Neolytix

Smarter Operations, Better Healthcare.

REVENUE CYCLE · PHYSICIAN GROUPS

The **50-point** revenue cycle assessment checklist

Revenue rarely leaks where you notice it. A denial that lands in AR often started weeks earlier at the front desk, in an enrollment file or in a coding decision. This checklist sets out the 50 checks a thorough revenue cycle assessment should cover, so you can find where your own revenue is slipping, decide what to fix first, and hold any billing partner to the same standard.

300+	31	40	14+
healthcare organizations	specialties, certified coders	US states	years in US revenue cycle

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TRUSTED BY

300+

healthcare organizations

31

specialties, certified coders

40

US states

14+

years in US revenue cycle

Is this for you?

It is if you run, or oversee, the revenue cycle at a physician group or multi-site practice — typically 5 to 50 providers — and want to see where revenue is being lost before you speak to anyone.

Running a single location? It works for you too: every item is answerable in-house.

START HERE

How to use it

1. Work through it against your own operation before you speak to any vendor, including us. Every item is answerable in-house.
2. Tick yes, no or don't know for each item. "Don't know" is the most useful answer in the list — an unmeasured stage is an unmanaged one. The PDF is fillable, so you can score it on screen.
3. Count your "no" and "don't know" answers in each stage's tally, then add them up on the scorecard at the end.
4. Take it to any RCM partner and ask them to walk through it with you. A partner who cannot speak to every line has a gap in scope, not a gap in the checklist.

Quick glance

Sixteen checks to start with. The full 50 begin on the next page.

FRONT END

- Appointments reconciled to charges
- Eligibility verified pre-service, and measured
- Authorization requirement identified before service
- Enrollment status visible per provider, per payer

MID CYCLE

- Charge entry lag under 1 business day
- Coding audited monthly against a stated threshold
- Modifier usage reviewed for high-risk codes
- Clearinghouse rejections tracked separately from denials

BACK END

- Contracted rates loaded and checked against remittances
- Every denial root-cause coded and trended
- AR reported at over-90 and over-120 separately
- Write-off policy documented with an approval threshold

GOVERNANCE

- One set of numbers for staff and leadership
- Thresholds published, with a named owner per metric
- Reporting available at entity and portfolio level
- Audit trail sufficient for a payer audit or diligence

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Front end

Most denials are preventable — HFMA cites estimates as high as 90%[2] — and the front end is where prevention costs least.

FROM OUR WORK

20%

revenue loss traced to four gaps across patient access, credentialing and billing at a merged OB/GYN group. Closing them together restored collections above pre-merger levels.

YOUR TALLY

Count of "no" + "don't know"

Stage 01 _____ / 5

Stage 02 _____ / 6

01 Scheduling and registration

Errors introduced here tend to surface as denials weeks later, several handoffs away from the person who could have prevented them.

	YES	NO	DON'T KNOW
Demographic and insurance data captured at the point of booking, not at check-in	☐	☐	☐
Payer ID and plan type validated against the current payer list, not a stored default	☐	☐	☐
Secondary and tertiary coverage identified before the visit	☐	☐	☐
Registration error rate measured, with a named owner	☐	☐	☐
No-show and cancellation rate tracked by location and by provider	☐	☐	☐

IF YOU FIX ONE THING HERE

If appointments are not reconciled to charges, start there. It is one of the cheapest missing-revenue checks in the cycle, and many groups have never run it.

02 Eligibility and prior authorization

Providers rank intake and registration errors among the three most common causes of denials,[1] which makes the front end the cheapest place to prevent one.

	YES	NO	DON'T KNOW
Real-time eligibility run before every visit, not batched overnight	☐	☐	☐
Benefit limits, visit caps and accumulators checked, not just active/inactive status	☐	☐	☐
Authorization requirement identified by CPT and payer before the service is rendered	☐	☐	☐
Authorization expiry tracked against scheduled dates	☐	☐	☐
Percentage of encounters with eligibility verified pre-service, measured weekly	☐	☐	☐
Retro-authorization pathway documented for each major payer	☐	☐	☐

IF YOU FIX ONE THING HERE

Measure the share of encounters with eligibility verified before service. If nobody owns that number, that is the finding — not the number itself.

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Mid cycle

Coding problems rarely stay small. An overpayment found in a later audit can reach back years.

FROM OUR WORK

~30% → <10%

We reduced the charge error rate at a large, multi-entity health system.

YOUR TALLY

Count of "no" + "don't know"

Stage 03 _____ / 6

Stage 04 _____ / 8

03 Provider credentialing and payer enrollment

A provider who is not credentialed with a payer cannot bill that payer at all, regardless of the care delivered.

	YES	NO	DON'T KNOW
Enrollment status visible for every provider against every payer, in one place	☐	☐	☐
CAQH profiles attested and current	☐	☐	☐
Re-credentialing dates tracked with lead time, not chased on expiry	☐	☐	☐
State licensure current, and mapped to every state the group bills in	☐	☐	☐
Credentialing start dates reconciled against provider start dates	☐	☐	☐
Multi-entity groups: enrollment visible at entity level and portfolio level	☐	☐	☐

IF YOU FIX ONE THING HERE

Build one view of enrollment status across every provider and payer. Multi-entity groups often discover a provider billing a payer they were never enrolled with.

04 Charge capture and coding

Medicare requires providers to report and return overpayments going back up to six years,[3] so coding accuracy is an exposure question as well as a revenue one.

	YES	NO	DON'T KNOW
Charge entry lag measured in business days from date of service	☐	☐	☐
Missing-charge reconciliation between the schedule and the billed encounters	☐	☐	☐
Coding accuracy audited on a sample, monthly, against a stated threshold	☐	☐	☐
E&M level distribution reviewed against documentation, not against peer averages alone	☐	☐	☐
Modifier usage reviewed for the specialty's high-risk modifiers	☐	☐	☐
NCCI bundling and payer-specific edit libraries applied before submission	☐	☐	☐
Undercoding reviewed as deliberately as overcoding	☐	☐	☐
Coders credentialed (AAPC or AHIMA) and specialty-assigned rather than pooled	☐	☐	☐

IF YOU FIX ONE THING HERE

Run a modifier-usage review for your specialty's three highest-risk modifiers before you audit anything else. Undercoding deserves the same attention as overcoding.

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Back end

Where a claim turns into cash: submitting it cleanly, posting what the payer paid, and checking it against what you were owed.

FROM OUR WORK

97.2%

Clean claim rate we achieved for a behavioral health group.

YOUR TALLY

Count of "no" + "don't know"

Stage 05 _____ / 6

Stage 06 _____ / 6

05 Claim submission

Every day of lag uses up the timely filing window. Medicare allows one calendar year from the date of service;[4] commercial windows vary by contract and are often shorter.

	YES	NO	DON'T KNOW
Clean claim rate measured as first-pass payer acceptance, with the definition written down	☐	☐	☐
Clearinghouse rejections tracked separately from payer denials	☐	☐	☐
Same-day rejection working, so nothing ages in a queue	☐	☐	☐
Timely filing windows recorded per payer, and monitored against them	☐	☐	☐
Claim scrubbing rules reviewed and updated on a stated cadence	☐	☐	☐
Secondary claims submitted automatically on primary adjudication	☐	☐	☐

IF YOU FIX ONE THING HERE

Separate clearinghouse rejections from payer denials in your reporting. Groups that combine the two usually understate their true denial rate.

06 Payment posting and reconciliation

This is where underpayment hides. A claim paid below the contracted rate looks the same as one paid correctly unless someone is checking.

	YES	NO	DON'T KNOW
Payments reconciled to bank deposits, not only to the remittance	☐	☐	☐
Contracted rates loaded and every payment checked against them	☐	☐	☐
Underpayment variance reported by payer and by CPT	☐	☐	☐
Electronic remittance and virtual-card processing fees identified and quantified	☐	☐	☐
Contractual adjustments distinguished from write-offs in the reporting	☐	☐	☐
Credit balances and refunds reviewed on a cycle	☐	☐	☐

IF YOU FIX ONE THING HERE

Load your contracted rates and check one month of remittances against them. In our experience it is one of the most overlooked sources of recoverable revenue.

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Governance

If none of this is measured against a published threshold on a stated cadence, nobody would know if it broke.

FROM OUR ASSESSMENTS

68%

of one sleep center's denials traced to a single upstream cause — a Medicare provider-type enrollment mismatch — with $754K of AR at risk.

Neolytix assessment, sleep diagnostic center

YOUR TALLY

Count of "no" + "don't know"

Stage 07 _____ / 7

Stage 08 _____ / 6

07 Denials, appeals and AR

The older a claim gets, the harder it is to collect, so AR that ages quietly tends to become a write-off rather than a delay.

	YES	NO	DON'T KNOW
Denial rate measured as first-pass denials over total submitted	☐	☐	☐
Every denial root-cause coded, and the codes rolled up to a trend	☐	☐	☐
Denial patterns routed back to the stage that caused them	☐	☐	☐
Appeal rate and appeal win rate both measured	☐	☐	☐
AR aged by bucket and by payer, with over-90 and over-120 reported separately	☐	☐	☐
Write-off policy documented, with an approval threshold	☐	☐	☐
Patient balance follow-up sequenced and measured, not ad hoc	☐	☐	☐

IF YOU FIX ONE THING HERE

Root-cause code every denial for one month and roll the codes up. The pattern often points upstream of where the denial appeared.

08 Reporting and governance

If none of the above is measured against a published threshold on a stated cadence, the real finding is that nobody would know if it broke.

	YES	NO	DON'T KNOW
A single set of numbers used by billing staff and by leadership	☐	☐	☐
Performance reviewed against published thresholds, weekly or monthly, with a named owner	☐	☐	☐
Reporting available at location, entity and portfolio level for multi-site groups	☐	☐	☐
Forecast of expected collections, not only a record of past collections	☐	☐	☐
Payer contract terms held somewhere reviewable, including clawback and filing windows	☐	☐	☐
Audit trail sufficient to withstand a payer audit or sponsor diligence request	☐	☐	☐

IF YOU FIX ONE THING HERE

Pick the three metrics you would defend to a lender, and put a named owner and a review cadence against each. Everything else comes after that.

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NOW WHAT

Your scorecard

Copy each stage's tally of "no" and "don't know" answers into the scorecard below, then add them up.

	STAGE	CHECKS	NO + DON'T KNOW
01	Scheduling and registration	5	
02	Eligibility and prior authorization	6	
03	Provider credentialing and payer enrollment	6	
04	Charge capture and coding	8	
05	Claim submission	6	
06	Payment posting and reconciliation	6	
07	Denials, appeals and AR	7	
08	Reporting and governance	6	
	Total	**50**	

0–10 GAPS
Well run
Tighten the few stages with gaps and set a review cadence so they stay closed.

11–25 GAPS
Leaking in places
Several stages need attention. Size the gaps in dollars to decide which to fix first.

26+ GAPS
Structural
The cycle needs a full review, starting with your highest-scoring stage.

A rough guide, not a diagnosis.

If you run billing today, this is not an audit of your work. Few practices of any size tick every box, and the gaps are usually about systems and staffing, not people. Your "no" answers are evidence for what you have been asking for.

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WHAT GOOD LOOKS LIKE

Benchmarks to read your answers against

41%
of providers say more than 1 in 10 of their claims are denied, up from 30% in 2022.[1]

60%
of medical group leaders saw their denial rates rise year on year.[7]

Up to 90%
of denials are preventable, according to estimates HFMA cites.[2]

METRIC	REFERENCE POINT	SOURCE
Claims denied on first submission	**8% aggregate, single-specialty groups**	MGMA DataDive, 2023[5]
Days in AR	**30–40 days preferred; under 50 at minimum**	AAFP[6]
AR aged over 90 days	**Under 10% of total AR**	Neolytix operating standard
Clean claim rate (first-pass acceptance)	**95% or higher**	Neolytix operating standard
Medicare timely filing window	**1 calendar year from date of service**	42 CFR 424.44[4]
Overpayment look-back	**Up to 6 years from receipt**	CMS 60-day overpayment rule[3]

WHAT TO DO NEXT

Find out what your gaps are costing you

Schedule an in-depth assessment with us. We run all eight stages against 90 days of your own claims, denial and AR data, put a dollar figure on each gap and show you what to fix first. There is no cost, and the findings are yours to act on however you choose.

What we'll need: 90 days of claims, remittance and AR reports. We sign a BAA before any data is shared.

YOUR CONTACT

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Book a 30-minute call →

SECURITY & COMPLIANCE ● HIPAA compliant ● ISO 27001 certified ○ HITRUST e1 certification in progress

Sources. 1 Experian Health, State of Claims 2025 (survey of 250 providers, Jun–Jul 2025). 2 HFMA, "Denials management," hfm, Sept 2018, citing Advisory Board (2014) and Becker's (2016). 3 42 CFR 401.305, Medicare 60-day overpayment rule. 4 42 CFR 424.44(a)(1). 5 MGMA DataDive Practice Operations 2023, as reported by MGMA Stat, March 2024. 6 AAFP, "Evaluating your practice's revenue cycle: days in accounts receivable." 7 MGMA Stat poll, March 5, 2024 (235 responses). Neolytix results are from individual client engagements; outcomes vary by specialty, payer mix and baseline.

This checklist may be shared and used freely inside your organization. Nothing here is a guarantee of recovery.