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Find the pattern.

The Office Ally
Self Audit Checklist

Fifty checks you can run on your own account in about thirty minutes.

Billing problems are rarely where people think they are. A denial that looks like a coding issue is often a setup issue three screens away, and a claim that keeps bouncing is usually one setting doing exactly what somebody told it to do two years ago.

This is the same pass I make when I audit an account, written so you can run it yourself. Nothing here needs me. Sit down with whoever knows the system best, work through the fifty checks, and answer honestly. Not sure is a real answer and it counts, because a setting nobody can vouch for is a setting nobody is watching.

You are not looking for a perfect score. You are looking for the pattern. When four of your no answers all sit in the same group, that group is where your money is going.

> **How to use it**
>
> Print it, or fill it in on screen. Work top to bottom, because the early groups feed the later ones. Tally your no and not sure answers at the end, then read the short scoring note. It will tell you whether you have a list of small fixes or one setting causing most of it.

WHAT IS IN IT

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This checklist is written to be useful whatever practice management system you run. The language matches how Office Ally users describe their work, because that is who asks me most often.

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GROUP 1

Practice and provider setup

Almost nothing downstream works if the identity of the practice and the provider is wrong at the top.

CHECK	YES	NO	NOT SURE
01 Your practice name, address, and tax ID in the system match exactly what your payers have on file.	☐	☐	☐
02 Every rendering provider has a current NPI recorded, with a taxonomy that matches how they are credentialed.	☐	☐	☐
03 The billing NPI and the rendering NPI are correct for the way you actually bill, group or individual.	☐	☐	☐
04 Every location you see patients in exists in the system, with the right address and the right place of service.	☐	☐	☐
05 A provider who has left is deactivated rather than deleted, so old claims and old payments still reconcile.	☐	☐	☐

GROUP 2

Payers and enrollments

A payer ID typed into a field is not the same thing as an enrollment. This is where quiet failures live.

CHECK	YES	NO	NOT SURE
06 Every payer you bill electronically has a completed enrollment, not only a payer ID entered.	☐	☐	☐
07 Electronic remittance is enrolled for every payer that offers it, not only your largest one.	☐	☐	☐
08 You can name which payers you are still handling on paper, and why.	☐	☐	☐
09 Duplicate payer entries have been merged or retired, so claims do not split across two versions of the same payer.	☐	☐	☐
10 Secondary and supplemental payers are set up to actually receive a claim, not recorded as a note on the account.	☐	☐	☐

GROUP 3

Codes, fees, and claim defaults

A default is a decision someone made once and nobody has looked at since. It rides along on every claim.

CHECK	YES	NO	NOT SURE
11 Your CPT list contains only the codes your providers bill, with retired codes removed.	☐	☐	☐
12 Your fee schedule reflects what you charge now, not what you charged last year.	☐	☐	☐
13 Your diagnosis code list is current for the code set year in use.	☐	☐	☐
14 The modifiers on your list are ones your payers accept, and nobody on the team is guessing at them.	☐	☐	☐

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CHECK	YES	NO	NOT SURE
15 No claim template carries a default that is not always true, such as a place of service or a referring provider.	☐	☐	☐
16 A test claim built from your defaults would go out clean without a single manual correction.	☐	☐	☐

GROUP 4

The front desk

Most denials are created at check in, weeks before anyone in billing sees them. This is the highest value group on the list.

CHECK	YES	NO	NOT SURE
17 Insurance cards are captured front and back at every visit, not only at the first one.	☐	☐	☐
18 When the subscriber and the patient are different people, they are entered as different people.	☐	☐	☐
19 The patient name in your system matches the name on the card exactly, including a middle initial or a compound surname.	☐	☐	☐
20 Date of birth and member ID are verified against the card, not typed from memory or carried over from last year.	☐	☐	☐
21 Secondary coverage is asked about at every registration, not only when the patient volunteers it.	☐	☐	☐
22 The person at the front desk knows which fields will bounce a claim if they are wrong.	☐	☐	☐

GROUP 5

Eligibility and benefits

An electronic check tells you less than people assume. Knowing its limits is the skill.

CHECK	YES	NO	NOT SURE
23 Eligibility is checked before the visit, not after the claim rejects.	☐	☐	☐
24 Someone reads what comes back, including plan effective dates, not only the word active.	☐	☐	☐
25 You know what your electronic check does not tell you, and when to pick up the phone instead.	☐	☐	☐
26 A failed eligibility check gets worked the same day rather than sitting in a queue.	☐	☐	☐

GROUP 6

Claims going out

A claim that was never sent does not show up anywhere as a problem. It just quietly ages.

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CHECK	YES	NO	NOT SURE
27 Claims are submitted on a set schedule that one person owns, not when someone remembers.	☐	☐	☐
28 The submission report is read every time, not only when something already feels wrong.	☐	☐	☐
29 You can name the timely filing deadline for your three largest payers.	☐	☐	☐
30 Nothing is sitting in a ready to send state that nobody has actually sent.	☐	☐	☐
31 You can tell within one screen how many claims went out last week and how many are still waiting.	☐	☐	☐

GROUP 7

Rejections and denials

These are two different animals in two different places, and treating them as one is the most common mistake I see.

CHECK	YES	NO	NOT SURE
32 You know the difference between a rejection at the clearinghouse and a denial from the payer.	☐	☐	☐
33 Rejections are worked daily, because a rejection means the payer never received the claim at all.	☐	☐	☐
34 Denials are categorized by reason, so you can see which reason keeps repeating.	☐	☐	☐
35 The same denial reason every week is treated as a setting to fix, not a claim to refile.	☐	☐	☐
36 You have a written appeal path for your top three denial reasons, so it does not live only in one head.	☐	☐	☐

GROUP 8

Payments and posting

This is where an error stops looking like a billing problem and starts looking like an accounting problem.

CHECK	YES	NO	NOT SURE
37 Remittances are posted line by line against the charge, not as a lump sum against the account.	☐	☐	☐
38 Autoposting is reviewed rather than trusted, and a person reads what it did.	☐	☐	☐
39 Patient responsibility is posted as what the payer said it was, not as what you expected it to be.	☐	☐	☐
40 Adjustments and write offs use the correct reason, so your reports still mean something.	☐	☐	☐
41 Unapplied payments and credit balances are reviewed monthly, not discovered at year end.	☐	☐	☐
42 A claim that crossed over to a secondary is tracked, so it is not billed twice and not forgotten.	☐	☐	☐

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GROUP 9

Reports and reconciliation

A report nobody reads is the same as a report nobody runs.

CHECK	YES	NO	NOT SURE
43 Someone runs an aging report at least monthly, and reads it.	☐	☐	☐
44 You can see accounts receivable broken out by payer, not only as one total.	☐	☐	☐
45 Your deposits reconcile to your posted payments every month.	☐	☐	☐
46 Anything over ninety days has been looked at in the last thirty days.	☐	☐	☐

GROUP 10

People and permissions

A system is only as good as what happens when the person who knows it is out for two weeks.

CHECK	YES	NO	NOT SURE
47 Every user has their own login and nobody shares one.	☐	☐	☐
48 Permissions match the role, so the person posting payments is not also adjusting them off unreviewed.	☐	☐	☐
49 The person who owns each task knows that they own it.	☐	☐	☐
50 If your biller were out for two weeks, somebody else could run the claims.	☐	☐	☐

NOW READ THE PATTERN

What your answers mean

Count every no and every not sure together. Not sure counts, because an unverified setting behaves exactly like a wrong one until somebody checks it.

0 to 5	**Your account is in good shape.** Fix them this week and move on. Put a note in your calendar to run this again in six months, because systems drift when staff change.
6 to 15	**This is normal, and it is usually smaller than it looks.** Group your answers. There is very often one setting underneath four or five of them, and correcting that one thing clears the rest.
16 or more	**Your system is working against the people using it.** This is almost never about the person doing the work. Start with the front desk group and the payments group, in that order, because that is where the money moves.

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Write down your three

Before you close this, pick the three answers that made you wince. Those are the ones to work first, and naming them is most of the job.

NEXT

If you want a second pair of eyes

Most of this list you can fix yourself, and you should. If you get to a check you cannot answer, or you find the same denial reason showing up week after week and you cannot see why, that is the point where an outside look is worth an hour.

In a sixty minute session we start with whatever made you book the call. You share your screen and you stay at the keyboard, so you are driving your own software while I show you the fix and you learn it well enough to do it again next week without me. Then we go find why it kept happening, and then I make a pass through the rest of the account. You leave with a recording and a written list of what I found in priority order.

If the task belongs to one specific person at your clinic, bring them to the call and I will train them on it directly.

> **Where to start**
>
> **Book the 60 minute session**
> https://link.tekmatix.com/widget/bookings/officeally60marie
>
> **Bring one short question to the free 15 minute Q and A**
> https://link.tekmatix.com/widget/bookings/15marieqa
>
> **More free forms and resources, including the fillable superbill and CMS 1500**
> https://mariematteson.com/resources
>
> **Office Ally User Tips, free video walkthroughs**
> https://www.youtube.com/playlist?list=PLKy3v1MYIfrena2qTaydfTilPkTcZ2cmD
>
> **Office Ally consulting and training**
> https://mariematteson.com/officeally

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AND IF GROUP FOUR LANDED

The course this came out of

Group four is the one most people skim, and it is the one I built a whole module around. Most denials are not created in billing. They are created at the front desk, at check in, weeks before anyone in billing ever sees the claim. If your no answers clustered there, you already know this is true in your own office.

That is what makes this course different from the others. Every other billing course teaches you where the buttons are in one software system. Buttons move, and vendors change. What does not change is why the payer denied the claim, and that is judgment, not clicks. So this course teaches the judgment, and points you at your own vendor free training for the software layer.

Becoming a Medical Receptionist and Biller

Seven modules. How practice management software actually works, the front desk as the billing department, eligibility and benefits, building a clean claim, rejections and denials and appeals, payments and accounts receivable, and compliance and getting hired.

Video lessons, worksheets, worked scenarios with fictitious patients, weekly live Q and A with me on Zoom, a private support group on WhatsApp, and a certificate of completion.

Opening October 2026. Join the list and you will hear from me first, with the start date and founding pricing before it goes public.

Join the waitlist
https://mariematteson.com/medcourse

Almost no certificate program at any price puts you in a room with the person who wrote it every week. That is the part I would not give up.

Marie Matteson, MS is a healthcare consultant, educator, and Office Ally specialist with more than 30 years in healthcare, emergency medicine, and practice management. Helping you understand what is really going on.

Marie Matteson is an independent consultant and is not affiliated with, employed by, or endorsed by Office Ally. This checklist is educational and is not billing, legal, coding, or accounting advice. Always follow your payer contracts, your practice policies, and current coding guidelines.

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