KARENZUPKO & ASSOCIATES, INC.

KZA Billing Service Evaluation Checklist

Use this checklist with each billing service under consideration. Mark each item on the list to indicate that you have requested or inquired, and that the billing service has responded with the information. In addition to completing the checklist, evaluate the company's profile and service costs for a complete comparison.

KZA Billing Service Evaluation Checklist	
HIPAA Omnibus Requirements	
	Standard Business Associate Agreement (BAA)
	Breach Notification Procedure
	Data Security Policy
	Privacy Policy
	HIPAA Business Associate Employee Training Policy
Contracting & Risk Management	
	Standard Service Agreement
	Indemnification Clause – *Holds your practice harmless from billing and other mistakes or misconduct.*
	Certificate of Errors & Omissions (E&O) Insurance – *Coverage limit minimum: $1 million.*
	Certificate of General Liability Insurance – *Coverage limit minimum: $1 million.*
	Confirmation of Employee Theft Bond – *Coverage limit minimum: Ask your accountant for a limit that's typical in your market.*
Data Security Questions	
	Name of secure messaging system used for communication with practice clients.
	Confirmation that all employees and contractors been supplied with screen savers/privacy screens.
	Offshore coding staff Y/N
	Confirmation of automated system time-out for all employees, please include duration.
	Name of encryption system for data downloads from the client's system.
	Description of data storage system or devices including procedures for access, storage, protection, and destruction.
	Procedure, method and frequency for data backup including encryption if stored off site.
	Protocol for PHI storage, transfer, maintenance, and disposal. Include a list of positions and entities with access to PHI as well as shredding service vendor name.
	Protocol for data return/destruction at conclusion of agreement.
Human Resources	
	Have you done background checks, including criminal, for all employees and new hires?
	Confirmation of initial and annual employee HIPAA business associate training and availability of attendance records. *(Required by HIPAA Omnibus Rule)*
	Documentation of recent employee training in orthopaedic coding, ICD-10, Medicare and non-Medicare reimbursement.
	Annual employee turnover rate.

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	Number of staff likely to be allocated to account. *The ideal number varies depending on the scope of billing services in contract.*
	Account Manager? Coverage for account for vacations and leave.
	Define responsibilities of account manager.
Human Resources - Independent Contractors (if used)	
	Confirmation of signed a BAA for each contractor. *(Required by HIPAA Omnibus Rule.)*
	Confirmation of initial and annual contractor HIPAA business associate training and availability of completion records. *(Required by HIPAA Omnibus Rule.)*
	Independent contractor compensation model (salary, hourly, incentive bonus, piece rate).
Human Resources - Home-Based Workers & Telecommuters	
	Confirmation that each home office environment and network have been audited to ensure they meet the service's privacy and security standards and are password protected?
	Confirmation that contractor's computer system is used only by that contractor, and not by others in the home?
Coding Expertise & Compliance	
	Number of certified coders and confirmation of current certification, CEU completion and ICD-10 certification status. *Employment of certified coders indicates the service's commitment to compliance and coding accuracy. Certificates should be on file as well as records of completed CEUs.*
	Number of certified coders that are employees vs. independent contractors. *The higher the number, the stronger the service's expertise in coding.*
	Copy of company compliance plan provided or available. *Such a plan indicates the billing service's understanding of billing regulations, commitment to coding compliance, and audit preparedness.*
	Protocol for changing CPT or diagnosis codes when errors are discovered a) before submission and b) after submission. *Ideally, the service only changes after physician approval. Remember that you are ultimately held responsible for what is submitted to the insurance plan.*
Use of Technology	
	How many employees have experience? How much experience in years? On what segments of the rev cycle? How many current and previous clients on the system?
	Experience with and ability to use of [NAME OF YOUR PRACTICE EHR/PMS] *The billing service should have experience with your system. It is inadvisable to contract with a billing service that will not use your practice's technology. Requiring separate logs, additional computer systems, or other paper-based systems is inefficient, risky, and costly.*
	Do you send billing statements electronically?
	What is the amount it costs to send a paper statement? (include paper, postage, staff time, etc.)
	Percentage of claims submitted electronically (rather than paper). *This should be a high percentage and reasons for paper submissions should be specified and payor based.*
	Percentage of remittances received electronically. *This should be a high percentage and reasons for paper submissions should be specified and payor based.*
	Clearinghouse used by billing service.

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	Names and uses of software systems used by billing service.
Service Orientation	
	Days/hours/time zone and phone number(s) for patient calls. *Minimum for ideal service orientation is one phone number Monday – Friday 9AM – 5PM in same time zone as practice. Ideally extended hours such as 7AM-9PM in same time zone as practice.*
	Calls answered: by billing service employee, billing service automated menu, external call center? If external call center, location. What is your pickup rate? Average hold time? *Ideal is up to your practice preferences.*
	Voice mail messaging available for after hour patient calls.
	Is there a guaranteed response time for patient inquires? *Ideal answer: By the end of the business day if they call during the week before 2PM. By the end of the next business day if a patient leaves a message on a weekend.*
	Secure patient convenience technology used (i.e., text messaging reminders, electronic patient statements, on-line bill payment options). If so, what systems/service are used?
Accounts Receivable & Unpaid Claims	
	What are the days in receivable and net collection ratio for other orthopaedic practices you work for? Other surgical practices? *Ideal answer: Days in receivable – a standard metric that measures how long it takes for a claim to be paid – should be 45 or less. Net collection ratio – which measures the percentage of 'collectible' dollars collected – should be 95% or more.*
	Frequency of claims submission. Frequency of correcting electronic claims errors. *Claims should be submitted daily, and all errors fixed and resubmitted daily. Is there a Schedule QA Process to capture unsent/undocumented charges?*
	Payor follow up protocols for at 15, 30, 45, 60, 90, and 120+ days outstanding.
	Patient collections protocols for at 15, 30, 45, 60, 90, and 120+ days outstanding.
	Explain the process of appealing claims that are incorrectly denied. *Answers will vary. Look for responses that are not vague, and that indicate tenacity and a willingness to pick up the phone instead of simply "resubmitting." Ask for sample appeal letters.*
	Protocol and approval process for refunds. *All refunds should be approved by the practice before they are made.*
	Procedure for non-contractual adjustments. *Non-contractual adjustments are key to accurate net collections data and identifying opportunities for improvement in the revenue cycle.*
Management Reports & Metrics	
	Sample monthly reports. *Ideally, user-friendly format including: payor mix by charges and by payments, net collections ratio, days in A/R, percentage A/R over 90 days, adjustments summary report, recommended accounts for write-off/external collections, budget plan report and aged A/R over 45 days for insurance and separate report for patient accounts, aged accounts receivable by payor, as well as in summary with insurance patient balances broken out separately; individual patient balance report, credit balances, refunds.*
	Sample quarterly reports. *Ideally user-friendly format, including: E&M utilization by physician, denial report by CPT code and by payor and reimbursement rates for top 25 CPT codes by payor.*