# Billing company switch checklist

To switch medical billing companies without losing claims, read your contract's notice and exit terms first, confirm who owns the clearinghouse account, EDI credentials and payer logins, run the old and new processes in parallel until the claim-level reconciliation matches, cut over by date of service, and decide in writing who works the old A/R.

Tick each line when it is done. Your contract and each payer's own rules decide the details, so read them alongside this list.

PRACTICE _____ CHECKLIST OWNER _____ CUT-OFF DATE OF SERVICE _____

## 01 Before you decide

One bad month is a conversation. A pattern with no owner is a decision.

- [ ] Days in A/R, denial rate, over-90 share and unworked denials are pulled with published formulas before any meeting.
  Net days in A/R and the remittance denial rate as HFMA's MAP Keys define them.
- [ ] Front-end problems the switch cannot fix are named and assigned at the same time.
  Charges captured late, eligibility not checked at scheduling, notes that do not support the codes.

## 02 Read the current contract

The contract decides your timeline. Read it before anyone at the company hears the word switch.

- [ ] The term, renewal date, notice period and termination fees are read, including any runout or data export fee.
- [ ] Claims in flight have a named owner, a fee and an end date in writing.
- [ ] You know whether the fee percentage keeps applying to collections that arrive after the end date.
- [ ] The handback list is known: open claims, denial log, payer notes and fee schedules.
- [ ] The business associate agreement has termination and return-or-destroy clauses.
- [ ] The signed agreement with the billing agent that Medicare requires is located or requested.

## 03 Confirm what is yours

You own the enrollment, the EDI access, the payments and the records.

- [ ] The clearinghouse account, EDI credentials and payer portal logins are confirmed to be in your name.
- [ ] Every system and login the old company uses on your behalf is listed. Anything in their name moves to yours.
- [ ] ERA and EFT routing is mapped payer by payer, and every payer pays into your own bank account.
- [ ] Aging, open denials, recent remittances, fee schedules and payer notes are exported while you still have access.

## 04 Decide, then give notice

Give notice only after the new company has signed its BAA and you know who works the old A/R.

- [ ] Who works the old A/R is decided in writing: the old company for a runout fee, the new company as a project, or your staff.
- [ ] The new company's BAA is signed and the access list agreed before notice goes out.
- [ ] Notice goes in the form the contract requires, with the end date, the handback list, the cut-off date of service and who works claims in flight. Nothing with PHI is attached.
- [ ] The MAC is told in writing, before the effective date, that the billing agent is changing, and its EDI help desk confirms which forms it wants.
- [ ] Each commercial payer's and Medicaid MCO's rules for a change of billing company are checked, and ERA and EFT enrollments routed to the old company are moved.
- [ ] If your Medicare enrollment record names the old company as your billing agency, the enrollment is updated.

## 05 The parallel run

The current process keeps billing while the new biller works the same charges, claims and remittances alongside it.

- [ ] Nobody stops billing on a handover day. The current process keeps going until the new one is proven.
- [ ] Charges, claims, acknowledgements, posting and denials are reconciled line by line, and go-live waits for a match.
  - [ ] **Charges.** Encounters in the schedule against charges entered.
  - [ ] **Claims out.** Claims created against the clearinghouse's accepted count.
  - [ ] **Acknowledgements.** Clearinghouse and payer acknowledgements against claims sent.
  - [ ] **Posting.** 835 totals against payments posted and bank deposits.
  - [ ] **Adjustments.** CARC and RARC pairs against the adjustment codes posted.
  - [ ] **Denials.** Denied lines against the denial log.
  - [ ] **Patient balances.** Statements sent against balances due.
- [ ] Every difference has a cause before go-live: either the old process was right and the new biller copies it, or it was leaking and the claim shows it.
- [ ] Timely filing limits are watched for every payer. The clocks do not pause for a switch.

## 06 Cut-over day

The cut-off by date of service is the rule that stops arguments.

- [ ] The cut-off is a date of service written into both agreements.
- [ ] The queue is handed over at the cut-off. Claims before it follow the old A/R plan you chose.
- [ ] The old company's users are removed from the PM system, EHR and clearinghouse, and the removals are logged.
- [ ] Any shared password is changed, active submitter IDs are confirmed with the clearinghouse and the MAC, and each payer portal's administrator is confirmed.
- [ ] The old clearinghouse account stays open only until the last 835s for claims in flight arrive.

## 07 After go-live

Judge the switch on these, not on the demo.

- [ ] The first report has every open claim with an owner and the old A/R on its own line.
- [ ] A report arrives on a fixed day every week.
- [ ] The numbers pulled before the switch are measured again with the same formulas, with the count of denials that have no next action date.
- [ ] A review meeting is on the calendar before go-live, with the denial log and the aging on the table.

### Where the rules come from

CMS Medicare Claims Processing Manual, Chapter 24 (billing agent agreements, EDI and ERA enrollment, telling the MAC). 45 CFR 164.504 (business associate contracts) and 164.308 (ending access). 42 CFR 424.73 and 424.80 (payment to billing agents), 424.516 (enrollment changes and records), 424.44 and 447.45 (filing and payment limits). HFMA MAP Keys and AAFP benchmarks (the numbers).

### The full guide

Each step, the rule behind it and its source:
remitwright.com/guides/how-to-switch-medical-billing-companies/

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