

Practice Revenue Health Checklist

Monthly review to keep your practice financially strong and growing

Revenue health means your practice is collecting the money it earns — without delays, leaks, or surprises. This checklist should be reviewed by the billing manager or practice administrator every month. Think of it as a financial check-up for your practice.

ACCOUNTS RECEIVABLE (A/R) – Money Owed to You

- **Total A/R is reviewed and compared to last month ★**
A/R is the total amount owed to your practice. If it's growing month over month, something is wrong.
- **A/R aging report reviewed — categorized by 0–30, 31–60, 61–90, 90+ days**
The older a claim, the harder it is to collect. More than 20% of A/R in the 90+ bucket is a red flag.
■ *Tip: Aim to keep A/R over 90 days below 15–20% of total A/R.*
- **Top 10 largest outstanding balances have a follow-up plan**
Identify the biggest unpaid claims and assign someone to work them this week.
- **Insurance A/R and patient A/R tracked separately**
These require different collection strategies. Mixing them makes it hard to see where the problem is.

■ *The industry benchmark for Days in A/R is under 35 days. If yours is higher, review your billing and follow-up processes.*

DENIAL RATE – Claims That Were Rejected

- **Denial rate for this month is calculated ★**
Divide denied claims by total claims submitted. Best practices target under 5% denial rate.
- **Top 3 denial reasons identified**
Most practices have the same 2–3 denial reasons accounting for 80% of their denials. Find them and fix the root cause.
- **Denials are being appealed or corrected within 14 days**
Every denial that isn't followed up on is money left on the table. Timely appeal is critical.
- **First-pass resolution rate is tracked**
This is the percentage of claims paid the first time, without needing corrections. Target: above 95%.

COLLECTIONS – Are You Collecting What You Bill?

- **Collection rate is calculated and reviewed ★**
Collection rate = money collected ÷ money billed (minus contractual adjustments). Target: 95–99%.

■ **Patient collection rate tracked separately**

Patient payments are the hardest to collect. Know your rate. If below 80%, improve your front-desk collection process.

■ **Write-offs for this month are reviewed and approved**

Write-offs (amounts you can't collect) should be approved by a manager. Unexpected write-offs signal a problem.

■ **Charity care and hardship accounts are documented properly**

If you are writing off accounts for financial hardship, make sure you have signed patient forms on file.

■ *Every 1% improvement in collection rate can mean thousands of dollars per year for an average practice.*

CODING & DOCUMENTATION QUALITY

■ **Random sample of claims reviewed for coding accuracy**

Each month, pull 10–15 random claims and verify that codes match documentation. This is your quality control.

■ *Tip: Consider a quarterly external coding audit for objective feedback.*

■ **Upcoding and undercoding patterns identified**

Upcoding = billing higher than documented (compliance risk). Undercoding = billing lower (revenue loss). Both need correction.

■ **E/M (evaluation & management) level distribution reviewed**

If all your providers are billing Level 2 or 3 for every visit, they may be undercoding. Compare to national benchmarks.

PAYER CONTRACT PERFORMANCE

■ **Reimbursement rates compared to contract rates ★**

Are payers paying you what your contract says? Underpayments are surprisingly common and go unnoticed.

■ **Contracts up for renewal in the next 6 months identified**

Start renegotiating contracts 6 months before expiration. Last-minute negotiations get worse results.

■ **New payer fee schedules reviewed if received**

Payers sometimes reduce rates without clear notice. Compare new fee schedules to old ones.

■ *Track your top 5 payers each month. They likely represent 80% of your revenue — know how they're performing.*

Completed by: _____

Date: _____

Supervisor: _____