

# Specific Revenue Cycle Management Checklist



## DAILY RCM CHECKLIST — O&P SPECIFIC

### Patient Intake & Documentation

- Confirm patient demographics (full legal name, suffix, permanent address, phone, email).
- Collect patient ID and insurance card copies (front/back).
- Verify Medicare Beneficiary Identifier (MBI) when applicable.
- For minors: obtain guarantor demographics and ID.

### Physician Documentation (*O&P Required Detail*)

- Ensure documentation supports the O&P device prescribed:
- Orthotics: ROM, strength testing, instability findings, conservative treatment tried, fall risk if applicable.
- Prosthetics: Amputation level, K level documentation, current functional capabilities, mobility goals, component justification.
- Confirm that SWO/Order includes all required elements.
- Ensure chart notes support the HCPCS codes being billed (LCD-driven requirements).

### Insurance Verification

- Confirm coverage for O&P benefits (orthotics vs prosthetics vs DME).
- Same/Similar check (especially for Medicare L Codes).
- Review:
  - Deductible, co-pay, co-insurance
  - Prior authorization requirements
  - OTS vs custom-fit vs custom-fabricated coverage
- Verify the correct claims address and payer ID.

### Prior Authorization Management

- Submit auth requests with all required items:
  - Clinical notes
  - Justification
  - Codes & units
  - Pricing
  - Photos/measurements if required
- Follow up on pending auths; log expiry dates.

### Fabrication Documentation

- Ensure scanned/attached documents are complete:
  - Measurements
  - Casts/scans
  - Fabrication work orders
  - Component selections
- Confirm delivery timeline aligns with medical necessity and authorization.

### Charge Capture & Delivery

- Confirm all deliveries are charged the same day.
- Upload:
  - Proof of Delivery (POD)
  - Delivery ticket with serial numbers (prosthetics)
  - Component invoices (if required by payer)
  - Patient instructions documentation
- Verify that codes reflect OTS, custom-fit, or custom-fabricated status accurately.

### Billing & Claims Processing

- Resolve daily clearinghouse rejections.
- Confirm:
  - RT/LT modifiers
  - Units match documentation
  - Medical necessity supported
  - K-level is correct for prosthetics
- Apply appropriate modifiers (NU, RR, MS, QE/QF/QG for orthotics if applicable).
- Double check NCCI/MUE edits before submitting the claim.

### Payments & AR

- Post daily payments from EOBs/ERAs.
- Reconcile deposits.
- Work high-priority denials (Same/Similar, invalid modifiers, incorrect place of service, invalid prescriber/PECOS).

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## WEEKLY RCM CHECKLIST — O&P SPECIFIC

### Intake & Clinical Documentation Audit

- Review 10–20 random patient files for:
  - Full chart note justification
  - Correct HCPCS alignment with documentation
  - OTS vs custom-fit vs custom-fabricated accuracy
  - Proof of Delivery completeness
  - K-level or orthotic clinical metrics present

### Insurance & Authorization Review

- Check expiring authorizations.
- Review outstanding auth requests not yet approved.
- Validate payer-specific documentation requirements.

### Coding & Compliance Review

- Spot-check coding for:
  - Proper RT/LT usage
  - Component-level billing accuracy for prosthetics
  - Proper use of miscellaneous (“99”) codes with Supplier Retail Price
  - PDAC required codes billed correctly (e.g., AFOs, spinal braces)
- Validate MUE quantities for O&P supply items.

### Claims & AR

- Run denial reports and work:
  - Same/Similar denials
  - Missing documentation denials
  - Bundling denials for orthotic add-on codes
- Check claims close to timely filing limits.

### Payment Variance Analysis

- Review underpayments for:
  - Incorrect payer allowable
  - Contract vs billed vs U&C misalignment
- Flag reimbursements under contracted U&C rates.

### Fabrication & Delivery Workflow Review

- Confirm fabrication timelines are aligned with auth dates.
- Ensure delivery tickets match billed codes.

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## MONTHLY RCM CHECKLIST — O&P SPECIFIC

### Month-End Financial Review

- Track O&P-specific KPIs:
  - Clean claim rate
  - Denial rate (with categories such as Same/Similar, documentation missing, modifier errors)
  - Days in AR
  - AR > 90 days by payer
  - Write-offs and reversals
  - Net collection rate (O&P-specific target: 94–98%)

### Payer Contract & Reimbursement Review

- Compare actual reimbursements to contracted and Medicare allowables.
- Identify payers reimbursing incorrectly for:
  - Custom-fabricated vs OTS codes
  - Prosthetic component levels
  - WC state fee schedule discrepancies
- Review reimbursement for miscellaneous codes (L2999, L3999, etc.).

### Compliance & Accreditation

- Confirm:
  - NPI/PTAN accuracy by location (Box 32/33).
  - DMEPOS accreditation updates for each site.
  - Licenses and Surety Bonds are active.
  - PDAC requirements met for spinal and AFO/KAFO products.

### Documentation & Quality Audit

- Conduct a monthly review of 10–15 O&P claims to assess:
  - Correct HCPCS coding and modifiers
  - Chart notes meet LCD requirements
  - Fabrication documentation complete
  - Proof of Delivery compliant
  - Correct use of K-levels & foot/ankle component codes
  - Accurate referral/PECOS validation

### Operational & Training Updates

- Address recurring issues (patient intake errors, documentation gaps).
- Provide training on new O&P Medicare LCD changes.
- Update internal SOPs as payer rules evolve.

### Strategic Planning

- Identify root causes of repeated denials.
- Evaluate caseload distribution and RCM staffing.
- Prioritize high-impact process improvements (Same/Similar workflows, documentation templates, etc.).