Medical Billing Process Checklist

All 10 steps from encounter to payment: the owner, the timeline, and the failure point for every stage of the cycle.

How to use this checklist

Getting paid for care you have already delivered is a ten-step operational chain. A break at any link stalls the whole thing, and the break usually happens weeks before anyone notices. This checklist gives you the owner, the realistic timeline, and the specific failure point for each of the ten steps.

1. **Audit your current process.** Walk the ten steps with your team and tick only what is genuinely happening today, not what is supposed to happen.
2. **Onboard new billing staff.** Hand this over on day one. The owner column tells them what is theirs; the failure notes tell them what to watch for.
3. **Assign every unticked box.** An unowned step is an unworked step. Put a name and a cadence against anything left blank.

> **Timelines assume electronic workflows.** Add 7 to 14 days anywhere paper is still involved, and treat any step without a named owner as your most likely source of revenue leakage.

The 10 steps, in order

STEP 1 | SCHEDULING AND PRE-REGISTRATION — 3 to 7 days before visit

FRONT OFFICE | Owner, 1 to 5 providers: Front desk | Owner, 20+ providers: Patient access team

- [ ] Full legal name, date of birth, and address captured exactly as they appear on the insurance card
- [ ] Subscriber name entered separately from patient name whenever the two differ
- [ ] Member ID and group number double-keyed and checked against the scanned card image
- [ ] Referring provider and referral number on file where the plan requires one
- [ ] Reason for visit recorded in enough detail to support medical necessity downstream

> **Fails when:** a transposed member ID turns four seconds of data entry into forty minutes of rework six weeks later.

STEP 2 | ELIGIBILITY AND PRIOR AUTHORIZATION

48 to 72 hours before visit

FRONT OFFICE | Owner, 1 to 5 providers: Front desk or office manager | Owner, 20+ providers: Verification and auth specialists

- [ ] Coverage confirmed active for the date of service, not merely active today
- [ ] Plan type, network status, copay, coinsurance, and remaining deductible documented
- [ ] Planned CPT codes checked against your payer authorization matrix
- [ ] Authorization approved and the number attached to the appointment before service is rendered
- [ ] Authorized units and valid date range confirmed to cover the full course of treatment

Fails when: the service is rendered before the authorization is approved. This denial is almost never appealable, which makes it the most expensive error in the cycle.

STEP 3 | CHECK-IN AND POINT-OF-SERVICE COLLECTION

Day of service, 2 to 5 minutes

FRONT OFFICE | Owner, 1 to 5 providers: Front desk | Owner, 20+ providers: Patient access representative

- [ ] Photo ID and current insurance card scanned at every visit, not only the first
- [ ] Eligibility re-verified at the desk; coverage terminates between pre-visit check and arrival
- [ ] Consent, HIPAA acknowledgement, and financial responsibility forms signed and dated
- [ ] Copay and estimated patient responsibility collected before the patient is roomed
- [ ] Any prior balance surfaced and either collected or moved onto a payment plan

Fails when: nothing is collected at the desk. A balance that costs nothing to collect in the lobby costs real money to chase through three statement cycles.

STEP 4 | MEDICAL CODING

Within 24 to 48 hours of encounter

MID CYCLE | Owner, 1 to 5 providers: Provider or outsourced coder | Owner, 20+ providers: Certified coding department

- [ ] Documentation reviewed against the E/M level billed before the claim is built
- [ ] ICD-10-CM codes assigned to the highest specificity the note supports
- [ ] CPT and HCPCS codes matched to the documented service and place of service
- [ ] Modifiers applied and justified; bundling and CCI edits reviewed
- [ ] Undercoding flagged as rigorously as overcoding; both are revenue and compliance exposure

Fails when: E/M levels are chronically undercoded. It never triggers a denial, so it never gets caught.

STEP 5 | CHARGE ENTRY

Same day as coding

MID CYCLE | Owner, 1 to 5 providers: Biller or office manager | Owner, 20+ providers: Charge entry team

- [ ] Correct fee schedule, rendering provider, and place of service applied to every line
- [ ] Units, dates of service, and NDC numbers verified where applicable
- [ ] Daily reconciliation: completed encounters matched line by line against posted charges
- [ ] Any encounter without a charge investigated the same day, never at month end

Fails when: charges are simply missed. Nothing gets denied, no report flags it, and the revenue never existed.

STEP 6 | CLAIM SCRUBBING AND SUBMISSION

24 to 48 hours after charge entry

BACK OFFICE | Owner, 1 to 5 providers: Biller | Owner, 20+ providers: Billing operations, daily batches

- [ ] Claims run through payer-specific edits, not standard CCI edits alone
- [ ] Clearinghouse acceptance confirmed for every batch; no batch assumed successful
- [ ] Rejection queue worked every morning without exception
- [ ] Timely filing deadline tracked per payer and per claim, not per practice

Fails when: rejections sit unworked in the clearinghouse queue. They are free do-overs that expire against timely filing limits.

STEP 7 | PAYER ADJUDICATION

14 to 30 days electronic

BACK OFFICE | Owner, 1 to 5 providers: Payer controlled; monitoring is yours | Owner, 20+ providers: Payer controlled; monitoring is yours

- [ ] Claim acknowledgement reconciled against every submitted batch
- [ ] Status check triggered automatically for any claim with no response by day 30
- [ ] Payer portal or phone status documented in the claim note with a reference number

Fails when: silence is mistaken for progress. A claim with no response at day 30 needs a status check, not more patience.

STEP 8 | PAYMENT POSTING AND RECONCILIATION

24 to 48 hours after remittance

BACK OFFICE | Owner, 1 to 5 providers: Biller or bookkeeper | Owner, 20+ providers: Cash posting team

- [ ] ERA and EOB posted line by line with adjustment and denial reason codes recorded
- [ ] Payments reconciled against the bank deposit daily
- [ ] Allowed amount compared against the contracted rate on every line
- [ ] Underpayment variances routed to appeals rather than absorbed into contractual write-offs

Fails when: underpayments post as contractual adjustments. You write off revenue you were owed and leave no record that it happened.

STEP 9 | DENIAL MANAGEMENT AND AR FOLLOW-UP

Touch at day 30, 45, and 60

BACK OFFICE | Owner, 1 to 5 providers: Biller, often part time | Owner, 20+ providers: Dedicated denial and AR analysts

- [ ] Denials categorized weekly by CARC and RARC code, by payer, and by root cause
- [ ] Root cause fixes pushed upstream to the step that caused them, not just appealed
- [ ] Corrected claims and appeals filed inside the payer appeal window
- [ ] Every open claim touched at day 30, 45, and 60; nothing reaches timely filing unworked
- [ ] Percentage of AR over 90 days reported weekly, not monthly

Fails when: denials are never reworked at all. Not because they are unwinnable, but because nobody has bandwidth. Every abandoned claim is pure margin walking out the door.

STEP 10 | PATIENT BILLING TO ZERO BALANCE

Statements at 30, 60, and 90 days

BACK OFFICE | Owner, 1 to 5 providers: Office manager | Owner, 20+ providers: Patient financial services

- [ ] Statement issued within 5 days of insurance resolution, not on a monthly batch cycle
- [ ] Balance explained in plain language with the insurance adjustment clearly shown
- [ ] Payment plan and online payment option offered proactively at the first statement
- [ ] Escalation and write-off policy applied by rule at a defined day count, not by default

Fails when: balances drift past 120 days. They collect at a fraction of face value, and the write-off decision gets made by inertia rather than by policy.

Weekly scorecard: the six numbers that matter

Review these weekly, not monthly. Monthly reporting means you discover problems thirty days after they start costing you. Targets below are the ranges commonly used across the industry; adjust for your specialty and payer mix.

Metric	Common target	What it measures	Your number
Clean claim rate	95% or higher	Claims accepted on first submission without edits	
First-pass resolution rate	90% or higher	Claims paid on the first submission	
Denial rate	Under 5%	Denied claims as a share of claims submitted	
Days in AR	Under 35 days	Average age of outstanding receivables	
AR over 90 days	Under 15%	Share of total AR sitting in the oldest bucket	
Net collection rate	96% or higher	Collected against what you were contractually owed	

Six red flags worth acting on this week

- [ ] Your clearinghouse rejection queue has items older than 7 days.
- [ ] Nobody can tell you your denial rate by payer without building a report first.
- [ ] Claims are written off at timely filing rather than appealed.
- [ ] Charge reconciliation happens at month end, or not at all.
- [ ] One person holds all the billing knowledge and has no documented backup.
- [ ] Point-of-service collection is optional, informal, or skipped when the lobby is busy.

Ticking three or more of these usually means the problem is structural rather than personal. No amount of individual effort fixes a process with unassigned steps.

Notes and owner assignments

Write the name and review cadence against every box you could not tick.