

Claims Performance Audit

A self-assessment for medical practices

Most practices lose 5–10% of net revenue to preventable claims issues, denials they can't trace, rules they didn't know changed, dashboards that report problems weeks after the money has stopped moving. This 23-question audit benchmarks your claims operation against industry standards and surfaces exactly where the leaks are.

Time required: 15 minutes

Best completed by: Practice Manager or RCM Lead



GETTING STARTED

How to use this audit

The audit is organized around the five operational areas where claims revenue is most often lost. For each question, score your practice from 0 to 3. At the end, you'll calculate a total score out of 69 and compare it to four performance bands.

1

Answer honestly

Where you don't know an exact metric, score yourself a 0. The unknowns are themselves a finding.

2

Use real data

Pull the last 90 days of claims, denials, and A/R reports before you start. Estimates from memory skew high.

3

Total each section

Section sub-scores reveal where the biggest gaps are — sometimes more useful than the headline number.

4

Interpret the result

The final pages translate your score into a performance band and a recommended next step.

Scoring scale

0

Not in place — capability is missing or unknown

1

Reactive — handled informally or only when problems surface

2

Operational — process exists and works, with manual gaps

3

Optimized — automated, measured, and continuously improved

About the highlighted questions: Four questions in this audit are marked **WEDGE**. These items most strongly differentiate high-performing claims operations from average ones. If you can't score a 2 or 3 on any wedge question, that's where to focus first — the ROI is almost always immediate.

Front-End Accuracy & Eligibility

Errors at the front desk become denials downstream. Eligibility, demographics, and prior auth capture are the cheapest places to fix problems — and the most expensive places to ignore them.

INDUSTRY BENCHMARK

Eligibility-related issues drive 11–25% of all initial denials (HFMA / Change Healthcare Index). Manual eligibility checks cost approximately \$7.74 per transaction; electronic checks cost roughly \$0.10 (CAQH Index).

Q1

Do you verify insurance eligibility electronically at scheduling AND at check-in?

- 0 Manual or paper-based; checked only when needed
- 1 Electronic at check-in only
- 2 Electronic at scheduling only
- 3 Electronic at both, with results visible in the EHR/PM
- I don't have that information*

Q2

How is demographic and insurance data validated at intake?

- 0 Free-text entry, no validation
- 1 Electronic capture with basic format checks
- 2 Electronic with payer-agnostic validation rules
- 3 Electronic with payer-specific validation (subscriber ID format, group number, etc.)
- I don't have that information*

Q3

What share of your denials trace back to eligibility, registration, or COB?

- 0 More than 10% — or we don't track this
- 1 6–10%
- 2 3–5%
- 3 Less than 3%
- I don't have that information*

Q4

How are prior authorizations tracked before service is rendered?

- 0 No formal process — we react to denials
- 1 Manual tracking via spreadsheet or binder
- 2 Tracked electronically inside the PM/EHR
- 3 Integrated with scheduling — service can't be booked without auth status
- I don't have that information*

Q5 · WEDGE

When a payer changes an eligibility, COB, or auth requirement, how quickly does your front-end workflow reflect it?

- 0 We find out from the denials
- 1 Monthly payer bulletins, manually reviewed
- 2 Clearinghouse pushes alerts; we manually update workflows
- 3 Automated rule updates flow into our front-end within 24 hours
- I don't have that information*

SECTION 1 SUBTOTAL

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Claim Scrubbing & First-Pass Acceptance

Every claim that fails the first time is a claim that costs you twice — once to submit, once to fix. Strong scrubbing turns the cost curve back the right way.

INDUSTRY BENCHMARK

Best-in-class clean claim rates exceed 95% (HFMA MAP Keys). The industry average sits closer to 75–85%. Each percentage point of improvement directly reduces rework cost and accelerates cash flow.

Q6

What is your clean claim rate (claims accepted by the payer on first submission)?

- 0 Below 80% — or we don't measure it
- 1 80–89%
- 2 90–94%
- 3 95% or higher
- I don't have that information

Q7

How deep are your scrubber edits?

- 0 No automated scrubbing
- 1 Generic CMS edits only
- 2 Generic plus commercial payer edits
- 3 Payer-specific edits with LCD/NCD checks
- I don't have that information

Q8

How often are scrubber rules updated when CMS or commercial payers change requirements?

- 0 Manual updates, if at all
- 1 Quarterly
- 2 Monthly
- 3 Continuous and automated, within hours of payer change
- I don't have that information

Q9

When a claim fails scrubbing, what does the re-submission workflow look like?

- 0 Manual re-keying required
- 1 Some claims can be edited in place
- 2 Most failed claims are edited and re-submitted in the same tool
- 3 Bulk edit and auto-resubmit, with full audit trail
- I don't have that information

Q10 - WEDGE

Can you produce a top-10 list of your most common scrubber edits this month, segmented by payer, in under 5 minutes?

- 0 We don't track this
- 1 Possible to compile, but takes effort
- 2 Available via a standard report
- 3 Reviewed weekly and fed back into front-end training
- I don't have that information

SECTION 2 SUBTOTAL

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Denial Management & Rework

Denials are the single largest source of preventable revenue loss in most practices. The organizations that win this category aren't necessarily the ones working denials hardest — they're the ones who've made denials measurable.

INDUSTRY BENCHMARK

Reworking a single denied claim costs \$25–\$118 (MGMA, Change Healthcare). Up to 65% of denied claims are never resubmitted. Best-in-class first-pass denial rates run below 5%; the industry average is closer to 8–12%.

Q11

What is your overall first-pass denial rate?

- 0 Above 12% — or we don't measure it
- 1 8–12%
- 2 5–7%
- 3 Below 5%
- I don't have that information

Q12

How are denials categorized?

- 0 We see CARC/RARC codes only
- 1 Reason codes are tracked but not analyzed
- 2 Categorized by reason and payer
- 3 Full root-cause analysis (people, process, system, payer)
- I don't have that information

Q13

How quickly are denied claims worked?

- 0 No SLA — and some denials never get worked
- 1 15–30 days to first touch
- 2 8–14 days
- 3 Under 7 days, with payer-deadline tracking
- I don't have that information

Q14

How do you measure appeal performance?

- 0 We don't track appeals separately
- 1 We track appeal volume only
- 2 Win rates by payer
- 3 Win rates by payer AND denial reason; used to prioritize work
- I don't have that information

Q15 · WEDGE

Do you know your true blended cost per claim — including labor, rework, write-offs, and technology?

- 0 No
- 1 We've estimated it informally
- 2 Calculated annually
- 3 Tracked monthly, segmented by payer and service line
- I don't have that information

SECTION 3 SUBTOTAL

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ERA/EFT & Posting Efficiency

Cash arrives faster — and with less labor — when remits and payments are reconciled automatically. Manual posting is the silent overhead that grows linearly with volume.

INDUSTRY BENCHMARK

CAQH estimates the medical industry could save \$2.3B annually by fully adopting electronic remittance and payment. Auto-posting above 85% of payments is the operational threshold for efficient back-office staffing.

Q16

What share of your payers send you ERAs (vs. paper EOBs)?

- 0 Below 70%
- 1 70–79%
- 2 80–89%
- 3 90% or higher
- I don't have that information

Q17

What share of payments post automatically without manual intervention?

- 0 Below 60%
- 1 60–74%
- 2 75–84%
- 3 85% or higher
- I don't have that information

Q18

How are ERAs reconciled to EFTs (matching the remit to the actual payment)?

- 0 Manual matching of payments to remits
- 1 Some matching automated; gaps require investigation
- 2 Most payments auto-matched
- 3 Full auto-reconciliation with exception reporting
- I don't have that information

Q19 · WEDGE

Can you trace a single claim from submission to ERA posting in under 2 minutes, from a single screen?

- 0 Possible, but takes 10+ minutes and multiple systems
- 1 5–10 minutes
- 2 Under 5 minutes
- 3 Under 2 minutes from a single screen
- I don't have that information

SECTION 4 SUBTOTAL

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Reporting & Visibility

You can't fix what you can't see. The strongest claims operations distribute the right view to the right person, every day — not buried in a monthly PDF that nobody opens.

INDUSTRY BENCHMARK

MGMA benchmarks for high-performing practices: days in A/R under 30; A/R over 90 days under 15%. Practices without daily, role-based dashboards typically discover problems weeks after they start losing money.

Q20

What are your current days in A/R?

- 0 Above 50 — or we don't measure it
- 1 41–50
- 2 31–40
- 3 Below 30
- I don't have that information

Q21

What share of your A/R is over 90 days old?

- 0 Above 25%
- 1 20–25%
- 2 15–19%
- 3 Below 15%
- I don't have that information

Q22

What dashboards do leadership and billing staff have access to?

- 0 No dashboards — ad-hoc reports only
- 1 Monthly reports distributed by email
- 2 Weekly dashboards; same view for everyone
- 3 Daily, role-based dashboards (front desk, billers, leadership)
- I don't have that information

Q23 · WEDGE

If revenue dropped last week, how quickly could you produce a payer-level, denial-level, and CPT-level breakdown?

- 0 We can't answer this in any timeframe
- 1 Days, with manual analysis
- 2 Hours, with effort
- 3 Minutes — the breakdown is one click
- I don't have that information

SECTION 5 SUBTOTAL

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RESULTS

Calculate your score

Add your section subtotals to get your overall claims performance score. Then find your performance band below.

SECTION 1 — FRONT-END

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SECTION 2 — SCRUBBING

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SECTION 3 — DENIALS

_____ / 15

SECTION 4 — ERA/EFT

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SECTION 5 — REPORTING

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TOTAL SCORE

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Performance bands

Optimized

56–69 points · 80%+

Your claims operation is running at industry best-practice. Gains from here come from edge cases — payer-specific tuning, deeper analytics, and white-glove handling of your most complex claims.

Functional with gaps

42–55 points · 60–79%

Your fundamentals are in place, but specific weaknesses are likely costing you 2–4% of net revenue annually. Look at your lowest-scoring section first — that's almost always the highest-ROI fix.

At risk

28–41 points · 40–59%

Several core systems are reactive rather than proactive. Practices in this band typically lose 4–8% of net revenue to preventable issues and spend significantly more on rework labor than benchmark peers.

Significant revenue leakage

0–27 points · Below 40%

Your claims operation is exposing the practice to material financial risk. Days in A/R, denial rates, and posting overhead are likely well above benchmark, and visibility into why is limited. A structured intervention almost always pays for itself within 90 days.

Turning the audit into action

A score is only useful if it leads to a decision. Here's the recommended path from completed audit to measurable improvement.

1 Identify your weakest section

Section subtotals matter more than the headline number. The lowest section is almost always the source of the most recoverable revenue.

2 Look at your wedge questions

The four wedge questions distinguish high-performing operations from average ones. Any wedge question scored 0 or 1 is a candidate for immediate attention.

3 Quantify the leak

Multiply your annual claim volume by your denial rate, then by an average rework cost of \$25 to \$118. That's the conservative annual cost of your current denial workflow alone.

4 Pressure-test your results with us

Every audit benefits from an outside read. We offer a complimentary 30-minute deep-dive where we benchmark your scores against our database of practices and identify the two or three highest-leverage interventions for your specific situation.

Harris Secure Connect

HSC is a healthcare clearinghouse and revenue cycle solutions provider with 26+ years of experience helping medical practices, billing companies, and EHR/PM vendors get paid faster and with less friction. We own our clearinghouse infrastructure end-to-end, which means when payer rules change, you're not waiting on a third party.

What sets us apart

- ✓ **Owned clearinghouse infrastructure**, not a reseller. Faster issue resolution and direct payer relationships.
- ✓ **Claims Correct™ scrubbing**, payer-specific edits updated continuously, not on quarterly cycles.
- ✓ **Flexible connectivity**, Web UI, REST API, and SFTP. We integrate with how you already work.
- ✓ **26 years of clearinghouse experience**, the institutional knowledge to handle edge cases your team shouldn't have to.

WHO WE SERVE

Independent medical practices, billing and RCM companies, and EHR/PM vendors who need white-label clearinghouse infrastructure.

CORE CAPABILITIES

Claims management, eligibility verification, ERA/EFT processing, denial management, and a full white-label clearinghouse platform.

Schedule your complimentary deep-dive

Bring us your completed audit and we'll spend 30 minutes interpreting your scores against industry benchmarks, sizing the revenue opportunity, and identifying which fixes would move the needle most for your practice. No obligation, no slide deck.

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