

A/R Recovery Self-Assessment

Score your accounts receivable in 15 minutes — and find what's still recoverable.

Who this is for: practice owners, managers and billing leads who want an honest read on their accounts receivable in about 15 minutes.

No patient information is needed. Everything here uses totals from reports your practice management (PM) system already runs.

Before you start — pull these 5 reports

- Aged trial balance (A/R aging) by payer — 0–30, 31–60, 61–90, 91–120, 120+ days
- Total charges for the last 3 months
- Payments and contractual adjustments for the last 3 months
- Denial / rejection report for the last 90 days (claims submitted vs. denied)
- Unbilled or claims-on-hold report (date of service vs. date submitted)

Part A — Your 6 numbers

Calculate each number, then circle the column it lands in. Ranges are commonly used industry benchmarks; your specialty and payer mix can shift them a little.

Metric	How to calculate	Your number	Healthy = 0	Watch = 1	Problem = 2
1. Days in A/R	Total A/R ÷ (last 3 months of charges ÷ 90)		Under 40	40–50	Over 50
2. A/R over 90 days	A/R older than 90 days ÷ total A/R		Under 15%	15–25%	Over 25%
3. Denial rate	Claims denied ÷ claims submitted (90 days)		Under 5%	5–10%	Over 10%
4. Clean claim rate	Claims accepted on first submission ÷ claims submitted		95% or more	90–94%	Under 90%
5. Net collection rate	Payments ÷ (charges – contractual adjustments)		95% or more	90–94%	Under 90%
6. Charge lag	Average days from date of service to claim sent		3 days or less	4–7 days	Over 7 days

Part A score (0–12): _____

Part B — 10 process checks

Answer honestly. Each **No** = 1 point. These are the habits that decide whether money gets collected or quietly expires.

#	Check	Rule to know	Answer
1	Every denial is opened and worked within 7 days of receipt.		Yes / No
2	Timely-filing limits are tracked for each payer (they range from about 90 days to 12 months).	Medicare: 12 months from date of service.	Yes / No
3	Appeal deadlines are on a calendar, not in someone's head.	Medicare redetermination: 120 days from receipt of the initial determination. MA and commercial: check each contract.	Yes / No
4	Eligibility is verified before every visit — including monthly Medicare Advantage and Medicaid changes.		Yes / No
5	Prior authorizations are logged with their approval number and expiration date.		Yes / No
6	Payments are compared against your contracted fee schedule to catch underpayments.		Yes / No
7	Credit balances and overpayments are reviewed every month.	Medicare requires identified overpayments to be reported and returned within 60 days (42 CFR 401.305).	Yes / No
8	Claims with no payer response are followed up at 30 days.		Yes / No
9	Clearinghouse rejections are corrected within 48 hours.		Yes / No
10	Secondary coverage is captured and billed — including dual-eligible patients.	QMB patients may not be billed for Medicare cost-sharing.	Yes / No

Part B score (0–10): _____

Part C — Find the money that's still recoverable

This is the most important page. A claim is only worth chasing if it's still inside its timely-filing or appeal window. Past that date, it's almost always a write-off — no matter how hard anyone works it.

For each of your top payers, fill in the A/R by age, then estimate how much of it is still inside the window.

Payer	Filing limit	31-60	61-90	91-120	120+	Still in window (\$)

Your recoverable estimate	Amount
A. Total A/R 31+ days still inside its window	\$ _____
B. Of that, amount at risk in the next 30 days (deadline approaching)	\$ _____
C. Denials in the last 90 days not yet appealed	\$ _____

Why line B matters most

Line B is money with a countdown on it. If nobody works it in the next 30 days, it disappears from your books for good. That's where a recovery project starts.

Your result

Total score = Part A + Part B (0-22): _____

Score	What it means	Best next step
0-5	Strong. Your process is working. Small leaks only.	Recheck quarterly. Focus on line C (unappealed denials).
6-12	Leaking. Money is aging past the point of easy collection.	Work line B first, then fix the 'No' answers in Part B one at a time.
13-22	Urgent. A meaningful share of earned revenue is likely to be written off.	Get outside help on the backlog so your team can fix the process going forward.

Want a second set of eyes?

Send us your de-identified aging report (no patient names) and we'll return a free recovery summary showing what's still collectible, what expires soon, and which payers to start with. No system access, no obligation.

info@procarepr.com • procarepr.com

Educational material. Benchmarks are general industry ranges, not payer requirements. Always confirm filing and appeal limits in your payer contracts and current CMS guidance.