.

- **Who usually does this?** The whole gang through the processes outlined above. Once all payments are applied the claim is considered closed.
- **How is this done?** As above depending on who is paying. The financial ledger is kept in the EMR/PM and will show a $0.00 on the line item paid!
- **How often?** Daily as above.

**NON-PAYMENT TO COLLECTIONS** – If a patient will NOT pay their bill after several attempts to collect, the balance is recommended for Collections with a traditional outside collections agency. At Auctus, we have a few recommendations, but will work with anyone at the provider's discretion/decision. Once the balance is shifted to collections, it is closed and zeroed in the EMR/PM to get it off the books so to speak. The collections aagency is then responsible for following up and confirming payment or closing the balance out if they cannot obtain payment for whatever reason. CAVEAT – not everyone is comfortable with colletions and many providers have concerns about utilizing this necessary lever due to online reviews or the potential for negative reviews, despite inaccuracy. Anyone can write whatever they want on the interwebs. We do recommend collections OR if you're not comfortable with it, adjust the balance after 3 statements are sent. No point in sending a dead bill…

- **Who usually does this?** The Medical Biller will prepare the list depending on provider specifications (e.g., no balances under $X and sent more than Y times – we recommend 3 and $50). The RCM will review the list and the provider must approve it.
- **How is this done?** Balances and statement submissions are pulled from the client statement system, moved to a report and submitted to the provider to review and approve for adjustment versus collections. This is a manual review process because we want to be 100% spot on here.
- **How often?** This should be done monthly at WORST. No point in skipping a month or two because the balances just sit…unpaid…clogging up your patient AR.

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## Monthly Actions

**WORK AR** – This action was referred to several times in the previous sections. Essentially every month, at the beginning of the month, the RCM and Medical Biller run the Aged Receivables by Insurance Company report to see "what is outstanding unpaid." This report then becomes a guide to calling payers, doing web searches, and sniffing out every unpaid claim to see why as well as obtain payment. This is where billers carry their weight…or don't. Every claim should have an actionable step towards payment every month!

- **Who usually does this?** This is the Medical Biller and the RCM based on the claim escalation level. For Auctus, claims denied 2x+ or over $2,000 require RCM review to ensure trouble/big claims get pushed appropriately.
- **How is this done?** The report is run, downloaded, standardized in format (every EMR/PM system is different) and some custom fields are added like Root Cause, Action Taken, Status, which most EMR/PMs don't have. This allows metric tracking to follow trends and identify process improvement each month. In terms of "how" to work a claim, similar to denials/rejections. In terms of "how" do we work an AR? In general, oldest, biggest balances with insurance companies who have larger bulk balances…and if you're on an account hitting the 120+ aged bucket for BCBS, address all open claims on that patient even if the other claims are in a different bucket. This work is again done in the EMR/PM as well as the spreadsheet so the notes are in one spot PLUS we can refer back to the audit trail.
- **How often?** Monthly. Every claim. Every month.

**WO REPORT** – This is a unique Auctus process. Most billing companies just write off what they want to. We don't. We write off ONLY contractual obligations and post ONLY valid patient balances (copay, coinsurance, deductible). These can be summarized with CARC/RARC codes CO-45 and PR-1/2/3 respectively. Any claim that CANNOT be paid as determined by the Medical Biller/RCM is presented to the client in a WO Report to approve BEFORE that money disappears. This is in the spirit of transparency/communication. We submit the report once/month, for approval at the end of the month after month end close to give the RCM time to review/submit to the provider. This is usually the 5th-10th business day of the month.

- **Who usually does this?** The list is generated while working the AR by the Medical Biller, submitted to the RCM for review and then to the provider for final review/approval.
- **How is this done?** The Medical Biller will manually fill out notes on the tab in the Monthly AR report on the WO Report tab. This sheet is then manually reviewed against the EMR/PM to ensure it is correct and then emailed encrypted to the provider for review/approval. Once approved the adjustments are posted.
- **How often?** Monthly. EOM.

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**MISSING $ LIST** – This is another Auctus home brew process. Essentially if we find money that the payer has confirmed paid (e.g., ACH and account number/date/amount and/or check and cash address sent to/date/amount). This is produced to the client for posting old payments to the current month on the first Sunday of the month. The goal here is to clear out paid claims and be sure they stick out like a sore thumb on a Sunday to assist with bookkeeping at the practice. Most billing companies just post and move on without communicating. We want to share the info, confirm the info, post the info AND solve the cause of the Missing $...could be and ERA issue, could be checks not getting forwarded to the billers, could be we need to get you set up for EFT!

- **Who usually does this?** The list is generated while working the AR by the Medical Biller, submitted to the RCM for review and then to the provider for final review/approval.
- **How is this done?** The Medical Biller will manually fill out notes on the tab in the Monthly AR report on the Missing$ tab. This sheet is then manually reviewed against the EMR/PM to ensure it is correct and then emailed encrypted to the provider for review/approval. Once approved the payments are posted.
- **How often?** Monthly. EOM.

**SCHEDULE QA** – This is the process of ensuring every billable visit on the schedule is actually billed. EMR/PMs will vary in process, but generally the schedule is run for specific appointment types (e.g., INSCONSULT but not COSCON) against the "what is actually billed." Any gaps are identified and billed or submitted to the client with questions to clarify if we cannot discern "should this be billed."

- **Who usually does this?** The RCM.
- **How is this done?** The RCM will run the Appointments by Type report (or whatever it is titled in the source Billing System) as well as a Charges Report. We then look up to confirm that all appointments that should have insurance bills do indeed have insurance bills by cross referencing the two. From this list we can ascertain if the office is NOT sending certain bills as well as identify patterns and get things billed that would otherwise be missed.
- **How often?** Monthly. EOM.

**AUDITS** – Auditing is a must. Sounds like a scary thing, but it ensures tasks are completed correctly and allows a direct feedback loop to Training & Coaching so that individuals who are underperforming can improve, tasks that are incorrect are fixed and future trainees come into processes stronger. We typically will review 5% of the work done in a given timeframe and if 95% accuracy is not attained, we expand to 15% for a more focused audit to catch all potential opportunities for improvement.

- **Who usually does this?** The TL with support from the Dir of Billing Operations.
- **How is this done?** The TL will pull a charge/payment/AR report and manually review the work by checking the billing system as well as the notes and all other relevant data points. From there a scorecard is prepared for the full scope of the audit to deliver the results. In this process any errors are corrected, the Biller/RCM is coached and Training is informed. Audit results are available to clients upon request.
- **How often?** Monthly or On Demand.

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