Provider Prime

CLINIC GROWTH VAULT 2.0
FREE RESOURCE · 2026

CHECKLIST | BILLING & CLAIMS

The Clean Claim Checklist

30 checks to run before a claim leaves the building — each one tied to the rejection or denial code it prevents.

INSIDE

- 30-point pre-submission checklist
- 10-minute daily rejection routine
- One-page desk version
- The CARC each miss usually triggers
- One-week miss tally to find your top 3

Clean Claim Checklist

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How to use this

1. Print the one-page desk version (last content page) and keep it at charge entry.
2. For one week, tally every miss on the tally sheet — rejections and denials both.
3. Fix the top 3 recurring misses at the source (intake, template, or PM setting), not on the claim.
4. Repeat the tally monthly. A clean claim rate of 95%+ is the bar we hold ourselves to.

WHO IT'S FOR
Billers, charge-entry staff, practice managers

TIME TO PUT IN PLACE
10 minutes a day; one week to baseline

PAIRS WITH
Denial Code Field Guide · Denial Tracker (XLSX)

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

Where a claim actually dies

A claim can fail in four places. Only the last one is a "denial." The first three are rejections — cheaper to fix, but invisible if nobody works the clearinghouse queue every day.

1 · PM SCRUBBER
Your own edits. Missing fields, invalid codes.

2 · CLEARINGHOUSE
999 / 277CA. Format, NPI, payer ID errors.

3 · PAYER FRONT END
Member not found, wrong payer, duplicate.

4 · ADJUDICATION
835 / ERA. Paid, adjusted, or denied with a CARC.

Outcome	What it means	Who should see it, and when
Rejection	Claim never entered adjudication. No claim number at the payer. It does **not** stop the timely filing clock.	Biller, same day. Fix and resend within 24–48h.
Denial	Claim was processed and paid $0 (or a line was denied). Comes back on the 835/ERA with a group code + CARC + usually a RARC.	Biller within 2 business days; root cause to the owner of that step.
Underpayment	Paid, but not what the contract says. Looks "fine" in most reports.	Weekly variance report. See the Underpayment Detection guide.

DEFINITION WE USE

Clean claim rate (first-pass acceptance) = claims accepted by the payer on first submission ÷ claims submitted, same period. Target: **95%+**. If you can't calculate it today, start by counting rejections per day in the clearinghouse — that number alone tells you a lot.

SECTION 02

The 30-point checklist

Each check shows the code you'll usually see when it's missed. Codes are CARCs (claim adjustment reason codes) as they appear on the ERA; the group prefix (`CO` , `PR` , `OA`) can vary by payer.

A · Patient & coverage (checks 1–9)

- [ ] `01` **Patient name matches the insurance card exactly** — including hyphens, suffixes (Jr, III), and no nicknames.
  Miss → rejection "subscriber not found" or `CO-31` / `CO-140` (patient cannot be identified as insured / name and ID don't match).
- [ ] `02` **Date of birth and sex match the payer's file**, verified on the 271 response, not just the intake form.
  Miss → `CO-31` ; sex mismatches can also trigger `CO-7` / `CO-10` on gender-specific codes.
- [ ] `03` **Member ID is current** — prefix included (e.g. three-letter BCBS prefix), Medicare MBI not an old HICN, Medicaid ID for the right month.
  Miss → rejection or `CO-31` .
- [ ] `04` **Subscriber vs patient relationship is right** (self / spouse / child) and the subscriber's own DOB is captured.
  Miss → rejection; one of the most common front-desk misses on dependents.
- [ ] `05` **Eligibility checked for this date of service** (270/271 or portal), within 72 hours of the visit, with the result saved.
  Miss → `CO-27` (coverage terminated), `CO-26` (before coverage), `CO-109` (wrong payer).

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- [ ] 06 **Right payer and payer ID** — Medicare Advantage billed to the MA plan, not Medicare; carved-out behavioral or lab benefits to the carve-out.
  Miss → `CO-109` (not covered by this payer/contractor — send to the correct payer).

- [ ] 07 **Coordination of benefits confirmed**: primary vs secondary, other insurance asked at every visit, Medicare Secondary Payer questions for Medicare patients.
  Miss → `CO-22` (may be covered by another payer per COB).

- [ ] 08 **Referral on file** when the plan requires a PCP referral (HMO, many Medicaid plans) — number, dates, visit count.
  Miss → `CO-288` (referral absent) or plan-specific network denials.

- [ ] 09 **Prior authorization obtained and attached** — number in Box 23 / loop 2300 REF*G1, CPT and units match the auth, DOS inside the auth window.
  Miss → `CO-197` (auth absent), `CO-15` (auth number invalid), `CO-198` (auth exceeded).

B · Provider & practice setup (checks 10–15)

- [ ] 10 **Rendering provider is credentialed and effective** with this payer on this DOS — not "submitted," *effective*.
  Miss → `CO-B7`, `CO-185`, or out-of-network processing.

- [ ] 11 **Rendering NPI (Box 24J) and billing NPI (Box 33a)** are the right type: Type 1 individual vs Type 2 group.
  Miss → rejection (RARC `N290` rendering provider identifier invalid).

- [ ] 12 **Taxonomy code** sent where the payer requires it and matches what's on file with them.
  Miss → `CO-8` (procedure inconsistent with provider type/specialty) or rejection.

- [ ] 13 **Service facility (Box 32) and billing address (Box 33)** match enrollment — billing address must be a physical address, not a PO box, for most payers.
  Miss → rejection or `CO-16` with an address RARC.

- [ ] 14 **Tax ID (Box 25)** matches the TIN the provider is enrolled under.
  Miss → rejection or payment to the wrong entity.

- [ ] 15 **Referring / ordering provider NPI** present for labs, imaging, DME, therapy — and that provider is enrolled (Medicare requires PECOS enrollment for ordering/referring).
  Miss → `CO-16` + `N286` (referring provider identifier missing/invalid).

C · Coding & documentation (checks 16–24)

- [ ] 16 **Note is signed** before the claim drops. No signature, no claim.
  Miss → fine until a records request, then a recoupment.

- [ ] 17 **CPT/HCPCS codes match the note** — level of E/M supported by MDM or total time, procedures documented with site and method.
  Miss → `CO-150` (info doesn't support this level of service) on review.

- [ ] 18 **Codes valid on the date of service** — annual CPT/HCPCS and ICD-10-CM updates loaded (Jan 1 and Oct 1).
  Miss → `CO-181` (procedure code invalid on DOS) / `CO-146` (diagnosis invalid on DOS).

- [ ] 19 **ICD-10 coded to highest specificity** — 7th characters, laterality, no truncated codes.
  Miss → `CO-16` + `M76`, or `CO-11`.

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- [ ] 20 **Diagnosis pointers (Box 24E)** link each line to the diagnosis that justifies it — primary reason first.
  Miss → `CO-11` (diagnosis inconsistent with procedure) or `CO-50` (medical necessity).

- [ ] 21 **NCCI edits checked** for every same-day code pair; modifiers 25 / 59 / X{EPSU} only when documentation supports a distinct service.
  Miss → `CO-97`, `CO-236`, or `CO-4`.

- [ ] 22 **Required modifiers present** — laterality (RT/LT, 50), professional/technical (26/TC), telehealth (95 or payer-specified), ABN (GA).
  Miss → `CO-4` (modifier inconsistent or missing).

- [ ] 23 **Units and time** — timed codes follow the 8-minute rule (Medicare) or payer rule, and units don't exceed the MUE.
  Miss → `CO-151` or MUE line denials (RARC `N362`).

- [ ] 24 **Drugs and vaccines** billed with correct HCPCS units and NDC (11-digit, N4 qualifier) where the payer requires it.
  Miss → `CO-16` + `M119` (NDC missing/invalid).

D · Claim form & submission (checks 25–30)

- [ ] 25 **Place of service** matches where care happened — 11 office, 22/19 outpatient hospital, 02/10 telehealth, 20 urgent care (if contracted that way).
  Miss → `CO-5` (inconsistent with place of service) or wrong fee schedule.

- [ ] 26 **Charges are your full fee schedule**, not the expected allowed amount. Bill the same charge to every payer.
  Miss → silent underpayment when a payer pays "lesser of billed or allowed."

- [ ] 27 **No duplicate** — check for an existing claim for this patient + DOS + code before sending. Corrected claims use frequency code 7 (replace) or 8 (void) with the original claim number.
  Miss → `CO-18` (exact duplicate).

- [ ] 28 **Secondary claims carry primary payment info** — primary paid amount, adjustments and CARCs (loop 2320/2430) or the primary EOB attached.
  Miss → `CO-16` + `MA04` / `N479`.

- [ ] 29 **Timely filing clock checked** — days since DOS vs this payer's limit. Anything past 50% of the window goes to the top of the queue.
  Miss → `CO-29` (time limit expired). Usually unrecoverable.

- [ ] 30 **Accepted, not just sent** — confirm the 999 and 277CA acknowledgments the next business day.
  Miss → claims that "went out" but never arrived; discovered at 90 days.

SECTION 03

The 10-minute daily rejection routine

Rejections are the cheapest money in the building. They just need someone to look every single day.

1. **Open the clearinghouse rejection report** (both 999 file-level and 277CA claim-level). Filter: yesterday + anything still open.
2. **Sort by reason, not by patient.** Ten "subscriber not found" rejections are one problem with ten symptoms.

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3. **Fix and resend every claim** that can be fixed from the chart or a portal lookup. Target: same day, never later than 48 hours.
4. **Route the rest with a reason and a name** — "need new card from patient → front desk (Ana) by Thursday."
5. **Write one line in the miss tally** (next page) per rejection reason. That's where your top-3 list comes from.
6. **Check yesterday's acknowledgments**: every batch sent should have a 999 accepted and a 277CA. No acknowledgment = it didn't arrive.

THE TIMELY-FILING TRAP

A rejected claim was never received by the payer. If it sits in the rejection queue for 60 days, the payer's clock kept running the whole time. Common commercial limits are 90–180 days from DOS; Medicare is 12 months; Medicaid varies by state. Proof of timely filing = an accepted 277CA, not your "sent" log.

Common rejection messages and the first thing to check

Rejection says…	Check first	Usual owner
Subscriber / patient not found	Name spelling, DOB, ID prefix, relationship code. Run a fresh 271.	Front desk
Invalid / missing rendering NPI	Provider setup in PM; Type 1 vs Type 2 NPI in 24J vs 33a.	Billing lead
Payer ID invalid / not on file	Payer mapping in PM. MA plan vs Medicare. Clearinghouse payer list.	Billing lead
Diagnosis code invalid	Truncated code, wrong code set year, missing 7th character.	Coder / provider
Billing provider address invalid	PO box in Box 33, ZIP+4 missing, address not matching enrollment.	Billing lead
Duplicate claim	Was the original accepted? If yes, follow up instead of resending.	Biller

SECTION 04

One-week miss tally

Put a stroke in the box each time a check is missed (rejection, denial, or caught internally). After five days, circle the three highest totals. Those are your fixes for next month.

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Check	Mon	Tue	Wed	Thu	Fri	Total	Fix at source
01–04 Patient / subscriber data							Intake script, card scan
05–07 Eligibility, payer, COB							72h eligibility batch
08–09 Referral / prior auth							Auth tracker, scheduling hard stop
10–15 Provider setup							Provider master file
16–20 Documentation & dx							Template, provider feedback
21–24 Edits, modifiers, units							Scrubber rules, coder review
25–28 Claim form fields							PM defaults, payer setup
29–30 Timeliness & acknowledgment							Daily queue SLA

THE RULE THAT MAKES THIS WORK

If the same miss shows up twice, someone changes a system — a required field, a template, a scrubber rule, an intake question. Fixing the claim is the job. Fixing the *reason* is the improvement.

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Clean Claim — desk version

30 CHECKS · PRINT ME

A · PATIENT & COVERAGE

- [ ] 01 Name exactly as on card
- [ ] 02 DOB + sex match 271
- [ ] 03 Member ID current (prefix / MBI)
- [ ] 04 Subscriber + relationship right
- [ ] 05 Eligibility ≤72h before DOS, saved
- [ ] 06 Right payer + payer ID (MA ≠ Medicare)
- [ ] 07 COB: primary / secondary confirmed
- [ ] 08 Referral on file if required
- [ ] 09 Auth #, CPT, units, dates match

B · PROVIDER SETUP

- [ ] 10 Provider effective with payer on DOS
- [ ] 11 Type 1 NPI in 24J · Type 2 in 33a
- [ ] 12 Taxonomy matches payer file
- [ ] 13 Box 32 / 33 match enrollment
- [ ] 14 TIN matches enrollment
- [ ] 15 Referring / ordering NPI present

C · CODING & DOCUMENTATION

- [ ] 16 Note signed
- [ ] 17 Codes supported by note
- [ ] 18 Codes valid on DOS
- [ ] 19 ICD-10 full specificity
- [ ] 20 Dx pointers right, primary first
- [ ] 21 NCCI checked; 25/59/X only if earned
- [ ] 22 Required modifiers present
- [ ] 23 Units / time within MUE
- [ ] 24 NDC + units on drugs

D · CLAIM & SUBMISSION

- [ ] 25 Place of service right
- [ ] 26 Full fee schedule charge
- [ ] 27 Not a duplicate; corrected = freq 7/8
- [ ] 28 Secondary has primary data
- [ ] 29 Timely filing clock checked
- [ ] 30 999 + 277CA accepted next day

DAILY

Work rejections same day → sort by reason → fix the source when it repeats twice. Target: 95%+ first-pass acceptance.

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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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