REVENUE CYCLE SELF-ASSESSMENT

Where is your revenue getting stuck?

A practical checklist for behavioral health leaders who want clearer answers about credentialing, authorizations, billing, denials and collections.

How to score

Give every statement 0 points if it is not in place, 1 point if it is inconsistent or undocumented, and 2 points if it is consistently performed, documented and reportable. Add each section, then prioritize the lowest scores.

Start with the revenue path

1. Provider readiness

Can every billed service be connected to an eligible provider, group and location?

0 ☐ 1 ☐ 2 ☐ Payer participation and effective dates are verified before scheduling insured patients.
0 ☐ 1 ☐ 2 ☐ Approved service locations, group affiliations and billing arrangements are documented.
0 ☐ 1 ☐ 2 ☐ Enrollment changes are communicated to scheduling and billing before claims are released.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Create one payer-provider-location matrix showing participation status, effective dates and approved billing arrangements.

2. Eligibility and benefits

Does the team confirm the coverage details that affect payment?

0 ☐ 1 ☐ 2 ☐ Eligibility is checked close to the date of service and saved in a consistent location.
0 ☐ 1 ☐ 2 ☐ Behavioral health benefits, exclusions, copays, deductibles and network status are reviewed.
0 ☐ 1 ☐ 2 ☐ Coverage discrepancies are resolved before the account becomes avoidable self-pay.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Adopt one benefits-verification standard and require unresolved discrepancies to be cleared before the visit.

3. Authorization

Can the practice prove that authorized services match the care delivered?

0 ☐ 1 ☐ 2 ☐ Authorization requirements are confirmed by payer, level of care and service.
0 ☐ 1 ☐ 2 ☐ Approved dates, units, codes and servicing providers are visible to clinical and billing teams.
0 ☐ 1 ☐ 2 ☐ Expiring or exhausted authorizations trigger action before additional services are rendered.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Use a centralized authorization tracker with dates, units, owners and advance expiration alerts.

Before a claim leaves the practice

Catch leakage before it becomes AR

4. Documentation and charge capture

Can leadership reconcile care delivered to charges created?

0 ☐ 1 ☐ 2 ☐ Completed encounters are reconciled to billed encounters on a defined schedule.
0 ☐ 1 ☐ 2 ☐ Unsigned or incomplete notes are escalated before billing and filing deadlines are affected.
0 ☐ 1 ☐ 2 ☐ Missed charges and duplicate charges are identified through routine reconciliation.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Reconcile scheduled, completed, documented and billed encounters at least weekly and escalate every exception.

5. Claim configuration and submission

Are claims built from current payer and provider information?

0 ☐ 1 ☐ 2 ☐ Billing provider, rendering provider, taxonomy, location and identifiers are validated.
0 ☐ 1 ☐ 2 ☐ Claims are submitted within an established turnaround time after documentation is complete.
0 ☐ 1 ☐ 2 ☐ Rejected claims are corrected promptly and tracked separately from payer denials.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Implement pre-bill validation and a separate rejection queue with daily ownership and turnaround expectations.

6. Denial prevention and resolution

Does denial work change the process that caused the denial?

0 ☐ 1 ☐ 2 ☐ Denials are categorized by root cause, payer, provider, service and responsible department.
0 ☐ 1 ☐ 2 ☐ Recurring denials trigger corrective action rather than repeated one-claim fixes.
0 ☐ 1 ☐ 2 ☐ Appeal deadlines, documentation requests and outcomes have clear owners.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Create a denial root-cause report and assign corrective action whenever a denial pattern repeats.

7. Accounts receivable

Can the practice explain why balances remain unpaid?

0 ☐ 1 ☐ 2 ☐ AR is segmented by age, payer, denial status, balance size and next action.
0 ☐ 1 ☐ 2 ☐ Work queues prioritize financial risk and filing deadlines, not only oldest balances.
0 ☐ 1 ☐ 2 ☐ Leadership reporting distinguishes collectible AR from balances needing correction or adjustment.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Segment AR by cause and financial risk, then assign every balance a next action, owner and follow-up date.

From payment to accountability

Finish the cycle - then improve it

8. Payment posting and reconciliation

Can every payment and adjustment be traced and explained?

0 ☐ 1 ☐ 2 ☐ ERA, EFT and deposit activity is reconciled to the billing system and bank activity.
0 ☐ 1 ☐ 2 ☐ Contractual adjustments and write-offs follow defined approval rules.
0 ☐ 1 ☐ 2 ☐ Unapplied cash, credits and recoupments are researched and resolved.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Reconcile ERA, EFT, deposits, adjustments and unapplied cash through a documented close process.

9. Patient balances

Are patient statements accurate, timely and easy to act on?

0 ☐ 1 ☐ 2 ☐ Insurance processing is complete before balances are transferred to patients.
0 ☐ 1 ☐ 2 ☐ Statements and collection outreach explain the balance and offer secure payment options.
0 ☐ 1 ☐ 2 ☐ Disputes, financial assistance and payment arrangements follow documented procedures.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Validate insurance completion before patient transfer and standardize statements, disputes and payment options.

10. Reporting and ownership

Do reports produce decisions - or simply describe activity?

0 ☐ 1 ☐ 2 ☐ Leadership can identify unbilled encounters, denial trends, aging risk and revenue at risk.
0 ☐ 1 ☐ 2 ☐ Every exception has a named owner, required next action and follow-up date.
0 ☐ 1 ☐ 2 ☐ The practice monitors whether corrective actions reduce recurrence over time.

Section score: ____ / 6 Risk: ☐ High (0-2) ☐ Moderate (3-4) ☐ Controlled (5-6)

Recommended action: Build a weekly exception dashboard that identifies revenue at risk, required action, owner and due date.

Overall score	Recommended response
48-60	Controlled: continue monthly exception monitoring and validate that performance is sustained.
30-47	Moderate risk: implement the recommended actions for the three lowest-scoring sections within 60 days.
0-29	High risk: begin a structured revenue-cycle review and assign immediate ownership to filing-deadline and cash-flow exposure.

Your three-action plan

Priority area	Score	Next action	Owner	Due
1.	__/6			
2.	__/6			
3.	__/6			

Want a clearer view of where reimbursement is being delayed?

MedAuditz helps medical and behavioral health organizations connect credentialing, billing and revenue-cycle operations so leaders can identify the source of delayed reimbursement - not just the balance left behind.

Visit medauditz.com to learn more.

This checklist is an educational self-assessment and does not constitute legal, accounting or payer-specific advice. It does not require or request protected health information.