

Reduce Urology Accounts Receivable: The 90-Day Checklist

A practical, step-by-step sequence for bringing down aged A/R in a urology practice.

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Process steps only. No performance percentages, no benchmark figures, no invented industry averages — brand rules per `CLAUDE.md` rule 5. No PHI, no client names, no competitor names, no guarantees.

Phase 1 — Days 1–15: Inventory and triage the aging A/R

Start from a clean, claim-level picture of what is actually owed before touching anything.

- ☐ Pull a full A/R aging report by individual claim, not by summary bucket — segmented 0–30 / 31–60 / 61–90 / 91–120 / 120+.
 - ☐ Separate insurance A/R from patient A/R.
 - ☐ Separate true denials from claims that are simply unworked and sitting as "pending."
 - ☐ Strip out anything already paid, adjusted, or written off so the number reflects only what is still recoverable.
 - ☐ Flag any claim approaching a payer's timely-filing or appeal deadline and pull it forward regardless of its age bucket — those expire on a clock, not on priority.
 - ☐ Assign a named owner and a target close date to every claim over 90 days old.
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Phase 2 — Days 16–30: Diagnose payer mix and denial patterns

Find out why the money is stuck before working claims one at a time.

- ☐ Run a denial report by CARC/RARC code and by payer for the trailing 12 months.
- ☐ Rank denial reasons by dollar volume, not claim count.
- ☐ Cross-reference denial reasons against payer mix — which payers make up the bulk of the aged A/R, and does each deny for different reasons?
- ☐ Sort the top recurring, fixable urology denial reasons into one of three buckets: front-end (eligibility/authorization), coding, or payer processing.

- ☐ Record a baseline: total aged A/R dollars, count of claims over 90 days, and denial counts by category, so the plan has something to measure against on day 90.
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Phase 3 — Days 31–60: Work the oldest recoverable claims first

This is the bulk of the recovery work. Sequence matters more than volume.

- ☐ Work claims closest to a timely-filing or appeal deadline first, regardless of dollar amount.
 - ☐ Within that, sequence by dollar value — highest-dollar recoverable claims at a given age before smaller ones of the same age.
 - ☐ For each claim: confirm the original clean-claim submission, pull the EOB/ERA and denial code, correct the specific defect, and resubmit or appeal with the documentation that payer specifically requires.
 - ☐ Route genuine write-offs (timely filing already missed, provider not enrolled with that payer at time of service, no other coverage) to a separate write-off review — don't let them sit as "still working" A/R.
 - ☐ Check claim status before any resubmission. A second copy of a claim the payer is still processing denies as CARC 18, "Exact duplicate claim/service."
 - ☐ Track every reworked claim to a final outcome: paid, appealed again, or written off.
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Phase 4 — Days 61–75: Close the urology-specific coding and authorization gaps

Fix the upstream defects Phase 2 identified so the same denials stop generating new A/R.

- ☐ Build a payer-specific prior-authorization matrix for the procedures that generate urology's highest-dollar denials — robotic/laparoscopic prostatectomy, HoLEP, UroLift, Rezum, sacral neuromodulation (trial and permanent implant stage), ESWL.
- ☐ Confirm authorization is obtained and logged before the date of service for every procedure on that matrix.
- ☐ Audit E/M visits billed during a procedure's 10- or 90-day global period; confirm modifiers 24, 25, 57, or 79 are applied correctly and documented.
- ☐ Check NDC numbers, administered units, and wastage documentation on claims for testosterone, Lupron, Eligard, and other in-office injectables.
- ☐ Confirm claims for elevated PSA, hematuria, and BPH carry the specific ICD-10 code a payer's coverage policy requires, rather than a default unspecified code.
- ☐ Check that in-office lab and reflex urinalysis billing carries the correct distinct-service modifier when billed alongside an E/M visit or procedure the same day.

- ☐ Confirm laterality on bilateral and one-sided procedures (ureteroscopy, stent placement): modifier 50 on one line or RT/LT on two, per each payer's convention.
 - ☐ Hold procedure claims until the operative note is signed and attached.
 - ☐ Feed every fix back into the practice's coding and documentation templates.
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Phase 5 — Days 76–90: Front-desk and eligibility changes that stop new A/R from forming

The recovery work is wasted if the same gaps keep creating new aged A/R behind it.

- ☐ Verify eligibility in real time at scheduling and again at check-in.
 - ☐ Capture and confirm secondary/supplemental coverage for Medicare patients at intake.
 - ☐ Move prior-authorization capture to the scheduling step for any procedure on the Phase 4 matrix; hold scheduling until the authorization number is on file.
 - ☐ Flag self-pay and high-deductible patients at registration for a cost estimate and a collection attempt before the visit.
 - ☐ Put a standing weekly aging review in place, using the same report built in Phase 1, so claims entering the 61–90 day bucket get worked before they become the next round of 90-day-old A/R.
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Where this leaves you at day 90: the old backlog triaged and worked in dollar-and-deadline order, the specific urology coding and authorization defects that were creating denials fixed at the source, and a front-desk process that keeps new claims from aging into the same backlog again. This is a working sequence, not a guarantee of any specific dollar recovery or timeline.