FOR PRACTICE OWNERS AND OFFICE MANAGERS

How solid is your revenue cycle?

Use this checklist to find where claims leak — from the front desk through denials, accounts receivable, and credentialing. There are 25 items. No procedure codes are listed; the point is the process, not a coding manual.

Mark each item **Yes**, **Partial**, or **No**. Scoring is on page 2.

Front desk and eligibility

Catch coverage problems before the visit, not after the denial.

- ☐ **01** Insurance is verified before every visit, including coverage dates and plan type.
- ☐ **02** Copay, deductible, and referral requirements are checked and collected or noted at check-in.
- ☐ **03** Patient demographics and member IDs are matched to the payer's eligibility response, not copied from an old record.
- ☐ **04** Prior authorizations are obtained and logged — including units and date range — before scheduled services that require them.

Coding and charge entry

Speed matters, but only if the claim matches the documentation.

- ☐ **05** Charges are entered the same day or the next business day after the visit.
- ☐ **06** Documentation supports the level of service, the procedures billed, and the units submitted.
- ☐ **07** Same-day preventive and problem-focused visits are split only when the note clearly supports both.
- ☐ **08** Place of service, rendering provider, and supervising provider (when required) are correct before the claim is built.

Claim submission

A clean claim that goes out fast is the cheapest A/R program you can run.

- ☐ **09** Claims are scrubbed for errors before submission, and a person reviews anything the scrub flags.
- ☐ **10** Claims go out within 24 hours of charge entry.
- ☐ **11** Clearinghouse rejections are corrected the same day they arrive.
- ☐ **12** Electronic remittances and payments are posted the day they arrive.

Denials and appeals

Unworked denials become 90-day balances, then write-offs.

- ☐ **13** Every denial is categorized by reason and assigned an owner.
- ☐ **14** New denials are worked within a set number of business days (for example, 48 hours).
- ☐ **15** Appeals include the documentation the payer actually asked for, plus a clear timeline.
- ☐ **16** Repeat denial reasons are reviewed monthly and fixed at the source, not only appealed again.

Accounts receivable

Watch the aging mix, not just the headline days-in-A/R number.

- ☐ **17** Days in A/R are calculated the same way every month and reviewed with the practice owner.
- ☐ **18** The aging report is worked weekly, starting with high-dollar and 90-day-and-older balances.
- ☐ **19** Insurance A/R and patient A/R are tracked separately, and patient statements go out on a regular schedule.
- ☐ **20** Credits, contractual adjustments, and underpayments are reviewed against contracted rates, not auto-written off.

Payer contracts and credentialing

A visit you cannot bill is a scheduling problem as much as a billing problem.

- [ ] 21 Each rendering provider is enrolled and currently credentialed with the practice's major payers.
- [ ] 22 Revalidation, CAQH, and Medicare or Medicaid enrollment dates are tracked before they lapse.
- [ ] 23 Fee schedules and contract rates are sampled against payments to catch underpayments.

Reporting

If the owner cannot see the picture, the process will not improve.

- [ ] 24 The practice owner receives a monthly report of billed, paid, denied, and aged balances.
- [ ] 25 First-pass clean-claim rate and denial rate are tracked over time, with the top denial reasons named.

How to score

Give each item 2 points for Yes, 1 point for Partial, and 0 for No. The maximum score is 50.

- **40–50:** The process is in good shape. Use the Partial items as this quarter's cleanup list, and keep watching days in A/R and your first-pass clean-claim rate.
- **25–39:** There are meaningful gaps, often at eligibility, denial follow-up, or aging. Fix the lowest-scoring section first; that is usually where cash is stuck.
- **0–24:** The revenue cycle needs a structured reset. Claims, denials, and old A/R are likely competing for the same hours.

Scoring is a conversation starter, not a credential. If you want a second set of eyes, start with a Free Billing Assessment.

Free Billing Assessment

A 90-day claims review with a plain-English report in 5 business days. No PHI needed to start, and no obligation.

Free Billing Assessment

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