StratEdge
Operational & Medical Billing Consulting

Medical Billing Audit
Readiness Checklist

A quick self-check for healthcare practices that want to identify billing workflow gaps before they become bigger revenue problems.

Practice Information

Practice Name

Completed By

Role/Title

Date

How to Use This Checklist

Check each item that describes your current process. The more warning signs or unchecked controls you see, the more likely your practice may benefit from a targeted billing workflow review, accounts receivable review, or revenue cycle assessment.

Important note

This checklist is not a compliance audit or coding certification review. It is a practical readiness tool designed to highlight common process, documentation, billing, and follow-up issues that may affect revenue, workflow clarity, and operational performance.

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1. FRONT-END REGISTRATION & ELIGIBILITY

- [ ] Patient insurance information is verified before the visit.
- [ ] Insurance cards are collected or updated regularly.
- [ ] Patient demographics are reviewed for accuracy.
- [ ] Eligibility is checked before services are rendered.
- [ ] Staff verify whether referrals or authorizations are required.
- [ ] Coordination of benefits is reviewed when a patient has more than one insurance plan.
- [ ] Patient responsibility is communicated clearly when possible.
- [ ] There is a clear process for correcting registration errors before claims are submitted.

Warning signs:
Frequent eligibility denials, inactive coverage denials, incorrect payer denials, patient billing complaints, or claims delayed because front-end information was incomplete.

2. AUTHORIZATION & REFERRAL TRACKING

- [ ] Required authorizations are obtained before services are provided.
- [ ] Authorization numbers are documented and easy to find.
- [ ] Authorized visit limits or service limits are tracked.
- [ ] Expiration dates are monitored before additional services are provided.
- [ ] Referral requirements are checked before the appointment.
- [ ] Staff know who is responsible for authorization follow-up.
- [ ] Authorization issues are reviewed before claims are submitted.

Warning signs:
Claims denied for missing authorization, services provided beyond approved visit limits, staff uncertainty about payer requirements, or repeated payer-specific authorization denials.

3. DOCUMENTATION & CHARGE CAPTURE

- [ ] Provider documentation supports the service billed.
- [ ] Notes are signed, dated, and complete.
- [ ] Diagnosis codes are supported by the documentation.
- [ ] Services provided are captured and entered for billing.
- [ ] Units, dates of service, place of service, and provider information are reviewed before submission.
- [ ] Missed charges are monitored.
- [ ] Duplicate charges are checked before claims are submitted.
- [ ] Staff know how documentation issues are communicated and corrected.

Warning signs:
Medical necessity denials, missing documentation requests, inconsistent coding, delayed charge entry, missed charges, or services billed differently across providers or staff.

4. CLAIMS SUBMISSION & CLEARINGHOUSE REJECTIONS

- [ ] Claims are submitted on a consistent schedule.
- [ ] Claims are reviewed for missing or incorrect information before submission.
- [ ] Clearinghouse rejections are worked daily or within a defined timeframe.
- [ ] Rejected claims have an assigned owner.
- [ ] Claims are corrected and resubmitted quickly.
- [ ] Claims approaching timely filing limits are monitored.
- [ ] There is a report showing unsubmitted or rejected claims.
- [ ] Staff know the difference between a rejected claim and a denied claim.

Warning signs:
Claims sitting unsubmitted, repeated rejections, late claim corrections, timely filing denials, or staff unsure who is responsible for clearinghouse workqueues.

5. DENIALS MANAGEMENT

- [ ] Denials are categorized by reason.
- [ ] Top denial reasons are reviewed regularly.
- [ ] Denials are tracked by payer.
- [ ] Staff know which denials can be corrected and resubmitted.
- [ ] Appeal deadlines are monitored.
- [ ] Denials are not written off without review.
- [ ] Repeat denials are investigated for root causes.
- [ ] There is a process for preventing the same denial from continuing.

Warning signs:
The same denials happen every month, denial reasons are not tracked, claims are written off too quickly, or the practice does not know its top denial categories.

6. PAYMENT POSTING & ADJUSTMENTS

- [ ] Payments are posted according to remittance advice.
- [ ] Contractual adjustments are reviewed for accuracy.
- [ ] Patient responsibility is transferred correctly.
- [ ] Secondary insurance is billed before patient balances are sent out when applicable.
- [ ] Manual adjustments require clear notes or approval.
- [ ] Write-offs are reviewed before being finalized.
- [ ] Credit balances are reviewed regularly.
- [ ] Payments are reconciled against deposits.

Warning signs:
Patient balance complaints, unexplained credit balances, excessive write-offs, underpayments missed, or reports that do not reconcile to deposits.

7. ACCOUNTS RECEIVABLE FOLLOW-UP

- [ ] Accounts receivable aging is reviewed regularly.
- [ ] Claims over 30, 60, 90, and 120 days are monitored.
- [ ] High-dollar claims are prioritized.
- [ ] Follow-up notes are documented.
- [ ] Staff know who owns payer follow-up.
- [ ] Old claims are not left untouched.
- [ ] Unresolved claims have escalation steps.
- [ ] Accounts receivable reports are used to guide weekly work.

Warning signs:
High accounts receivable over 90 days, claims with no follow-up notes, inconsistent payer follow-up, aging balances increasing, or staff working accounts without a clear priority system.

8. WORKFLOW & STAFF ACCOUNTABILITY

- [ ] Billing responsibilities are clearly assigned.
- [ ] Front-office, clinical, and billing handoffs are documented.
- [ ] Staff know who owns each part of the billing process.
- [ ] Billing workflows are written down or mapped.
- [ ] Issues are tracked instead of handled informally.
- [ ] Reports are reviewed on a regular schedule.
- [ ] There is a process for communicating recurring problems.
- [ ] Staff have access to current billing procedures or standard operating procedures.

Warning signs:
Tasks fall through the cracks, staff duplicate work, no one owns follow-up, billing issues are handled reactively, or process knowledge lives only in one person's head.

9. REPORTING & PERFORMANCE VISIBILITY

- [ ] The practice reviews accounts receivable aging reports.
- [ ] Denial reports are reviewed by category and payer.
- [ ] Claim submission and rejection reports are monitored.
- [ ] Payment posting and adjustment reports are reviewed.
- [ ] Leadership has visibility into billing performance.
- [ ] Key billing issues are tracked month to month.
- [ ] Trends are used to guide process improvements.
- [ ] Reports are reviewed before problems become urgent.

Warning signs:
The practice does not know its denial rate, aging accounts receivable percentage, top payer issues, average claim follow-up time, or how much revenue may be delayed.

10. OVERALL RISK SELF-CHECK

- [ ] Claims are often delayed before submission.
- [ ] Denials are increasing or not being reviewed regularly.
- [ ] Accounts receivable over 90 days is growing.
- [ ] Staff are unsure who owns certain billing tasks.
- [ ] Authorization issues are recurring.
- [ ] Payment posting or patient balances are frequently questioned.
- [ ] Reports exist but are not reviewed consistently.
- [ ] Billing workflows are not documented.
- [ ] The practice relies heavily on one person for billing knowledge.
- [ ] Leadership suspects revenue is being delayed but is not sure where the problem starts.

WHAT YOUR RESULTS MAY MEAN

0-5 items checked	Your practice may have a fairly structured billing process, but a periodic review can still help identify small gaps before they become larger issues.
6-12 items checked	Your practice may have moderate billing or workflow risk. A targeted billing workflow review or accounts receivable review may help identify preventable delays.
13 or more items checked	Your practice may benefit from a more structured medical billing audit or revenue cycle workflow assessment. Multiple checked items may indicate process gaps that could affect cash flow, staff efficiency, claim accuracy, or follow-up consistency.

SUGGESTED NEXT STEP

A medical billing audit or workflow review can help determine:

- [ ] Where billing delays are occurring
- [ ] Why denials or rejections may be repeating
- [ ] Whether accounts receivable follow-up is consistent
- [ ] Whether documentation and billing handoffs are clear
- [ ] Which workflow gaps should be prioritized first
- [ ] What practical steps can improve process visibility and accountability

NOTES

Ready for a Fresh Look at Your Billing Workflow?

StratEdge Systems Consulting provides structured reviews designed to identify billing, accounts receivable, revenue cycle, and operational workflow gaps.

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