Billing & Coding Staff — New User Guide

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Everything the billing team needs to manage claims, payments, and billing workflows.

Chapter 1: Getting Started with Billing

> **BEFORE YOU BEGIN:**
> If you haven't already done so, check out the New User Orientation before diving in — this covers how DrChrono works at a high-level, which will make the role-specific content in this guide much easier to follow.

BILLING & CODING STAFF | GETTING STARTED WITH BILLING | ⏰ 5-MINUTE READ

In this first chapter, you'll learn about the billing tools you'll use daily along with the core concepts that drive the day-to-day billing workflow. This sets the stage for navigating the lifecycle of a claim throughout the rest of the chapters, so work through them in order to get the full picture before diving into your queue.

Before You Begin

> **REQUIREMENTS**
> You'll need the **Billing Staff** role applied to your account. If you experience access issues, contact your Practice Administrator to confirm your permissions.

Overview

This chapter orients you to DrChrono's billing interface — the menu, statuses, widgets, and terminology you'll use throughout every chapter that follows. Before working your first claim, spend time here. Understanding how billing statuses flow and where the system surfaces problems will save you significant time once you're in the queue.

Essential Billing Setup and Configuration:

In order to successfully bill claims, your account needs to be properly set up and configured. This includes:

- Completing all necessary payer enrollments (including claims, ERA/remittance, and eligibility)
- Ensuring the billing credentials (NPI, TIN, organization name, etc.) are correctly entered for each provider and/or office
- Confirming the fee schedule is loaded in

If you will be responsible for managing payer enrollments in the practice, check out **Manage Billing Settings** in the Practice Administrator module for step-by-step guides on these tasks and more.

Getting to Know Your Billing Workspace

The Billing Menu

The billing menu is your primary navigation hub for everything revenue cycle related. From here you can access:

- **Live Claims Feed** — your central claims management workspace
- **Patient Payments** — for posting and managing patient payment transactions
- **Billing Reporting** — all financial and AR reports
- **Fee Schedules and Billing Picklists** — your charge capture configuration tools

> **SUCCESS TIP:**
> Check out **Getting to Know the Billing Menu** and **Introducing Your Core Billing Tools** for more information about these features.

Billing Statuses

Every appointment and claim in DrChrono carries a billing status that tells you exactly where it is in the revenue cycle. Understanding these statuses is essential — they drive your workflow and power your reports.

Common statuses you'll work with daily include:

- **Bill Insurance** — claim is ready to submit to the payer
- **Submitted** — claim has been transmitted to the clearinghouse
- **ERA Received / ERA Posted** — payment has been received and posted
- **Rejected** — claim was rejected by the clearinghouse or payer and needs correction
- **Denied** — payer processed the claim but did not pay; requires follow-up
- **Balance Due** — a patient balance remains after insurance has paid
- **Paid in Full** — claim is fully resolved

> **SUCCESS TIP:**
> Check out **Billing Statuses: What Do They Mean?** for more details about billing statuses.

> **New customer setup:** Custom Billing Statuses (e.g. Ready for Billing Review) can help you track claims internally. Always check with your Practice Administrator before making configuration changes. Learn more about managing Custom Billing Statuses **here**.

Billing Widgets

The Dashboard in DrChrono includes widgets that give you a real-time snapshot of your claims queue and patient balances — without having to run a report.

- **Claim by Claim Status Widget** — shows a count of claims in each billing status so you can see at a glance where work is piling up
- **Patient Balance Widget** — surfaces outstanding patient balances
- **Post Widget** — a quick-access posting tool for applying payments directly from the dashboard

Daily Billing Problem Email

DrChrono can send you a daily summary of claims that need attention — rejections, missing information, scrubbing errors, and similar issues. This is one of the easiest ways to stay on top of your queue without running a report every morning.

Subscribe by adding your email in **Account Settings > Email > Recipients of Billing Email** for each provider you want to track. A step-by-step walkthrough can be found **here.** Contact your Practice Administrator for assistance if you do not have permission to access Account Settings.

Billing Terminology Reference

New to medical billing, or just new to the way DrChrono names things? The links below cover the foundational concepts and DrChrono-specific terminology you'll encounter throughout this guide.

- Explaining Basic Billing Concepts
- Getting Started with Billing Acronyms
- DrChrono Glossary

What Happens Next

Now that you're familiar with DrChrono's billing tools and statuses, the next chapter covers coding and charge entry — the tools that ensure every visit is accurately documented and ready to bill before it reaches the Live Claims Feed.

Helpful Resources

DrChrono Billing Resources
Getting Started with Billing through DrChrono
Getting to Know the Billing Menu
Introducing Your Core Billing Tools
Billing Status: What Do They Mean?
Is There a Dictionary to Search for CPT, HCPCS, and ICD-10 Codes?
Daily Billing Problems Email: Add | Remove
Insurance Plan Types Explained

External Resources
CMS Physician Fee Schedule Lookup Tool
CMS ICD-10-CM Code Lookup
AMA CPT Code Lookup
NUCC 1500 Claim Form Reference
AAPC Coder
CMS MAC Resources

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 2: Code Visits & Enter Charges

BILLING & CODING STAFF | CODING & CHARGE ENTRY | ⏰ 10-MINUTE READ

After reading this, you'll know how to use DrChrono's charge entry tools — Billing Profiles, the Billing Picklist, and Persistent Codes — and how to enter charges from both the appointment window and the Live Claims Feed, so your claims are coded accurately before they go out.

Overview

Before a claim can be submitted, two things need to be in place: the patient's insurance information needs to be accurate in the system, and the charges from their visit need to be properly entered. This chapter covers the coding tools and methods that drive consistent charge entry across your practice and the ways charges get into DrChrono — setting you up for a clean claim before it reaches the Live Claims Feed.

> **Note:** Insurance entry and eligibility verification is typically handled by the front desk team in most practices — see the **Patient Check-In guide** for a walkthrough. Billing staff should still understand this process, as insurance entry errors are among the most common causes of claim rejections downstream.

Charge Entry Tools & Methods

Before diving into charge entry, it helps to understand the methods for entering charges including the convenience tools available to make entering charges faster and more consistent:

Manual Entry is necessary for patient visits with uncommon or variable diagnosis and procedure codes, or for the patient's initial visit.

Billing Profiles are bundled sets of billing codes — CPT, ICD-10, and modifiers — that can be applied to a visit with a single click. Instead of manually searching for and entering each code, a Billing Profile lets you apply a pre-configured set of codes for a common visit type all at once.

The Billing Picklist is a saved shortlist of your most frequently used codes pulled from your fee schedule. Rather than searching the full code library each time, the Picklist gives you quick access to the codes your practice bills most often.

Copy Last Billing allows you to copy in the codes from this patient's last visit. You can also automate **copying codes from the patient's last visit** if this is a common occurrence. For patients on recurring treatments where the same codes are billed repeatedly, this eliminates manual re-entry and reduces the risk of missing a code.

> **INFO:**
> Setting up billing codes to automatically copy from the patient's last appointment must be configured per provider

Entering Charges

Charges can be entered in DrChrono from three places depending on your practice's workflow. All of these methods support the tools above:

From the Appointment Window

Charges are added directly to the appointment during or after the visit. This is where most practices have their users enter charges initially either using Billing Profiles, the Billing Picklist, or manually entering the codes.

From the Clinical Note

> **NOTE:**
> This method is commonly used in practices where providers or clinical staff are responsible for adding codes to their visit, meaning this is not the preferred approach for a billing user, but for reference, you can see this clinical workflow in action **here**.

From the Live Claims Feed

The Live Claims Feed is DrChrono's central claims workspace where all appointments with billable activity are queued for review and submission. Charges can be added or corrected here after the fact, making it useful for catching anything missed at the appointment level before the claim goes out. You can read the how-to guide **here** or watch the tutorial below— just know that we'll be covering the Live Claims Feed in the next chapter.

> **SUCCESS TIP:**
> Most practices enter charges from within the Appointment and use the Live Claims Feed as the review and submission stage — not the primary charge entry point. Chapter 3 covers the claim submission workflow.

No-Show Billing

If your practice charges a fee for missed appointments, DrChrono allows you to bill for no-shows directly from the appointment. Check with your Practice Manager to confirm your practice's no-show policy before applying charges.

How Do I Bill for a No-Show Appointment?

What Happens Next

With your charges entered and coding tools configured, the next chapter walks you through the Live Claims Feed and the full claim submission workflow — from reviewing your queue to transmitting claims to payers.

Helpful Resources

Insurance, Eligibility and Authorizations
How to Add, Edit, and Archive Patient Insurance

Insurance Plan Types Explained
Real-Time Eligibility Dashboard
Prior Authorization Alerts

Charge Entry
Creating Billing Profiles
Creating a Billing Picklist
How Does the Live Claims Feed Work?
How to Add a Charge from the Live Claims Feed

External Resources
CMS Medicare Eligibility & Benefits
CAQH CORE Eligibility & Benefits Operating Rules

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 3: Submit & Track Claims

BILLING & CODING STAFF | SUBMIT & TRACK CLAIMS | ⏰ 15-MINUTE READ

After reading this article, you'll know how to navigate the Live Claims Feed, review and submit claims to primary, secondary, and tertiary insurance, run bulk submissions, understand scrubbing errors, and know where to go for specialty claim types like Auto Accident and Workers' Compensation.

PLAN AVAILABILITY: Some claims tools on this page—including real-time eligibility checks, electronic claim submission, and ERA auto-posting—may not be included in your plan. Check with your Practice Manager or see the Compare Plans page to learn more about what's included in each plan. Start a chat with support if you are unsure what plan you are currently on.

Overview

With charges entered, claims move into the Live Claims Feed — DrChrono's central workspace for reviewing and submitting claims to payers. This chapter walks through the full submission workflow, from navigating the feed and understanding claim statuses to submitting electronically and handling specialty claim scenarios.

New customer setup: Electronic claim submission requires EDI enrollment with a clearinghouse— a one-time practice-level setup. If you're joining an existing practice, this may already be done. Learn more **here** but Check with your Practice Administrator, Practice Manager or Billing Manager before proceeding.

The Live Claims Feed

The Live Claims Feed is where all appointments with billable activity are queued for review and submission. Every claim in your practice flows through here — it's your primary workspace for managing what goes out to payers and tracking what comes back. If you didn't already see the Live Claims Feed overview in Chapter 2, you can check it out below:

Check out these helpful resources about the Live Claims Feed:
How Does the Live Claims Feed Work?
Can I Customize the View in the Live Claims Feed?
How to Filter a Claim by Billing Status
Billing Status: What Do They Mean

Filtering the Live Claims Feed by billing status is one of the most effective ways to prioritize your work queue. Start with **Bill Insurance** to see what's ready to go out, and **Rejected** to see what needs attention before it can be submitted.

Submitting Claims

SUCCESS TIP:
Rather than submitting claims one at a time, DrChrono lets you submit multiple claims to a payer in a single batch — a significant time saver when working through a large queue. Learn more about this feature **here**.

Primary Insurance

Most claims are submitted electronically to the patient's primary insurance directly from the Live Claims Feed. Once charges are reviewed and the claim is ready, set the billing status to **Bill Insurance** and submit.

How to Submit a Claim to an Insurance Company
Lifecycle of a Medical Claim
What Time Are Claim Files Submitted?

Secondary & Tertiary Insurance

Once primary insurance has paid and a balance remains, claims can be submitted to secondary or tertiary insurance. DrChrono carries the primary payment information forward so it's included on the secondary submission.

Why this matters:
Secondary billing is where practices quietly lose money — they collect the primary payment and stop. Always confirm secondary and tertiary claims are queued and submitted. DrChrono can automate this; verify your configuration handles it correctly.

How to Submit Claims to a Tertiary Insurance and Post Payments
Secondary Submission When Medicare is Primary
How to Mail a Claim to a Secondary Along with the Primary EOB

Scrubbing Errors

Before a claim transmits to the clearinghouse, DrChrono runs it through a scrubber that checks for common errors — missing information, invalid codes, formatting issues — that would cause a rejection. If a claim fails scrubbing, it won't go out until the error is resolved.

Understanding scrubbing errors and how to correct them is one of the most valuable skills for a new biller. Most errors are straightforward once you know what to look for.

SUCCESS TIP:
Use the **Preview EDI Claim** feature — found under the charges in the Billing Details screen — to review exactly what will be transmitted before submitting. Catching errors here is far easier than correcting and resubmitting after a rejection.

Specialty Claim Types

Some claim types require additional information or follow different submission rules than a standard professional claim. The resources below cover the most common specialty scenarios for ambulatory practices.

NOTE:
Electronic claims for Auto and Workers' Comp claims are billed per claim. See our Pricing page for details.

Auto Accident
Submitting Auto Accident Claims Through DrChrono
HCFA 1500 Form for Auto Accident Claims

Workers' Compensation
Submitting Workers' Comp Claims Through DrChrono
Workers' Compensation Condition Codes for HCFA Box 10D

Durable Medical Equipment (DME)
Submitting DME Claims Subject to $35 Out of Pocket Cap

Timely Filing

Every payer has a deadline for claim submission — after which they can deny the claim purely on timing, regardless

of whether it would otherwise have been paid. Timely filing limits vary by payer and are typically 90 days to 1 year from the date of service.

Timely Filing Letter
Medicare Rejection for Timely Filing

What Happens Next

With claims submitted, the next step is posting what comes back. Chapter 4 covers payment posting — ERAs, manual EOBs, adjustments, write-offs, and patient payments.

Helpful Resources

DrChrono Resources
Lifecycle of a Medical Claim
How Does the Live Claims Feed Work?
Billing Status: What Do They Mean?
How to Submit a Claim to an Insurance Company
How to Submit Bulk Claims to a Payer
Scrubbing Errors: What Do They Mean?
Clearinghouse 101
Secondary Submission When Medicare is Primary
Submitting Auto Accident Claims Through DrChrono
Submitting Workers' Comp Claims Through DrChrono

External Reference
CMS Medicare Claims Processing Manual
NUCC HCFA 1500 Claim Form Reference
CAQH Payer ID Directory

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 4: Post Payments & Review ERAs

BILLING & CODING STAFF | POST PAYMENTS & REVIEW ERAs | ⏰ 15-MINUTE READ

After reading this article, you'll know how to post manual insurance payments (EOBs), apply unmatched ERAs, apply adjustments and write-offs, allocate patient payments, correct posting errors, and close out your month using DrChrono's Month End Close workflow.

Overview

Once a claim has been adjudicated, the payer sends back payment information along with any adjustments — contractual discounts, denials, and other changes to the original billed amount. Remaining balances may then flow to the patient or be written off depending on your practice's policies. This chapter covers the full payment posting cycle: applying insurance payments, processing adjustments and write-offs, collecting patient balances, and keeping your books accurate through Month End Close.

ERA Processing

ERA Overview

An ERA (Electronic Remittance Advice) is an electronic payment file sent directly from the payer that automatically posts payment details — including adjustments and denials — to the corresponding claims in DrChrono. When an ERA processes correctly, most of the posting work is done for you.

Unmatched ERAs

ERAs don't always match automatically. An **unmatched ERA** occurs when the remittance cannot be tied to a specific claim — typically due to a claim number mismatch, a timing issue, or missing information. This is also a very common occurrence when transitioning EHRs. Unmatched ERAs need to be manually resolved to ensure the payment gets applied correctly and doesn't sit unposted.

You can learn more about unmatched ERAs here or check out the tutorial below:

New customer setup: ERA processing requires enrollment with the clearinghouse. If your practice hasn't completed ERA enrollment, contact your Practice Administrator or Billing Manager. Without it, all insurance payments will need to be entered manually as EOBs.

Manual Insurance Payment Entry (EOBs)

For payers that don't send electronic remittance, or in cases where an ERA fails to process, you'll need to manually enter payment details from the paper or portal EOB directly into DrChrono.

Adding an EOB
Posting Multiple Transactions from a Single EOB

SUCCESS TIP:
Manual posting is slow and error-prone. If you're hand-keying EOBs for payers that offer ERA, that's a high-priority fix. Refer to the **eProvider Solutions (ePS) Payer List** to see if the payer supports ERAs (835). Contact your practice administrator to enroll in ERAs.

Adjustments & Write-Offs

Note: Write-off policies vary by practice. Check with your Practice Administrator or billing manager before writing off balances to make sure you're following your practice's guidelines.

Not every dollar you bill gets paid in full — and that's expected. Adjustments account for the difference between what was billed and what the payer allows or the patient owes. Understanding how DrChrono handles these is essential to accurate payment posting.

ANSI Group Codes

When a payer processes a claim, they return adjustment information using ANSI group codes that tell you who is responsible for any remaining balance — the provider (CO), the patient (PR), or other scenarios (OA, PI). When payments post via ERA, DrChrono applies these automatically. When posting manually, you must select the correct group code yourself, as it directly affects how the system treats the remaining balance.

What do the CO, OA, PI & PR Mean on the Payment Posting?

Moving Insurance Balance to Patient Responsibility

You can see a step-by-step walkthrough on this process **here**.

Why this matters:
The moment insurance finalizes, the patient's remaining balance is set. Prompt, accurate transfer to the patient ledger is what drives timely collections. Balances that sit unresolved past 30 days collect at significantly lower rates.

The Adjustment Master

The Adjustment Master lets you create custom rules that control how specific adjustment reason codes are handled when an ERA is received or a payment is posted manually — overriding DrChrono's default behavior where needed.

New customer setup: Most practices won't need this feature right away. Once you identify adjustment patterns to handle differently, check with your Practice Administrator before building new rules in your DrChrono account.

How to Use the Adjustment Master Screen

Discounts and Write-offs

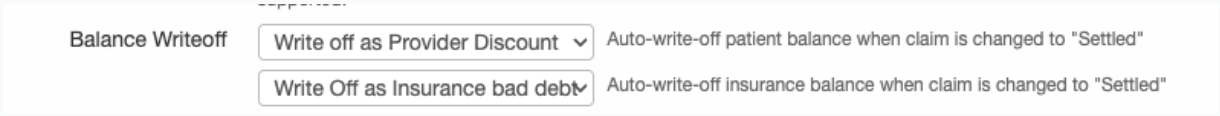
Discounts and Write-offs are applied at the charge level to zero out balances your practice has determined are uncollectible — small balances, bad debt, or charity care. Always follow your practice's write-off policy before applying.

Write-offs are irreversible. Before writing anything off, confirm:

1. the timely filing window is genuinely closed,

2. you've exhausted appeal options, and
3. it's categorized correctly — contractual adjustment vs. bad debt. Miscategorized write-offs distort your revenue picture and can hide systemic payer problems.

SUCCESS TIP:
You can automate balance write-off per provider by going to **Account Settings > Medical Billing > Balance Writeoff** and set the writeoff rules for both patient and insurance balances when the Billing Status is updated to "Settled" on the appointment.



Correcting Posting Errors

Posting errors happen — a payment applied to the wrong charge, an incorrect amount, a duplicate post. DrChrono allows you to correct most errors without voiding and restarting from scratch. Run the Unallocated Payment Report regularly to catch payments that came in but weren't properly applied — unallocated payments skew your AR and inflate open balances.

Correcting a Payment in the Patient Payments System
How to Run an Unallocated Payment Report

Month End Close

Month End Close is DrChrono's period-end workflow that freezes charges at a point in time for accurate financial reconciliation. Once a period is closed, charges within it are locked — protecting the integrity of your reporting while still allowing corrections through a controlled process.

All billing staff should understand how Month End Close affects their daily workflow, particularly what happens to charges, ERAs, and the Live Claims Feed during a frozen period.

Month End Close: An Overview
Month End Close: How to Utilize in My Account
Month End Close: Freezing Charges Each Month
Month End Close: Changes, Refunds, Takebacks or Reparsing While in the Frozen Period
Month End Close: Unposted ERAs
Month End Close: Live Claims Feed

What Happens Next

Not every claim pays on the first pass. Chapter 5 covers AR management and denials — how to work your aging

report, correct rejections, appeal denials, and recover revenue on claims that didn't resolve cleanly.

Helpful Resources

DrChrono Resources
How Do I Add an Insurance EOB to My DrChrono Account?
DrChrono Payments: Processing a Patient Payment on the Web
Auto Fill Patient Payments
Patient Payments Auto Allocation FAQ
Correcting a Payment in the Patient Payments System
How to Run an Unallocated Payment Report
Month End Close: An Overview

External Resources
CMS ERA/835 Transaction Overview
CAQH CORE ERA Operating Rules

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 5: Work AR & Resolve Denials

BILLING & CODING STAFF | AR MANAGEMENT & DENIALS | ⏰ 15-MINUTE READ

After reading this article, you'll know how to work your AR using the Aging AR report, set up Follow-up Dates to stay on top of outstanding claims, identify and correct claim rejections and denials, resubmit corrected claims, flag underpaid items, and protect your practice against timely filing limits.

Overview

Payment posting doesn't end the revenue cycle — it reveals what still needs attention. Unpaid claims, underpaid claims, denials, and rejections all require follow-up to recover revenue your practice has already earned. This chapter covers the tools and workflows that keep your AR moving and your denial rate in check.

The Aging AR Report

The Aging AR report is your primary tool for understanding what's outstanding and how long it's been sitting. Claims are bucketed by age — 0-30, 31-60, 61-90, 90+ days — so you can prioritize follow-up and identify patterns in where claims are getting stuck.

SUCCESS TIP:
Claims in the 61-90 day bucket should be your immediate priority — at 90+ days, timely filing limits become a real risk and recovery options narrow. Always follow your practice's collections policy for aged claims.

Follow-Up Dates

Follow-up Dates let you assign a date to a claim for when it needs to be worked next — essentially a built-in tickler system for your AR. Rather than relying on memory or spreadsheets to track what needs follow-up and when, DrChrono surfaces these claims for you on the date you set.

Customized Follow-up Dates: Setting Up Your Account
Customized Follow-up Dates: Utilizing Within Your Account
Running a Report by Patient Follow-Up Date

Why this matters:
An untracked claim is a forgotten claim. Every open claim needs a follow-up date — especially appeals, pending authorizations, and secondary claims. This is how you protect your timely filing window and keep aging AR from becoming written-off AR.

Claim Rejections

A rejection means the claim was turned back by the clearinghouse or payer before it was processed — it was never adjudicated. Rejections need to be corrected and resubmitted. The key is identifying the root cause quickly so the same error doesn't repeat across multiple claims.

DrChrono's intelligent rejection messaging surfaces the reason directly in the Live Claims Feed so you can act without logging into the clearinghouse separately.

Intelligent Claim Rejection Messages
Common Claim Rejections and How to Correct Them
How to Fix the Claim Filing Indicator Rejection
How to Resubmit a Corrected Claim

Rejection Analysis Report

While intelligent rejection messages help you fix individual claims, the **Rejection Analysis Report** gives you the bigger picture — showing your monthly clean claim rate, total rejections broken down by clearinghouse and payer, and the ability to drill into specific rejection reasons to identify patterns and root causes. If the same rejection keeps appearing, this report is where you'll see it clearly enough to fix it upstream.

Denials

A denial means the payer received and processed the claim but chose not to pay it. Unlike rejections, denials require you to either appeal the decision, correct and resubmit with additional information, or write off the balance depending on the denial reason.

The **Denial Analysis Report** breaks down your denials by reason code, payer, and provider — helping you identify whether a denial is a one-off or a systemic pattern that needs to be addressed upstream in your workflow.

SUCCESS TIP:
If you're seeing the same denial reason code repeatedly across multiple claims or payers, that's a workflow issue — not a one-off correction. Surface the pattern to your Billing Manager or Practice Administrator so it can be addressed at the source.

Underpaid Items

An underpaid item is a claim the payer processed but paid below your contracted rate. DrChrono's Underpaid Items tool lets you flag these claims, track them, and follow up with the payer for the difference. You'll need to set up your contracted rates first so DrChrono knows what to compare against.

What Are Underpaid Items?
Underpaid Items Report: Overview
Underpaid Items Report: Set Up
Underpaid Items Report: Running the Report

Timely Filing for Denied Claims

Staying on top of your AR aging and Follow-up Dates is your best defense against timely filing denials. For claims approaching a payer's deadline, DrChrono can generate a timely filing letter to document when the claim was originally submitted.

Timely Filing Letter
Medicare Rejection for Timely Filing

What Happens Next

With your AR worked and payments posted, the final chapter covers patient billing and reporting — generating statements, managing patient balances, and using DrChrono's key financial reports to measure your practice's revenue cycle performance.

Helpful Resources

DrChrono Resources
Aging AR Analysis Report: Overview
Customized Follow-up Dates: Setting Up Your Account
Intelligent Claim Rejection Messages
Common Claim Rejections and How to Correct Them
How to Resubmit a Corrected Claim
Denial Analysis Report
Rejection Report: Overview
Rejection Report: Detail Tab
Rejection Report: Drill In Tab
What Are Underpaid Items?
Underpaid Items Report: Overview
Timely Filing Letter

External Resources
CMS Timely Filing Guidelines
AMA Denial Management Resources

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 6: Bill & Collect from Patients

BILLING & CODING STAFF | PATIENT BILLING & COLLECTIONS | ⏰ 15-MINUTE READ

Once insurance has paid or denied, any remaining balance moves to the patient. This chapter covers generating and delivering patient statements, processing and allocating payments, applying refunds and write-offs, and correcting posting errors.

Overview

Once insurance has paid and adjustments have been applied, any remaining balance becomes the patient's responsibility. This chapter covers the patient-facing side of the billing cycle — collecting payments, generating statements, and managing patient balances through to resolution.

New Customer Setup: DrChrono Payments requires account setup before your team can process payments. If you do not already have DrChrono Payments set up, contact your Practice Administrator and provide these instructions **here**.

Patient Balance Ledger

The **Patient Balance Ledger** gives you a complete view of a patient's financial history — every charge, payment, adjustment, and balance across all their visits in a single screen. It's the fastest way to answer a patient's question about what they owe and why.

Patient Statements

Patient statements are how your practice communicates outstanding balances to patients after insurance has processed. DrChrono lets you generate statements individually or in bulk, include custom notes, and deliver them using our Enhanced Patient Statement Delivery feature via text message, email, and physical mail.

> **Why this matters:**
> Statements sent within 2–3 weeks of claim resolution collect at much higher rates than those sent at 30+ days.

More Patient Statements Resources:
Creating and Managing Patient Statements
How to Generate a Statement with the Responsible Party Information
Patient Statement Payments

Collecting Patient Payments

After statements go out, patients have three ways to pay their balance:

1. **Using the statement link sent via text, or the QR code on the mailed statement (more information about this feature here)**
2. **Using either the OnPatient portal**
3. **Call the phone number on the statement to pay by phone.**

Payments Made Online or via Text

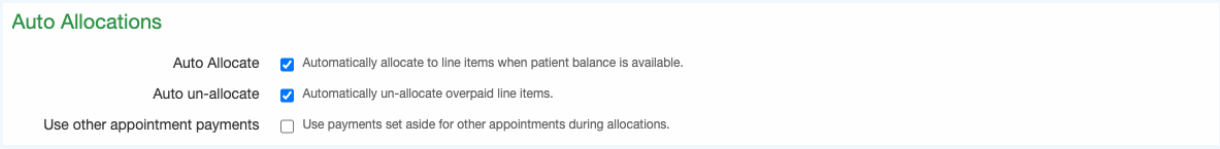
Patients who pay through OnPatient or via a text payment link are processed through DrChrono Payments — the payment is captured and flows into the Patient Payments screen for posting.

When a patient pays their balance online, the payment is automatically applied to the appointment on that statement but not down to the individual line items— at least not by default.

If you want these payments to apply to line items automatically, you'll need to enable the Auto Allocate feature. With Auto Allocate, payments can be applied to line items at the time the payment is recorded (it won't apply to line items created later).
A couple quick notes:

- If a payment is tied to a specific appointment, it will only allocate to line items within that same appointment.
- You can confirm what happened in Billing → Patient Payments by checking Allocated vs Unallocated.

> **Auto Allocate** preferences are set per provider under **Account Settings > Patient Payments > Auto Allocate**. If you don't see this section, work with your Billing Manager or Practice Administrator to contact DrChrono Support to have it enabled.



Payments Made Over the Phone

When a patient calls the office to pay their balance, you'll collect the payment information manually and post it directly to their account.

Managing Payment Allocation

After a patient makes a payment, it is automatically applied to the appointment on the statement but not down to individual line items— at least not by default. You can apply payments to line items manually or you can automate allocation using our **Auto Allocate** feature.

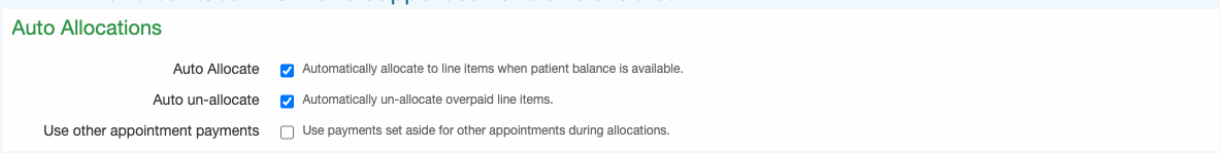
Manual Payment Allocation

A walkthrough on how to apply unallocated payments to line items can be found **here**.

Automate Payment Allocation

If you want these payments to apply to line items automatically, you'll need to enable the Auto Allocate feature. With Auto Allocate, payments can be applied to existing line items at the time the payment is recorded. Automating this process

> **Auto Allocate** preferences are set per provider under **Account Settings > Patient Payments > Auto Allocate**. If you don't see this section, consult with your Billing Manager or Practice Administrator and contact DrChrono Support to have this enabled.



Running an Unallocated Payments Report

In Patient Payments, you can run a report to show all **Unallocated Payments**. Keeping this clear is essential to accurate AR and financial reporting.

Correcting Posting Errors and Applying Refunds or Discounts

Mistakes happen and circumstances change — a payment posted to the wrong account, a patient who overpaid, or a balance that needs a courtesy discount applied. This section covers how to handle corrections, voids, refunds, and patient discounts in DrChrono without compromising your payment history or financial reporting.

Helpful Resources:
Correcting a Payment
Applying Discounts
Voiding and Refunding Payments

What Happens Next

With patient balances billed, collected and properly allocated, the final chapter covers reporting — the key financial and operational reports that give you visibility into your practice's revenue cycle performance.

Helpful Resources

DrChrono Payments: Processing a Patient Payment on the Web
Auto Fill Patient Payments
DrChrono Payments: Setting Up on OnPatient
Correcting a Payment in the Patient Payments System
Creating and Managing Patient Statements
Enhanced Patient Statement Delivery
How to Include Notes on Your Patient Statements
Patient Balance Ledger
Good Faith Estimate Tool Overview
How Do I Bill for a No-Show Appointment

Still Need Help?
Chat with Amelia by clicking Help at the bottom of your screen in your DrChrono account — available 24/7.

Chapter 7: Measure & Manage Financial Performance

BILLING & CODING STAFF | REPORTING & ANALYTICS | ⏰ 30-MINUTE READ

Before You Begin

PERMISSIONS REQUIRED:
You will need the **Billing Administrator, Billing Intelligence** and **Practice Intelligence** permissions enabled to view Reports.

Overview

Effective billing management isn't about running every report available— it's about knowing which reports to pull, how often, and what to do with what you find. This page outlines the core reporting workflow for a billing manager, organized by cadence.

Daily

Financial Transactions Report, also referred to as a Day Sheet, this is your go-to daily report. Review the Summary tab for charges posted, payments received, and adjustments applied. If payments received drop significantly without a corresponding drop in charges, something upstream needs attention.

Weekly

Aging AR Analysis Report buckets outstanding claims by age (0-30, 31-60, 61-90, 90+ days) so you can prioritize follow-up on anything approaching the 61-90 day range before timely filing becomes a risk. A growing 90+ bucket is the clearest signal that something in your workflow needs to change.

> **Why this matters:**
> If your AR over 90 days exceeds 15–20% of total AR, you have an active collection problem. Run this weekly. By the time it shows up in a monthly review, the window to recover those claims may already be closing.

Rejection Analysis Report helps you monitor your clean claim rate week over week. Rejections stopped by the clearinghouse or payer before adjudication are fully recoverable, but only if they're caught and corrected quickly. A declining clean claim rate almost always points to a systemic upstream issue in charge entry or coding.

Unallocated Patient Payment Report identifies payments received but not applied to a charge. Run this weekly without fail. Payments that came in but weren't properly applied inflate your AR and distort your collection rate. Catching them weekly keeps the problem manageable.

Monthly

Collections Analysis Report measures what you've collected against what was billed. Your collection rate is one of the most telling indicators of revenue cycle health — track it month over month and investigate any sustained downward trend.

Denial Analysis Report should be ran monthly to identify whether denials are isolated or patterned by payer, reason code, or provider. Patterns warrant upstream fixes — a denial you're correcting repeatedly is a workflow problem, not a one-off error.

Why this matters:
High denial rates from a single payer almost always have a fixable root cause — usually related to credentialing, configuration, or a workflow. Look for patterns across denials, not just one claim at a time. One systemic fix can recover thousands in future revenue.

Charge Lag Report measures the time between date of service and charge entry. Rising charge lag means revenue is sitting unbilled — and the longer it sits, the greater the timely filing risk. Use this monthly to identify which providers or locations are falling behind on documentation.

Why this matters:
Every day between service and charge entry is a day you're not billing. Most payers start the timely filing clock on the date of service, not the date you submit. Charge lag is invisible until it becomes a denial — it is best practice to check this report regularly.

Reimbursement Analysis Report compares what payers actually paid against contracted rates. Run this monthly to catch underpaying payers before the gap compounds. Feed findings into your Underpaid Items follow-up queue.

Underpaid Items Report works alongside the Reimbursement Analysis report to surface individual claims paid below contracted rates for follow-up with the payer. Requires fee schedules to be configured with contracted rates.

NOTE: This report requires your fee schedules to be configured with Allowed Reimbursement (contracted) rates before it can surface results. See the setup guide to get started. If you have a CSV of your fee schedule, you can also submit a support case to have our team upload it to avoid manual entry. Just note that if replacing an existing fee schedule, that fee schedule will be removed first.

As Needed

Insurance Submission Report confirm claims went out and identify any stuck before transmission.

Patient Balance Ledger allows you to investigate a specific patient account or respond to a patient balance inquiry.

Payment Waterfall Report helps you understand how a specific claim resolved across primary, secondary, and patient responsibility.

Billing Log Report provides an audit trail for billing activity and claim edits.

🛤 You're Ready to Keep Revenue Moving!

Congratulations! You've completed the Billing & Coding learning path.

You now understand the core billing and coding workflows within DrChrono and are prepared to help your practice submit cleaner claims, resolve issues efficiently, and support a healthy revenue cycle.

As you gain experience, you'll continue discovering features that can help improve accuracy and efficiency throughout the billing process.

What's next?

- Begin working through your practice's daily billing workflows.
- **Take advantage of our AI-powered Chat Assistant**, available 24/7, whenever you have a question. Whether you're looking for everyday best practices, step-by-step guidance, or help finding a feature, it's a fast and easy way to get answers on the spot.
- Bookmark the Knowledge Base as a reference for billing, coding, and claims workflows.
- Collaborate with your Practice Manager, Billing Manager, Providers and Clinical Staff to keep your revenue cycle running smoothly.

Your work plays a vital role in your practice's success.

Helpful Resources

Billing Reporting Learning Center

HFMA Revenue Cycle Metrics & Benchmarks
MGMA Data & Benchmarking