The Medical Practice Revenue Health Check

15 billing-workflow checks to discuss with your team. Use evidence to choose the next action; a checklist cannot establish lost or recoverable revenue.

How to mark: check an item only after reviewing supporting evidence. Leave a gap or unknown unmarked and put its next step in the action log on page 2. Do not total the boxes into a performance score.

01 Front desk and coverage

- ☐ **1. Eligibility and benefits.** Record the check date, service date, payer response and unresolved coverage questions. Eligibility is not a payment guarantee.
- ☐ **2. Patient and plan identifiers.** Compare the registration and claim records; give missing or conflicting identifiers an owner for correction.
- ☐ **3. Authorization and referral status.** Check the relevant payer requirements for the planned service. Record status, missing information and who resolves it.

02 Documentation and charges

- ☐ **4. Documentation and coding questions.** Route incomplete documentation or coding edits to the appropriate reviewer. Do not infer a service or code from a payment target.
- ☐ **5. Charge-entry handoff.** Track when complete billing information becomes available and when charges are entered. Agree a practical handoff and exception owner.
- ☐ **6. Encounter-to-charge reconciliation.** Compare completed encounters with entered charges; research differences before adding, correcting or removing a charge.

03 Claim submission and acknowledgment

- ☐ **7. Submission status.** Distinguish submitted, rejected, accepted and pending claims. Acknowledgment or acceptance does not establish payment. [1]
- ☐ **8. Payer edits and deadlines.** Check applicable payer rules and filing limits. Assign rejected claims and missing information a next action and review date.

Review period / as-of date: _____ Reviewed with: _____

Review, assign, follow through

04 Denials and open A/R

- ☐ **9. Denial work ownership.** Record the payer reason, supporting evidence, owner and applicable deadline. Choose a supported correction, appeal or other next step.
- ☐ **10. Aging report basis.** Record the as-of date, aging start, balance basis and payer/patient scope. Use non-overlapping buckets, such as 0-30 through 121+ days. [2]
- ☐ **11. Days in A/R and comparisons.** Document the formula, balance definition, denominator and period. Compare like with like; this guide sets no universal target. [2]

05 Patient balances and communication

- ☐ **12. Statement balance review.** Reconcile the EOB/remittance with posted payments, adjustments and any pending secondary claim before explaining a balance. An EOB is not a bill. [3]
- ☐ **13. Questions and follow-up.** Provide a clear route for balance questions and corrections. Follow the practice's approved follow-up and payment-arrangement policies.

06 Posting and reporting

- ☐ **14. Report definitions.** Label dates, populations, exclusions and pending outcomes. Review changes with the billing team before choosing practice-specific targets. [2]
- ☐ **15. Payment reconciliation.** Compare posting records with remittances and EFT/check records; reconcile bank deposits through the practice's approved process and assign differences.

Next actions

Choose the most time-sensitive or consequential gap first. Use process notes only; keep patient details in approved secure systems.

Check #	Evidence gap / next action	Owner	Review date

Discuss your next billing priority

Request a **free, no-obligation practice audit** at synergyb.com/contact-us or call **630-708-0271**. We can discuss your workflow questions and arrange a secure handoff if reports are needed. Do not send patient information through the website form.

Reference notes (definitions, not endorsement of this checklist): [1] CMS: Checking Medicare Claim Status (Medicare context). [2] HFMA MAP Keys (use the applicable measure definition). [3] CMS: Reading an EOB. Eligibility context: CMS HETS companion guide. Actual payer requirements and practice processes vary.