

Billing Status: What Do They Mean?

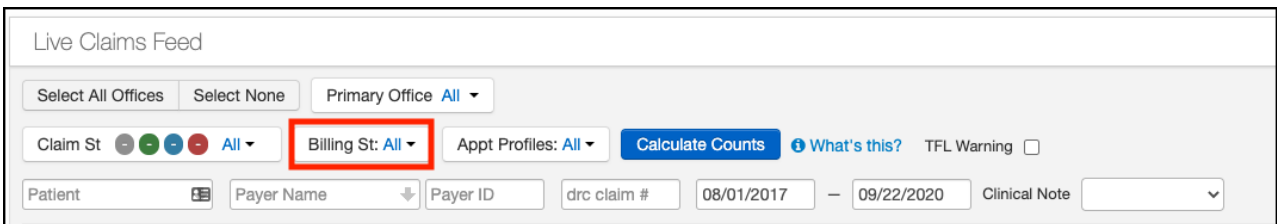
09/16/2024 9:04 am EDT

DrChrono uses statuses on appointments/claims to know, at a glance, where your claims are in the RCM process.

You will see these statuses in your Live Claims Feed.

1. Navigate to **Billing > Live Claims Feed**.

Billing St will be near the top of the gray shaded area; under your offices and just above the payer name search box.



The screenshot shows the 'Live Claims Feed' interface. At the top, there are buttons for 'Select All Offices' and 'Select None', and a 'Primary Office: All' dropdown. Below these are 'Claim St' (with colored bubbles) and 'Billing St: All' (highlighted with a red box). To the right of 'Billing St' is 'Appt Profiles: All' and a blue 'Calculate Counts' button. Further right are links for 'What's this?' and a 'TFL Warning' checkbox. At the bottom, there are search fields for 'Patient', 'Payer Name', 'Payer ID', 'drc claim #', a date range from '08/01/2017' to '09/22/2020', and a 'Clinical Note' dropdown.

Once you select your date range, if you click on the blue **Calculate Counts** button, the system will fill in the colored bubbles to let you see a count of how many claims are in that particular status at that time.



Please note, that these figures can and do change during the day as claims are submitted, patient payments posted and ERAs are received.

Your DrChrono account will have many common pre-populated billing statuses listed. Depending on your workflow, you may or may not use all of these. The ones below the gray line below (under the shortlist that ends with "other"), can be rearranged, or hidden from view if you would like.

Here is a [link](#) to an article showing you how to create additional or custom billing statuses for your practice.

Some of the listed statuses are utilized when you are using DrChrono RCM services, however, if you are doing your billing, they can be used by your billing staff as well. Your RCM Account Manager and Billing Manager will assist in talking through your workflow and which statuses the office should monitor.

<input checked="" type="checkbox"/>	All Statuses
<input checked="" type="checkbox"/>	<input type="radio"/> Paid In Full
<input checked="" type="checkbox"/>	<input type="radio"/> Settled
<input checked="" type="checkbox"/>	<input type="radio"/> Balance Due
<input checked="" type="checkbox"/>	<input type="radio"/> Internal Review
<input checked="" type="checkbox"/>	<input type="radio"/> Scrubbing Error
<input checked="" type="checkbox"/>	<input type="radio"/> Other
<input checked="" type="checkbox"/>	<input type="radio"/> Attention to Biller
<input checked="" type="checkbox"/>	<input type="radio"/> Specialist Review
<input checked="" type="checkbox"/>	<input type="radio"/> Pending Info Practice
<input checked="" type="checkbox"/>	<input type="radio"/> Coding Completed
<input checked="" type="checkbox"/>	<input type="radio"/> Coding Clarified
<input checked="" type="checkbox"/>	<input type="radio"/> Coding Clarification
<input checked="" type="checkbox"/>	<input type="radio"/> Patient Contact
<input checked="" type="checkbox"/>	<input type="radio"/> Payer Contact
<input checked="" type="checkbox"/>	<input type="radio"/> Internal Coding Review
<input checked="" type="checkbox"/>	<input type="radio"/> Analyst Review
<input checked="" type="checkbox"/>	<input type="radio"/> In Process w Payer
<input checked="" type="checkbox"/>	<input type="radio"/> Chrono Appeal
<input checked="" type="checkbox"/>	<input type="radio"/> Faxed/Mailed Claim or Appeal
<input checked="" type="checkbox"/>	<input type="radio"/> Paid Not Posted
<input checked="" type="checkbox"/>	<input type="radio"/> chrono audit
<input checked="" type="checkbox"/>	<input type="radio"/> Ready To Bill
<input checked="" type="checkbox"/>	<input type="radio"/> Voicemail Follow Up
<input checked="" type="checkbox"/>	<input type="radio"/> Enrollment Pending

- **Paid In Full** - There is no balance due from either the patient or the payer
- **Settled** - The claim has been settled. No further attempts to collect will occur
- **Balance Due** - There is a balance due from the patient
- **Internal Review** - This status can be used for any type of internal review/audit situation
- **Scrubbing Error** - This status is a placeholder for a future enhancement
- **Other** - Could include statuses such as not submitted, payer acknowledged, rejected or ERA denied
- **Attention to Biller** - Used to alert the biller that there is an action that needs to be taken on the claim
- **Specialist Review** - Used when a claim is referred to a senior biller/supervisor for review
- **Pending Info Practice** - Used when input from the office is needed to move forward with the claim
- **Coding Completed** - Used when the coding team has completed their review of the clinical note and has added the ICD-10, CPT, HCPCS, and/or custom codes to the claim

- **Coding Clarified** - Used when the provider has given additional details regarding the clinical visit so the claim can be coded appropriately
 - **Coding Clarification** - Used when the coding team needs additional clinical details to code the claim appropriately
 - **Patient Contact** - Used when a reach out to the patient is needed
 - **Payer Contact** - Used when a reach out to the payer is needed
 - **Internal Coding Review** - Used when a senior coder/supervisor reviews the coding. Also used for internal auditing purposes
 - **Analyst Review** - Used when a claim is referred to a senior biller/supervisor for review
 - **In Process w Payer** - Used when the billing team has received information from a payer that a claim has been received and is being processed. This status is usually used when no ERA "payer acknowledged" was received
 - **Chrono Appeal** - Used when DrChrono is appealing a claim denial
 - **Faxed/Mailed Claim or Appeal** - Used when DrChrono has sent the appeal to the payer and is awaiting a response
 - **Paid Not Posted** - Used when the billing team receives information from the payer that a claim has been processed and paid but we have not yet received the ERA or the EOB to post
 - **Chrono Audit** - Used when internal management staff is auditing a claim to ensure correct coding and billing
 - **Ready to Bill** - Used to signal the biller that a claim is ready to be billed to a payer
 - **Voicemail Follow-Up** - Used when the biller has left a voicemail for either the patient and/or payer and is awaiting a response. Claims will be followed up on if no response is received.
 - **Enrollment Pending** - Example of a custom billing status. Used when credentialing with a payer is complete and EDI enrollment is pending with the clearinghouse to submit claims.
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