The 90-Day A/R Recovery Checklist

A Step-by-Step Plan to Reclaim Aged and Denied Revenue

For: Office managers and practice owners struggling with aging A/R, mounting denials, and cash flow gaps

You will learn: Follow this 90-day checklist to systematically identify, prioritize, and recover aged and denied claims—turning stagnant A/R into collected revenue without hiring additional staff.

Why Most A/R Cleanup Efforts Fail

Before diving into the checklist, understand the three most common reasons practices leave money on the table:

- **No aging bucket strategy** — teams work claims randomly instead of by dollar impact and timely filing risk
- **Denials get filed, not fixed** — the same denial codes recur month after month because root causes are never addressed
- **No dedicated recovery time** — front desk and billing staff are pulled into daily tasks, so aged claims sit untouched

This checklist solves all three by giving you a structured, week-by-week plan you can run in-house or hand to a billing partner.

Days 1–10: Audit and Triage

Goal: Know exactly what you're working with before you touch a single claim.

- [ ] Pull a full A/R aging report broken into 0-30, 31-60, 61-90, 91-120, and 120+ day buckets
- [ ] Separate claims by payer, denial reason, and dollar value
- [ ] Flag claims approaching timely filing deadlines — these get worked first
- [ ] Identify your top 5 denial codes by frequency and dollar impact
- [ ] Calculate your true A/R percentage over 90 days (target: under 15% of total A/R)
- [ ] Run a **free A/R audit** if you don't have the internal bandwidth to do this analysis accurately

Why this matters: You can't fix what you haven't measured. Most practices are surprised to find 20-30% of "lost" revenue is recoverable with the right prioritization.

Days 11–30: Attack High-Value, High-Recoverability Claims

Goal: Recover the largest, most winnable dollars first.

- [ ] Work all claims within 10 days of timely filing deadline immediately
- [ ] Prioritize claims over $500 with a clear, correctable denial reason
- [ ] Correct and resubmit clean claims with simple errors (eligibility, coding, missing modifiers)
- [ ] Begin formal appeals on medical necessity and authorization denials with supporting documentation
- [ ] Verify patient eligibility and benefits on all claims tied to coverage denials
- [ ] Log every action taken per claim (date, method, staff member, outcome) for accountability

Pro tip: A dedicated denial management and appeals process at this stage typically recovers 60-70% of workable denials — most practices only recover 30-40% without one.

Days 31–60: Fix the Root Causes

Goal: Stop new denials from feeding the backlog while you're still clearing the old one.

- [ ] Analyze your top 5 denial codes for a common root cause (registration, coding, credentialing, or payer policy)
- [ ] Audit front-desk eligibility verification workflow — is it happening before every visit?
- [ ] Confirm all providers are properly credentialed and enrolled with every payer you're billing
- [ ] Review coding accuracy on denied claims — look for patterns tied to specific CPT/ICD-10 combinations
- [ ] Retrain front-desk and billing staff on the specific errors driving your denials
- [ ] Continue working 61-90 and 91-120 day buckets in parallel

Credentialing gaps are one of the most overlooked denial drivers. If "provider not enrolled" or "not credentialed with plan" shows up in your top denial reasons, that's a fixable, permanent leak — not a one-time cleanup item.

Days 61–90: Close Out, Write-Off Wisely, and Build the System

Goal: Finish the recovery push and put permanent guardrails in place.

- [ ] Complete final appeals on all workable claims 90+ days old
- [ ] Make informed write-off decisions on truly uncollectable claims (don't default to write-off out of fatigue)
- [ ] Re-pull your aging report and compare to Day 1 — calculate total dollars recovered
- [ ] Document denial trends and root-cause fixes in a simple tracking sheet for ongoing monitoring
- [ ] Set a recurring weekly cadence (30-60 minutes) to review new denials before they age
- [ ] Decide whether your team can sustain this cadence internally or whether a full-service RCM partner should take it over

A one-time cleanup without a sustained process just resets the clock — most practices see aging creep back within 4-6 months without a permanent workflow.

Your 90-Day Recovery Scorecard

Track these five numbers on Day 1 and Day 90 to measure real impact:

| Metric | Day 1 | Day 90 |

|---|---|---|

| Total A/R over 90 days | ___ | ___ |

| A/R over 90 days as % of total | ___ | ___ |

| Dollars recovered from denials | ___ | ___ |

| Top denial code volume | ___ | ___ |

| Average days in A/R | ___ | ___ |

Benchmarks to aim for:

- A/R over 90 days: under 15% of total A/R
- Denial rate: under 5-8% of submitted claims
- Average days in A/R: under 40 days

When to Bring in Reinforcements

This checklist works — but it requires consistent, focused hours that many in-house teams simply don't have alongside daily billing operations. Consider outside support if:

- Your A/R over 90 days exceeds 20% of total receivables
- The same denial codes keep recurring despite staff retraining
- Credentialing delays are causing claim rejections
- Your team is spending more time firefighting than billing new claims
- You've never had a professional A/R audit

A billing partner focused on **A/R cleanup, denial management, and credentialing** can run this exact playbook faster and recover revenue your team may not have the bandwidth to chase.

Ready to see exactly how much recoverable revenue is sitting in your A/R? Request a Free A/R Audit and get a clear, no-obligation breakdown of what's recoverable, what's at risk, and what a 90-day recovery plan would look like for your practice.

https://accuratebillingandcoding.com/free-ar-audit