CALIFORNIA MEDICAL ASSOCIATION

# General Encounter and Claims Submission Checklist

| Done | **Tasks** (and what's in it for you)<br>✓ONE-TIME/ANNUAL (BLUE) ✓DAILY (YELLOW) ✓EACH ENCOUNTER (GREEN) |
|---|---|
| ☐ | **PROVIDER CREDENTIALING IS UP TO DATE FOR EACH CONTRACTED PAYER.**<br>(Credentialing issues cause processing and payment delays, which impacts your revenue cycle.) |
| ☐ | **ENROLLED WITH APPROPRIATE CLEARINGHOUSES. UTILIZE ELECTRONIC SUBMISSION.**<br>(Missing or invalid NPI's, Tax ID's, and other provider info can cause processing and payment delays, which impacts your revenue cycle. Electronic submissions are easier and faster.) |
| ☐ | **YOU/YOUR BILLING TEAM KNOW THE PAYER AND/OR IPA REQUIREMENTS FOR TIMELY ENCOUNTER AND CLAIMS SUBMISSIONS.** (Timely, accurate and complete submissions can improve revenue. If you participate in any cost-sharing or quality-improvement incentive program (HEDIS, MIPS), you can also improve incentive payouts.) |
| ☐ | **PATIENT ELIGIBILITY CHECKS ARE DONE AT LEAST 2 DAYS BEFORE A PATIENT'S ENCOUNTER.**<br>(Not checking eligibility for patients [especially managed care/straight Medi-Cal] prior to encounters puts you at risk for loss of revenue due to write-offs.) |
| ☐ | **PAYER INFORMATION IS ACCURATE AND COMPLETE ON ALL CLAIMS AND ENCOUNTERS.**<br>(Inaccurate payer information can cause processing and payment delays, which can impact your revenue cycle.) |
| ☐ | **PRIOR AUTHORIZATIONS ARE ACTIVELY MANAGED.**<br>(Hold-ups with prior authorizations impact patients, practice staff, and your bottom line.) |
| ☐ | **AUDIT, TRACK, AND FOLLOW-UP ON REJECTIONS AND DENIALS.**<br>(Improved revenue cycle management and quality/cost-sharing incentives, less write-offs.) |
| ☐ | **PROVIDER INFORMATION (RENDERING AND BILLING) ARE ACCURATE ON ALL CLAIMS AND ENCOUNTERS.** (Inaccurate provider information can cause processing and payment delays, which can impact your revenue cycle.) |
| ☐ | **PATIENT DEMOGRAPHIC AND OTHER DATA IS ACCURATE ON ALL CLAIMS AND ENCOUNTERS.**<br>(Inaccurate patient demographics can cause processing and payment delays, which can impact your revenue cycle.) |
| ☐ | **ALL MEDICAL CODING IS ACCURATE, COMPLETE AND IS SUPPORTED BY DOCUMENTATION IN THE PATIENT'S MEDICAL RECORD. CODE FOR ALL SERVICES TO THE HIGHEST SPECIFICITY.**<br>(Get paid for the care you provide. Inaccurate or missed coding puts you at risk for leaving money on the table for reimbursement and cost-sharing/quality improvement incentives [HEDIS, MIPS].) |

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**Prepared as part of IHA's Encounter Data Improvement program**
Learn more at IHA's Encounter Data Resource Hub