REVENUE CYCLE REVIEW TOOL

Medical Billing Audit Checklist

A practical checklist for healthcare leaders who want to identify claim, documentation, reimbursement, and revenue cycle issues before they become repeated leakage.

How to use this tool	Score each item 0 if not in place, 1 if inconsistent or undocumented, and 2 if consistently performed, documented, and reportable. Prioritize the lowest-scoring sections first.

Start before the claim

1. Provider, location, and payer setup

Can each billed service be connected to the correct provider, group, location, and payer arrangement?

0 [ ] 1 [ ] 2 [ ] Rendering and billing provider information is validated before claims are released.

0 [ ] 1 [ ] 2 [ ] Service locations, taxonomy, NPI, TIN, and group affiliations are current in the billing system.

0 [ ] 1 [ ] 2 [ ] Payer participation and effective dates are reviewed when denial or underpayment patterns appear.

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

Recommended action: Build a payer-provider-location validation checklist before billing and during payer setup changes.

2. Documentation and charge capture

Can leadership reconcile care delivered to charges created?

0 [ ] 1 [ ] 2 [ ] Scheduled, completed, documented, and billed encounters are reconciled on a defined schedule.

0 [ ] 1 [ ] 2 [ ] Unsigned, incomplete, or late documentation is escalated before filing deadlines are affected.

0 [ ] 1 [ ] 2 [ ] Missed charges, duplicate charges, and late charges are tracked separately from routine billing.

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

Recommended action: Create a weekly charge capture reconciliation that identifies every exception, owner, and next action.

3. Coding, modifiers, and units

Are codes, units, modifiers, and payer rules aligned with the service documented?

0 [ ] 1 [ ] 2 [ ] Code selection is reviewed against documentation, payer policy, and medical necessity expectations.

0 [ ] 1 [ ] 2 [ ] Modifiers, units, places of service, and provider type requirements are validated for high-risk services.

0 [ ] 1 [ ] 2 [ ] Recurring coding edits are used to change process behavior, not only to fix individual claims.

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

Recommended action: Audit a sample of high-volume and high-denial services for documentation, coding, modifier, and unit alignment.

After the claim leaves

4. Claim submission and rejection control

Are claims leaving the practice cleanly and moving through the clearinghouse process?

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.

0 [ ] 1 [ ] 2 [ ] High-frequency rejections trigger configuration or front-end workflow corrections.

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

Recommended action: Separate rejections from denials and assign daily ownership for correction and reporting.

5. Denial and underpayment review

Does the team know why claims are denied or paid below expectation?

0 [ ] 1 [ ] 2 [ ] Denials are categorized by root cause, payer, provider, service, and responsible process area.

0 [ ] 1 [ ] 2 [ ] Underpayments are compared against expected reimbursement and contract terms when available.

0 [ ] 1 [ ] 2 [ ] Appeal deadlines, payer requests, and outcomes have assigned owners and follow-up dates.

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

Recommended action: Create a denial and underpayment report that highlights root causes and repeat patterns.

6. Payment posting, credits, and adjustments

Can every payment, adjustment, recoupment, and credit balance be explained?

0 [ ] 1 [ ] 2 [ ] ERA, EFT, deposit, adjustment, and recoupment activity is reconciled through a documented close process.

0 [ ] 1 [ ] 2 [ ] Contractual adjustments, write-offs, and non-covered adjustments follow approval rules.

0 [ ] 1 [ ] 2 [ ] Unapplied cash, credits, and patient transfers are reviewed before balances age unnecessarily.

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

Recommended action: Review posting controls and create a weekly unresolved cash, credit, and adjustment exception report.

Use the score to pick the first project

Overall score	Recommended response
29-36	Controlled: continue monitoring, sample high-risk areas monthly, and verify improvement is sustained.
18-28	Moderate risk: prioritize the three lowest-scoring sections and assign corrective actions within 60 days.
0-17	High risk: begin a structured billing audit and assign immediate ownership to filing-deadline and cash-flow exposure.

Three-action plan

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

Want help finding the root cause?

MedAuditz helps healthcare organizations review billing operations, denials, reimbursement patterns, and process gaps so leaders can prioritize the work most likely to improve visibility and cash flow.

This checklist is an educational self-assessment and does not constitute legal, coding, accounting, payer-specific, or medical advice. Do not include protected health information when using this tool or contacting MedAuditz.