FRONT-END REVENUE CYCLE

Health Assessment Checklist

A 10-minute check for physician practices, ASCs, and outpatient clinics

V erification
A uthorization
C oordination of Benefits

= The MD Billing Method that stops revenue leakage at the source.

The pre-claim firewall payers can't see coming

These are the three checks that stop denials before a claim ever leaves your office. In 2026, payer software flags claim defects in milliseconds. The VAC Method catches them first — at the front desk, where a denial still costs you nothing to fix.

We've developed this expertise over years of partnership with local doctors and clinics.

THE SHORT VERSION

Most denials look like coding mistakes, but they usually start earlier. A missed eligibility check, an authorization that doesn't quite match, insurance listed in the wrong order, or a name that doesn't line up with the payer's records — these are the real reasons claims come back. This quick check helps you see whether your front-desk process is strong enough to keep claims clean and payments on time. It takes less than 10 minutes. Fill it out, add up your score, and decide what to do next.

Prepared by MD Billing • 2026 Edition

How to Use This Check

Each section covers one part of the VAC framework. Only check a box if your practice does that step every single time — not once in a while, and not only when someone has a free moment, but as a written, standard part of your routine. When you're done, add up your score on the last page to see where your front-end process stands.

Quick Scoring Guide

☐ **Checked** = you do it consistently and document it. **Unchecked** = it's inconsistent, missing, or unverified. Only count the checked boxes.

V Verification — Eligibility & Patient Info

This step confirms two things: that the patient's coverage is active on the exact day you see them, and that their details match the payer's records perfectly. Payer software rejects mismatches right away — "Bill" is not the same as "William," and coverage that was active yesterday might be gone today.

☐ You check eligibility electronically for the exact date of service — not just the day the appointment was booked.
Coverage can change day to day, so a check from earlier in the week isn't good enough.

☐ You match the patient's legal name, date of birth, and member ID to the payer's response — not just what's on the insurance card.
The card is a starting point, not proof.

☐ You confirm the subscriber's name and how the patient is related to them for every dependent.
Whether the patient is the subscriber, spouse, or dependent changes how benefits are coordinated.

☐ You confirm the payer ID from the eligibility response instead of guessing based on the logo.
BCBS Commercial, BCBS Medicare Advantage, and BCBS Medicaid are all different.

☐ You identify the exact plan type — HMO, PPO, Advantage, MCO, Marketplace, Supplement, QMB, and so on.
The plan controls the payer ID, the auth rules, and the network. The logo doesn't tell you any of that.

☐ You confirm the provider is in-network for that specific plan.
A provider can be in-network for one plan and out-of-network for another.

☐ You check the coverage start and end dates to make sure they cover the visit.
Coverage that has ended means a same-day denial.

☐ You verify telehealth coverage separately when it applies.
Telehealth location and modifier rules change from one payer to the next.

☐ You save the verification reference numbers and screenshots to the patient's record.
If it isn't written down, it didn't happen — you need proof if you're ever audited.

A Authorization — Referrals, Auth, and Medical Policy

An authorization only counts when everything matches the claim: same payer ID, same plan, same procedure code, same provider, same dates. Close isn't good enough. And in 2026, even services that don't need an auth can still get reviewed after the fact.

- ☐ You confirm whether an auth is needed at the plan level, not just from the payer's name.
  Same payer, different plan, different rules.
- ☐ You tie the auth to the exact procedure code you're billing, with the right number of units.
  An auth for the wrong code is the same as no auth at all.
- ☐ You make sure the auth covers the actual date of service, the provider, and the location.
  A date outside the auth window means a denial.
- ☐ You confirm referral rules and get referrals from the correct primary care provider under the correct plan.
  HMO and Medicaid MCO referrals depend on the specific plan.
- ☐ You review the medical policy for high-risk services even when no auth is required.
  "No auth needed" does not mean "this will get paid."
- ☐ You check whether traditional Medicare now requires prior auth in the WISeR pilot states (AZ, NJ, OH, OK, TX, WA).
  In 2026, traditional Medicare isn't always auth-free.
- ☐ You send complete clinical notes with the auth request the first time — diagnosis, history, failed treatments, and test results.
  Incomplete requests get denied faster in 2026.
- ☐ You record auth numbers, expiration dates, and approved units where coders and billers can find them.
  An auth no one can find is the same as a missing one.
- ☐ You keep an eye on auths for expiration and used-up units on plans that cover multiple visits.
  An auth that runs out mid-treatment can trigger a string of denials.

C Coordination of Benefits — Getting the Order Right

Listing insurance in the wrong order is one of the easiest denials to prevent, and one of the most costly, because it holds up the entire payment chain. Which plan pays first depends on rules like the subscriber rule, the birthday rule, Medicare coordination, active-versus-retired status, and custody orders. You need to sort all of this out before you bill.

- ☐ You identify and put the primary, secondary, and tertiary payers in the right order before billing.
  "Primary wasn't billed" denials are 100% preventable.
- ☐ You apply the coordination rules correctly — subscriber rule, birthday rule for dependents, active-vs-retired, Medicare coordination, and custody orders.
  Getting the order wrong can cause denials across every payer.
- ☐ You check Medicare Secondary Payer status for working-age patients and anyone with other coverage.
  MSP mistakes cause denials and compliance risk.
- ☐ You identify QMB status before billing and remove any patient balance when it applies.
  Billing a QMB patient is a federal compliance violation.
- ☐ You spot Workers' Comp, auto, and liability coverage and bill them ahead of health insurance when they apply.
  Billing the wrong payer first means a denial, plus rework, plus delay.
- ☐ You re-check coordination of benefits at least once a year and after any big life change (marriage, divorce, retirement, COBRA, new job, or a change in dependents).
  Out-of-date benefit info is a quiet but constant cause of denials.

☐ You collect and document the patient's confirmation of all active coverage at check-in and at every re-check.
Coverage the patient forgot to mention can cause denials they never saw coming.

+ Process Maturity — Workflow and Accountability

VAC isn't a checklist one person runs on the side. It's a written process with clear owners, regular monitoring, and a way to learn from mistakes — because a job that belongs to everyone often ends up belonging to no one.

☐ Your front-end VAC steps are written down, and each step has an owner.
A process that isn't written down gets done differently every time.

☐ Verification happens on a set schedule (for example, 48 to 72 hours before the visit, and again the day of for high-risk services).
Last-minute checks lead to last-minute denials.

☐ You look at denials to find which ones came from front-end gaps, sorted by type and by payer.
Denials you don't track will keep happening. Denials you do track show you what to fix.

☐ Once a month, you use what you learned from denials to update the workflow and staff training.
Whatever the payer caught, you want to catch it first next time.

☐ Your front-desk staff are trained on plan types, why payer IDs matter, the 2026 code changes, and QMB rules.
Regular training keeps everyone's knowledge fresh.

Your Front-End Maturity Score

Add up your checked boxes across all four sections (30 total). Find your total in the chart below.

SCORE	TIER	WHAT IT MEANS
27–30	**High Performing**	You're VAC-aligned. Keep up the monthly reviews and feedback. Stay on top of new 2026 payer trends.
19–26	**Moderate Risk**	The basics are in place, but a few gaps are probably causing denials you could prevent. Fixing them pays off fast.
11–18	**High Risk**	You have real front-end exposure. Denials, days in AR, and write-offs are likely higher than they should be. A structured VAC setup makes sense.
0–10	**Critical Risk**	Your front-end process is mostly informal or undocumented. You're likely losing revenue and taking on compliance risk (QMB, MSP). Get help right away.

Your Next Step

No matter your score, the path is the same: find the exact front-end gaps causing your denials, then close them with a written, owned VAC process. That's exactly what MD Billing helps practices do.

VAC Audit	We review a sample of your patient encounters across verification, authorization, coordination of benefits, and patient info. You get a written report of the gaps and a step-by-step plan to fix them.
VAC Implementation	We build out the workflow, assign the roles, set the documentation standards, train your team, and set up the technology to make VAC part of your daily routine.
VAC Managed Service	MD Billing runs your front-end VAC for you, or alongside your team — with clear service agreements, monthly denial reports, and ongoing tracking of payer rule changes.

STOP PAYING FOR DENIALS YOU COULD HAVE PREVENTED

Every denied claim you could have caught up front is revenue you already earned and won't get back. Book a free 30-minute VAC Review, bring your finished checklist, and we'll show you exactly where your front-end is leaking money — and how fast you can stop it.

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