Provider Prime

CLINIC GROWTH VAULT 2.0
FREE RESOURCE · 2026

SOP | DENIALS & A/R

The A/R Follow-Up SOP

30/60/90+ touch rules, a work-queue that ranks itself, and a note format so no claim is ever touched twice for nothing.

INSIDE

- Aging buckets and what each one needs
- Touch rules and escalation clock
- The 4-line A/R note standard
- Priority score: dollars × age × risk
- Claim status codes: what to do next
- Write-off, credit balance and small-balance policy

A/R Follow-Up SOP

Provider Prime

How to use this

1. Adopt Sections 02–04 as your written SOP. Change the numbers to fit your payers, then sign and date it.
2. Build the work queue in the A/R Aging Workbook (XLSX) — it calculates the priority score.
3. Every collector works top-down by score, not by alphabet or by payer they like.
4. Review the A/R summary every Friday. The goal is movement, not effort.

WHO IT'S FOR
A/R specialists, billing leads, practice managers

TIME TO PUT IN PLACE
Half a day to adopt; daily habit after

PAIRS WITH
A/R Aging Workbook (XLSX) · Payer Call Script

WHAT'S INSIDE

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Educational resource. Not legal or coding advice; verify against current payer policies. Examples use invented data — no PHI. Benchmarks are commonly cited industry ranges; your payer mix and specialty will move them. Don't email PHI to anyone, including us.

SECTION 01

Purpose and scope

This SOP makes sure every open insurance claim is touched on a schedule, every touch produces a next step, and nothing ages into timely-filing territory because nobody looked.

Covers

- All open insurance balances, primary and secondary
- Unpaid, denied, partially paid and "no response" claims
- Credit balances on insurance accounts

Doesn't cover

- Patient balances (see Patient Collections Scripts)
- Rejections not yet accepted by the payer (see Clean Claim Checklist — those are worked daily)

Targets this SOP is built to hit

DAYS IN A/R
<35–40
Commonly cited target for physician practices.

A/R OVER 90 DAYS
<10–15%
Share of total insurance A/R. Under 10% is strong.

UNTOUCHED 30+ DAYS
0
Claims with no note in the last 30 days.

NET COLLECTION
95%+
Collected ÷ (charges – contractual adjustments).

Benchmarks are commonly cited industry ranges; specialty and payer mix move them. Odds of collecting a claim drop below 50% after 90 days (HFMA-cited) — that's why the touch rules front-load effort.

SECTION 02

Buckets: what each age needs

Bucket	What's usually going on	Required action	Touch cadence	Escalate when
0–30	Normal processing. Some rejections, some "not on file."	Confirm acceptance (277CA). At day 21–25 with no ERA, check status (portal or 276/277).	Once, at day 21–25	Not on file → resubmit same day with proof of original.
31–60	Denials, requests for records, pended claims, COB holds.	Status check; work denials within 2 business days; send records; correct claims.	Every 14 days	No progress after 2 touches → billing lead.
61–90	Appeals in progress, stubborn COB, credentialing gaps.	Call (not portal) for anything without a clear status. Appeal or reconsideration filed.	Every 10 days	Any claim within 30 days of an appeal or TF deadline → lead, same day.
91–120	Second-level appeals, payer disputes, bad data.	Second-level appeal, payer rep escalation, provider relations email.	Every 7 days	Over $500 → practice manager review.
120+	Low collectability. Decision time.	Final attempt with documented reason, then write-off review.	Every 7 days until decided	Monthly write-off review meeting.

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AGE FROM THE RIGHT DATE

Age claims from the **date of service** for timely-filing risk, and from the **last submission date** for follow-up timing. Your PM probably shows one by default — know which.

SECTION 03

The work queue: score, don't sort

Working A/R oldest-first sounds responsible. In practice it spends the morning on $18 claims that are already lost while a $1,400 claim slides past 60 days. Score every claim and work highest first.

PRIORITY SCORE (THE WORKBOOK CALCULATES THIS)

```
Score = Dollar points + Age points + Risk points
```

DOLLAR POINTS

Balance ≥ $1,000	40
$500–999	30
$200–499	20
$50–199	10
< $50	3

AGE POINTS

61–90 days	30
31–60 days	25
91–120 days	20
0–30 days	10
120+ days	10

RISK POINTS

≤30 days to TF / appeal deadline	+30
Denied, no action logged	+20
No touch in 30+ days	+15
Follow-up date is today or past	+10

Why 61–90 outranks 120+: it's the last window where effort still changes the outcome. The 120+ bucket gets a decision, not hope.

Daily rhythm for one A/R specialist

Time block	Work
First 30 min	New denials from yesterday's ERAs — categorize, action, note. (Denials worked within 2 business days.)
Next 2–3 hours	Queue top-down by score. Batch portal checks by payer; batch calls by payer.
After lunch	Calls for anything the portal couldn't resolve. Appeals and corrected claims.
Last 30 min	Follow-up dates set for every claim touched. Escalations sent. Tomorrow's call list printed.

Rule of thumb many teams use: 60–100 meaningful touches a day per specialist, depending on how much is calls vs portal. Measure yours; don't copy a number.

SECTION 04

What the status means — and what you do next

Whatever the portal, IVR or rep says, it maps to one of these. The "next step" column is not optional.

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Status	Next step	Follow up in	Note must include
Not on file	Check 277CA. If accepted: send proof, ask rep to locate. If not: resubmit today.	`7 days`	Date resubmitted, proof type
In process / pended	Ask what it's pending for (records? COB? review?) and the expected date.	`Expected date + 3`	Pend reason, expected date
Pended for records	Send records within 2 business days with claim # on every page.	`14 days`	Date sent, method, fax confirmation
Pended for COB	Call patient: they must update COB with their plan. Script in Front Desk guide.	`7 days`	Patient contacted, date
Paid	Locate the EFT/check (trace #). Post. Compare allowed to contract.	—	Check/EFT #, amount, date
Denied	Look up the CARC/RARC in the Field Guide. Correct, appeal, rebill or bill patient.	`Per action`	CARC, action taken
Paid to wrong provider / TIN	Request recoupment and reprocess. Escalate to provider relations if needed.	`14 days`	Who was paid, ref #
Appeal received	Confirm receipt date and decision timeline.	`30 days`	Appeal ref #, receipt date

SECTION 05

The 4-line A/R note standard

A note that says "called ins, in process" costs the next person a whole call. Every note follows this format, in this order:

A/R NOTE FORMAT	EVERY TOUCH
WHAT	Channel + who: *Portal / IVR / Call — rep first name + initial*
FOUND	Status + reason + payer claim # + dates
DID	Action taken (resubmitted, records faxed, appeal sent, patient called)
NEXT	Next step + follow-up date + call reference #

EXAMPLE — FAKE DATA

```
03/12 CALL Acme Health, rep Dana M. · FOUND: denied CO-22, other coverage on file (Beta Ins eff 01/01) · DID: called pt, LVM asking to update COB w/ Acme; sent pt portal msg · NEXT: f/u 03/19; if updated, rebill Beta as primary. Ref# 7781-22
```


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SECTION 06

Escalation ladder

Step	Trigger	Action	Owner
1	Two touches, no progress	Call (not portal). Ask for a supervisor if the rep can't resolve.	A/R specialist
2	Three touches, or ≤30 days to a deadline	Billing lead reviews; decides appeal / reconsideration route.	Billing lead
3	Pattern: same issue on 5+ claims with one payer	Email provider relations / network rep with a claim list (no PHI beyond what's needed). Request a project / bulk reprocess.	Billing lead
4	Payer unresponsive 30+ days on a pattern	Formal written complaint; for fully insured plans, state insurance department prompt-pay complaint is an option.	Practice manager
5	Contract dispute	Contract terms review; dispute-resolution clause.	Owner / counsel

SECTION 07

Write-offs, credit balances, small balances

Write-off policy (adapt and sign)

Write-off type	Allowed when	Approval
Timely filing	No proof of timely filing exists and appeal options are exhausted. Root cause logged.	Billing lead
Contractual / policy	Denial is correct per contract (e.g. bundled service, no modifier support).	Billing lead
Small balance	Insurance balance under `$__` after one full follow-up cycle.	Auto per policy
Uncollectable > `$500`	All levels of appeal exhausted, or cost to pursue exceeds expected recovery.	Practice manager

Every write-off gets a reason code and lands in the monthly report. If timely-filing write-offs aren't near zero, the problem is upstream — see Clean Claim Checklist, checks 29–30.

Credit balances

- Review insurance credit balances **monthly**. Identify cause: duplicate payment, overpayment, posting error, or payment for another patient.
- **Medicare overpayments** must be reported and returned within 60 days of being identified (the "60-day rule"). Many states and commercial contracts also set refund deadlines — check yours.
- Don't wait for the payer to recoup. Refund or request offset in writing, and keep the record.

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A/R desk card

SCORE · TOUCH · NOTE · NEXT DATE

Bucket	Do	Cadence
0–30	Confirm 277CA. Status check at day 21–25.	Once
31–60	Work denials ≤2 business days. Send records. Correct.	Every 14 days
61–90	Call. Appeal / reconsider. Deadlines → lead.	Every 10 days
91–120	2nd-level appeal. Rep escalation. >$500 → PM.	Every 7 days
120+	Final attempt → write-off review.	Every 7 days

SCORE = $ + AGE + RISK

- ≥$1,000 = 40 · $500+ = 30 · $200+ = 20
- 61–90d = 30 · 31–60d = 25 · 91–120d = 20
- ≤30d to deadline +30 · denied/no action +20
- No touch 30d +15 · f/u due +10

EVERY NOTE: 4 LINES

- **WHAT** channel + rep
- **FOUND** status, reason, claim #
- **DID** action taken
- **NEXT** step + date + ref #

THE ONE RULE

No claim leaves your hands without a follow-up date. "Pending" is not a status — it's a claim nobody owns.

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DONE READING? TWO OPTIONS.

Run it yourself. Or we run it for you.

Everything in this guide works without us. If your team doesn't have the hours, Provider Prime's billing team does this work every day — inside your EHR, PM and clearinghouse. You change nothing.

01 · SNAPSHOT

Free revenue snapshot: denial patterns, A/R by bucket, and the three fixes worth doing first.

02 · PILOT

30-day risk-free pilot. $0. Claims out every business day, denials reworked within 2 business days.

03 · DECIDE

Keep going at 4% of net collections, month-to-month, 30-day notice. Or keep the plan and walk.

Free revenue snapshot → providerprime.com/get-started

hello@providerprime.com · WhatsApp +20 100 539 8585

- We make money when you collect money.
- BAA before access
- Live in one week

You didn't go to med school to babysit a clearinghouse.

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Please don't send PHI by email or web form — we'll set up secure access after a BAA is signed.
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