

Billing Audit Checklist

A self-audit for independent medical and dental practices

Work through this once a quarter. Most practices that run it find money leaking in two or three predictable places: eligibility that was never verified, charges that were never captured, and denials that aged out before anyone worked them. Check each item against your own data, not your impression of how things are going.

Front end: stop the errors that cause back-end denials

Roughly three out of four denials start before a claim is ever sent -- a wrong plan ID, an unverified eligibility, a registration typo. Fixing the front desk is cheaper than appealing the denial it causes.

- Eligibility and benefits are verified before every visit, not just for new patients.
- Patient demographics and insurance ID are re-confirmed at each visit, not copied forward blindly.
- Prior authorization requirements are checked for the specific CPT codes being billed.
- Secondary and tertiary coverage is captured and coordinated, not left on the table.
- Time-of-service collection (copays, prior balances) has a defined script and is tracked.

Charge capture: bill for everything you actually did

Lost charges never show up as denials -- they simply never bill. Reconcile what was scheduled and documented against what was charged. A 1-2% charge-capture leak on a \$1.2M practice is \$12,000 to \$24,000 a year that no payer ever sees.

- Every encounter on the schedule has a matching charge, with a reconciliation report run daily.
- Your fee schedule is set above your highest contracted allowable, so you are never billing below what a payer would pay.
- Ancillary services (injections, supplies, in-office labs, after-hours codes) are captured, not forgotten.
- Provider documentation supports the level of service billed -- no automatic down-coding out of caution.

Coding: accuracy in both directions

Overcoding is a compliance risk; undercoding is a silent revenue cut. Both are common. Spot-check a sample of charts each quarter against the documentation.

- E/M levels match the documentation -- audit a 10-20 chart sample per provider per quarter.
- Modifiers (25, 59, and the like) are used correctly and supported by the note.
- The most common procedures are coded to the highest specificity the documentation allows.
- Coding updates (annual CPT/ICD-10 changes) are loaded before the effective date.

Denials and A/R: work them before they age out

A clean claim that is never followed up is the same as a charge you never captured. Most payers give you a limited appeal window; claims that age past it become write-offs by default.

- Denials are worked within a defined number of days, not whenever there is time.
- Denial reasons are categorized and trended, so the root cause gets fixed, not just the claim.
- Aged A/R is reviewed by bucket (0-30, 31-60, 61-90, 90+) with someone owning the 90+ pile.
- Small-balance write-off rules are written down, so staff are not guessing.

Payment posting: confirm you were paid what you are owed

Underpayments hide in posted payments. If you only check that a claim paid, not that it paid the contracted rate, you will never see the gap.

- Payments are posted against the contracted allowable, and underpayments are flagged and appealed.
- Contractual adjustments are reviewed, not auto-accepted, so payer downcoding gets caught.
- Patient statements go out on a predictable cycle with a clear path to pay.
- Credit balances and refunds are reconciled, not left to accumulate.

The five numbers to put on one page

If you track nothing else monthly, track these. They tell you whether the audit above is working.

Metric	Healthy target	What it means
Net collection rate	95% or better	Share of collectible revenue you actually collect
Clean claim rate	95% or better	Claims paid on first submission, no rework
Days in A/R	Under 40	How long, on average, money sits unpaid
Denial rate	Under 5-10%	Share of claims denied on first pass
A/R over 90 days	Under 15-20%	Share of your receivables that is aging out

Targets are general medical-practice-management benchmarks; your specialty and payer mix will move them. Use your own trend over time as the real signal.

If the audit surfaces more leakage than your team can work, comparing billing and RCM services is worth doing with real numbers. Compare medical billing services on GetPracticeHelp by specialty and payer mix.

General operational guidance for independent practices, not legal, compliance, or financial advice. Benchmarks reflect common industry norms and vary by specialty, payer mix, and state.