

# ■ Charge Capture Checklist

Use this checklist every time a patient visit or service happens — so nothing gets missed and no money is left behind.

## ■ What Is Charge Capture and Why Does It Matter?

Charge capture is the process of recording every service, procedure, or supply used during a patient visit so it can be billed correctly. If a charge is not captured, the clinic loses money it earned. If a charge is captured wrong, it may cause a claim denial or even a compliance problem. This checklist helps your team catch every charge — the right way, every time.

### 1 · Before the Visit Starts

- **Confirm patient appointment is in the schedule**  
*Check the schedule the day before. Make sure the visit type (new patient, follow-up, procedure, etc.) is correct.*
- **Verify the correct provider is assigned**  
*The provider who sees the patient must match the provider on the claim. Double-check this in your system.*
- **Pull up the patient's insurance information**  
*Confirm the insurance is active and the patient has a valid member ID. Old or wrong insurance = denied claim.*
- **Check if a referral or prior authorization is required**  
*Some insurances require a referral number or prior auth before the visit. Get this before the patient arrives.*
- **Review any outstanding charges from prior visits**  
*Close any open encounters or unsigned charges from previous visits before the new visit starts.*

### 2 · During the Visit

- **Document every service performed in the chart**  
*Write down everything done during the visit — exams, tests, injections, counseling, etc. If it is not documented, it cannot be billed.*
- **Assign the correct CPT codes**  
*CPT codes describe the service. Use the most specific code that matches what was actually done. Do not guess or use a similar code.*

- **Assign the correct diagnosis (ICD-10) codes**  
*The diagnosis must explain why the service was needed. Match the diagnosis to the service — they must link together logically.*
- **Capture all supplies and medications given**  
*Any drug, vaccine, or supply used during the visit should be recorded with the correct HCPCS or CPT supply code.*
- **Document the time if billing by time (E&M; visits)**  
*For Evaluation & Management (E&M;) visits billed by time, the total time spent must be clearly documented in the chart.*
- **Record any procedures done in addition to the office visit**  
*If the provider did a procedure on the same day as an office visit, capture both — but check modifier rules to avoid bundling issues.*

■ **TIP: Always link at least one ICD-10 code to every CPT code. If the diagnosis does not support the service, the claim will be denied.**

### 3 · After the Visit — Closing the Encounter

- **Provider signs and locks the clinical note**  
*The note must be signed before the charge is submitted. An unsigned note = unbillable charge.*
- **Review the charge sheet or superbill for completeness**  
*Make sure every service has a matching CPT code. Nothing should be blank or marked 'TBD.'*
- **Check that all modifiers are applied correctly**  
*Modifiers change how a code is interpreted. For example: Modifier 25 (separate E&M; on procedure day), Modifier 59 (distinct procedure). Apply only when truly needed.*
- **Enter charges into the billing system within 24–48 hours**  
*Delays in charge entry lead to late claims. Most payers require claims within 90–365 days of service — but faster is always better.*
- **Run a charge reconciliation report**  
*At the end of each day, compare the number of patients seen to the number of charges entered. Any difference needs to be investigated.*
- **Flag any missing or incomplete charges for follow-up**  
*If a charge cannot be completed right away, document why and assign it to the right person for follow-up.*

### 4 · Common Mistakes to Avoid

| ■ Mistake                                                 | ■ What to Do Instead                                                                   |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------|
| Billing a higher code than what was documented (upcoding) | Bill only what is documented. When in doubt, bill lower.                               |
| Forgetting to capture same-day procedures                 | Always review the full visit note before closing the encounter.                        |
| Using outdated CPT or ICD-10 codes                        | Update your code sets every October 1 (ICD-10) and January 1 (CPT).                    |
| Missing modifiers on bundled services                     | Use a billing software that flags potential bundling issues automatically.             |
| Not capturing facility vs. professional fees separately   | Know whether you are in a facility or non-facility setting — it affects reimbursement. |

## 5 · Daily Sign-Off

|                  |       |                        |       |
|------------------|-------|------------------------|-------|
| Date of Service: | _____ | Total Patients Seen:   | _____ |
| Reviewed By:     | _____ | Total Charges Entered: | _____ |
| Provider Name:   | _____ | Discrepancies Found:   | _____ |
| Supervisor:      | _____ | Resolved By:           | _____ |

■ **TIP: Save a completed copy of this checklist every day for audit purposes. Keep records for at least 7 years.**