Swift Billing Solutions

The Medical Billing Audit Checklist

A 91-point self-review to find revenue leaks in your practice's billing, coding and collections

How to use this checklist

- Work through each section with your office manager or billing lead. It takes about 60–90 minutes.
- Mark each item **Yes**, **No** or **Not sure**. Be honest: "Not sure" counts the same as "No".
- Fill in the KPI scorecard on the last page with your own numbers.
- Add up your "No" and "Not sure" answers and use the scoring guide to see where you stand.

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Practice: _____ **Completed by:** _____ **Date:** _____

1. Front Desk and Patient Intake

Most denials start here. Clean data at check-in prevents rework later.

#	Checkpoint	Yes	No	Not sure
1	Patient name, date of birth and address are verified against a photo ID at every visit.	☐	☐	☐
2	A copy of the front and back of every insurance card is scanned and current in the system.	☐	☐	☐
3	Primary, secondary and tertiary insurance order (coordination of benefits) is confirmed.	☐	☐	☐
4	Subscriber name, relationship and member ID are entered exactly as they appear on the card.	☐	☐	☐
5	Referring provider name and NPI are captured when the payer requires a referral.	☐	☐	☐
6	Financial policy, HIPAA notice and assignment of benefits forms are signed and on file.	☐	☐	☐
7	Copays and known patient balances are collected at check-in, not billed later.	☐	☐	☐
8	Front desk staff have a written script and checklist for new-patient registration.	☐	☐	☐

2. Insurance Eligibility and Benefits Verification

Verify before the visit, not after the claim denies.

#	Checkpoint	Yes	No	Not sure
9	Eligibility is verified 24–72 hours before every scheduled appointment.	☐	☐	☐
10	Benefits are checked for the specific service type (e.g., therapy, DME, infusion), not just active coverage.	☐	☐	☐
11	Deductible, coinsurance, visit limits and out-of-network status are recorded before the visit.	☐	☐	☐
12	Plan changes are checked for returning patients at least monthly and at the start of each year.	☐	☐	☐
13	Medicare Advantage, Medicaid managed care and secondary Medicaid plans are identified correctly.	☐	☐	☐
14	Patients are told their estimated responsibility before services are rendered.	☐	☐	☐

3. Prior Authorization and Referrals

Missing or expired authorizations are among the hardest denials to overturn.

#	Checkpoint	Yes	No	Not sure
15	A current list of services that require prior authorization is maintained for each major payer.	☐	☐	☐
16	Authorizations are obtained before the service date, with the auth number recorded on the claim.	☐	☐	☐
17	Authorized CPT/HCPCS codes, units, dates and rendering provider match what is billed.	☐	☐	☐
18	Visit and unit counts are tracked so services stop or are re-authorized before limits run out.	☐	☐	☐
19	Expiring authorizations trigger a renewal request at least 7–10 days in advance.	☐	☐	☐
20	Retro-authorization requests and denied authorizations are tracked and followed up.	☐	☐	☐

4. Clinical Documentation

If it isn't documented, it didn't happen, and it can't be billed.

#	Checkpoint	Yes	No	Not sure
21	Every note is signed and dated by the rendering provider within your policy timeframe (e.g., 48–72 hours).	☐	☐	☐
22	Documentation supports medical necessity for every service and diagnosis billed.	☐	☐	☐
23	Start and stop times are recorded for all time-based codes (therapy, psychotherapy, anesthesia, infusion).	☐	☐	☐
24	Treatment plans, plans of care and progress notes are current where the payer requires them.	☐	☐	☐
25	Cloned or copy-forward notes are reviewed so each visit reflects that day's care.	☐	☐	☐
26	Late entries, addenda and corrections follow a compliant, dated process.	☐	☐	☐
27	Orders, referrals and physician signatures (e.g., for DME or therapy) are on file before billing.	☐	☐	☐

5. Medical Coding Accuracy

Undercoding loses revenue. Overcoding creates compliance risk. Both show up in an audit.

#	Checkpoint	Yes	No	Not sure
28	CPT, HCPCS and ICD-10-CM code sets are updated every year, and staff are trained on changes.	☐	☐	☐
29	Diagnosis codes are coded to the highest level of specificity supported by the note.	☐	☐	☐
30	E/M levels are selected by medical decision making or total time under current guidelines.	☐	☐	☐
31	E/M level distribution by provider is reviewed against peers or specialty benchmarks.	☐	☐	☐
32	Modifiers (e.g., 25, 59, XE/XS/XP/XU, GP/GO/GN, KX) are used only when documentation supports them.	☐	☐	☐
33	Claims are checked against NCCI procedure-to-procedure edits and Medically Unlikely Edits (MUEs).	☐	☐	☐
34	Add-on codes are billed with their correct primary codes.	☐	☐	☐
35	Payer-specific coding policies (LCDs, NCDs, commercial medical policies) are followed.	☐	☐	☐
36	A sample of each provider's claims is coding-audited at least once a year.	☐	☐	☐

6. Charge Capture and Charge Entry

Services performed but never billed are pure lost revenue.

#	Checkpoint	Yes	No	Not sure
37	Every completed appointment is reconciled against charges entered at the end of each day.	☐	☐	☐
38	Charges are entered within 24–48 hours of the date of service.	☐	☐	☐
39	Your fee schedule is reviewed yearly and is set at or above your highest contracted payer rate.	☐	☐	☐
40	Supplies, injectables, drugs (with NDC numbers) and DME items are captured and billed.	☐	☐	☐
41	Place of service, rendering provider and billing provider are correct on every charge.	☐	☐	☐
42	Unbilled and on-hold charges are reviewed at least weekly.	☐	☐	☐

7. Claim Submission

The goal is simple: get paid on the first submission.

#	Checkpoint	Yes	No	Not sure
43	Claims are scrubbed for errors before submission, using payer-specific edits.	☐	☐	☐
44	Your clean claim rate is 95% or higher.	☐	☐	☐
45	Clearinghouse rejections are worked within 24–48 hours.	☐	☐	☐
46	Timely filing limits for each payer are documented and no claims are lost to late filing.	☐	☐	☐
47	Secondary and tertiary claims are sent promptly after the primary pays.	☐	☐	☐
48	Provider NPIs, taxonomy codes and tax ID are set up correctly for each payer.	☐	☐	☐
49	Corrected claims and voids use the right frequency code and original claim number.	☐	☐	☐
50	Paper claims are the exception, and electronic submission is used wherever payers allow it.	☐	☐	☐

8. Payment Posting and Underpayments

An accurate ledger is the foundation of every other report you run.

#	Checkpoint	Yes	No	Not sure
51	ERAs are posted daily and reconciled to bank deposits.	☐	☐	☐
52	Paper EOBs, lockbox payments and patient payments are posted within 48 hours.	☐	☐	☐
53	Each payment is compared to the contracted rate, and underpayments are flagged and appealed.	☐	☐	☐
54	Contractual adjustments are posted correctly, not used to hide unpaid balances.	☐	☐	☐
55	Denials and zero-pay lines on ERAs are routed to the denial queue, not simply adjusted off.	☐	☐	☐
56	Credit balances and overpayments are reviewed monthly and resolved promptly.	☐	☐	☐
57	Payer contracts and fee schedules are loaded into your system so expected payment can be checked.	☐	☐	☐

9. Denial Management

Most practices lose more to unworked denials than to denials that were truly unrecoverable.

#	Checkpoint	Yes	No	Not sure
58	Your overall denial rate is under 5–10%.	☐	☐	☐
59	Denials are tracked by payer, provider, CPT code and CARC/RARC reason code.	☐	☐	☐
60	The top 5 denial reasons are reviewed every month, with a root-cause fix assigned for each.	☐	☐	☐
61	Every denial is worked within 7 days of receipt.	☐	☐	☐
62	Appeals are filed within each payer's deadline, with supporting documentation attached.	☐	☐	☐
63	Appeal outcomes are tracked so you know which appeals succeed.	☐	☐	☐
64	Front desk, coding and billing teams get feedback on the denials they can prevent.	☐	☐	☐

10. Accounts Receivable (A/R) Follow-Up

The older a claim gets, the lower the odds of collecting it.

#	Checkpoint	Yes	No	Not sure
65	Days in A/R are under 40 (under 30–35 for most well-run practices).	☐	☐	☐
66	A/R over 90 days is under 15–20% of total A/R.	☐	☐	☐
67	Claims with no response after 30 days are followed up with the payer.	☐	☐	☐
68	A/R is worked by aging bucket (30/60/90/120+) and by highest dollar value.	☐	☐	☐
69	Every follow-up action and payer call is documented in the account notes.	☐	☐	☐
70	Aged claims are never written off without a documented reason and approval.	☐	☐	☐
71	A written write-off and adjustment policy exists and is followed.	☐	☐	☐

11. Patient Billing and Collections

Patient responsibility is a growing share of revenue, and often the least managed.

#	Checkpoint	Yes	No	Not sure
72	Patient statements are sent on a regular cycle (e.g., every 30 days) by mail and/or email.	☐	☐	☐
73	Statements are clear, show insurance payments and adjustments, and offer online payment.	☐	☐	☐
74	Patients can set up payment plans under a written policy.	☐	☐	☐
75	Patient balance calls and questions are answered within one business day.	☐	☐	☐
76	Accounts are sent to collections only after a documented, compliant sequence of notices.	☐	☐	☐
77	Card-on-file or pre-authorized payment options are offered where appropriate.	☐	☐	☐
78	Good Faith Estimates are provided to uninsured and self-pay patients as required.	☐	☐	☐

12. Compliance and Credentialing

Compliance gaps don't just cost money. They put the practice at risk.

#	Checkpoint	Yes	No	Not sure
79	Every provider is credentialed and enrolled with each payer before seeing its patients.	☐	☐	☐
80	Re-credentialing and revalidation dates are tracked, with reminders set well in advance.	☐	☐	☐
81	Providers and staff are screened against the OIG exclusion list (LEIE) before hire and monthly.	☐	☐	☐
82	Business Associate Agreements (BAAs) are signed with every vendor that handles patient data.	☐	☐	☐
83	HIPAA privacy and security training is completed by all staff every year.	☐	☐	☐
84	A written compliance plan exists, with a named compliance contact.	☐	☐	☐
85	Identified overpayments are reported and refunded on time (Medicare generally requires 60 days).	☐	☐	☐
86	Payer audit letters and records requests are logged and answered before their deadlines.	☐	☐	☐

13. Reporting and KPIs

You can't manage what you don't measure.

#	Checkpoint	Yes	No	Not sure
87	You receive a revenue cycle report at least monthly.	☐	☐	☐
88	The report includes collections, denial rate, clean claim rate, days in A/R and A/R aging.	☐	☐	☐
89	Results are compared month over month and against industry benchmarks.	☐	☐	☐
90	Collections are tracked by provider, payer and location.	☐	☐	☐
91	Someone owns each KPI and is responsible for fixing it when it slips.	☐	☐	☐

14. KPI Scorecard

Pull these numbers from your practice management system for the last 3–6 months. Targets are common industry benchmarks and vary by specialty and payer mix.

KPI	How to calculate	Common target	Your number
Clean claim rate	Claims accepted on first submission ÷ total claims submitted	95% or higher	
Denial rate	Claims denied ÷ total claims submitted	Under 5–10%	
Days in A/R	Total A/R ÷ average daily charges	Under 40 days	
A/R over 90 days	A/R older than 90 days ÷ total A/R	Under 15–20%	
Net collection rate	Payments ÷ (charges − contractual adjustments)	95% or higher	
First-pass resolution rate	Claims paid on first submission ÷ total claims paid	90% or higher	
Charge lag	Average days from date of service to charge entry	1–2 days	
Denial appeal success rate	Appeals overturned ÷ appeals filed	Track and improve	

Scoring Guide

Count every "No" and "Not sure" across all 91 checkpoints. Also note any KPI that misses its target.

0–10	**Healthy.** Your revenue cycle is in good shape. Keep monitoring KPIs monthly and run a full audit once a year.
11–25	**Gaps to fix.** You're likely losing revenue in a few specific areas. A focused audit of your weakest sections will pay off quickly.
26+	**Significant leakage.** Multiple parts of your revenue cycle need attention, and compliance risk may be building. A full RCM audit is strongly recommended.

Want an expert to run this audit for you?

Swift Billing Solutions' certified coders and billers review your claims line by line, show you exactly where revenue is slipping in dollars, and help you recover it. Flat 3% of monthly collections for ongoing RCM, no setup fees and no long-term contracts.

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This checklist is general guidance for self-assessment, not legal or compliance advice. Payer rules, timely filing limits and regulations vary by payer and change often. Always confirm requirements with the payer or your healthcare attorney.