
Prepare for Your SNF AR and Billing Bottleneck Review

A Short Working Guide for Skilled Nursing Operators

Your upcoming review is designed to help you identify the AR, denial, Medicaid-pending, authorization or workflow issues that may deserve immediate investigation.

This is not a full billing audit, legal review, coding review, reimbursement opinion or compliance assessment. It is a focused operational discussion based on the information you choose to share.

You do not need a perfect data package. Bring the reports you already use.

What to Bring

Bring one, two or all three of these reports. If you have other relevant information, such as a held-claims report or current billing-vendor service-level agreement, you may bring that as well.

☐ 1. AR Aging by Payer and Facility

Use your most recent AR aging report.

The most useful version includes:

- ☐ Facility name.
- ☐ Payer or financial-class category.
- ☐ Current, 30-day, 60-day, 90-day and older balance buckets.
- ☐ Total outstanding balance.
- ☐ Major credit balances, if visible.
- ☐ Report date.

WHAT THIS HELPS IDENTIFY

- Whether old AR is concentrated in a specific facility.

- Whether one payer is carrying a disproportionate share of older balances.
- Whether the issue appears to be payer-specific, facility-specific or widespread.
- Whether old AR may include credit balances, claims not yet resolved or resident-responsibility issues.

Notes

☐ 2. Medicaid-Pending List

Use the most current list available.

The most useful version includes:

- ☐ Facility name.
- ☐ Resident identifier or other approved reference. Do not send PHI through unsecured channels.
- ☐ Admission date.
- ☐ Medicaid application date.
- ☐ Current application status.
- ☐ Known eligibility-effective date, if available.
- ☐ Missing document or barrier.
- ☐ Assigned owner.
- ☐ Next action and next follow-up date.
- ☐ Current outstanding balance.

WHAT THIS HELPS IDENTIFY

- Cases without clear ownership.
- Missing documentation that has not been escalated.
- Applications that may require follow-up.
- Pending balances that are aging without a defined next action.
- Potential patterns by facility, state or workflow.

Notes

☐ 3. Denial Report From the Previous 90 Days

Use a denial report that includes the most recent 90 days where possible.

The most useful version includes:

- ☐ Facility name.
- ☐ Payer.
- ☐ Denial reason or denial code.
- ☐ Date of service or billing period.
- ☐ Dollar value.
- ☐ Current appeal or follow-up status.
- ☐ Assigned owner.
- ☐ Next action date.

WHAT THIS HELPS IDENTIFY

- Repeated denial patterns by payer.
- Authorization or concurrent-review issues.
- Eligibility, timely-filing, documentation or billing-edit issues.
- Denials that have not been appealed or followed up.
- Recurring root causes that require an operational fix rather than claim-by-claim follow-up.

Notes

Optional Information That Can Help

Bring these only if they are easy to access and relevant to the issue you want to discuss.

☐ Held or Unbilled Claims Report

Include the claim, reason it is held, dollar value, date held, assigned owner and next action.

This can help identify whether claims are delayed because of missing documentation, payer setup, authorization gaps, eligibility issues, system handoffs or unclear ownership.

Notes

☐ **Current Billing-Vendor Service-Level Agreement**

If you use an outsourced billing company, bring the portion of your agreement that describes:

- ☐ Claim-submission timelines.
- ☐ Denial follow-up.
- ☐ Cash posting.
- ☐ Reporting.
- ☐ Escalation response.
- ☐ Old AR responsibility.
- ☐ Termination support.

This can help compare the work the vendor committed to perform with the reporting and outcomes you are seeing.

Notes

☐ **Recent Billing or AR Reports**

Bring any report that helps describe the problem, such as:

- ☐ Medicare Advantage authorization tracker.
- ☐ Medicaid application tracker.
- ☐ Credit-balance report.
- ☐ Payer correspondence.
- ☐ Facility-level billing KPI report.

Notes

Questions to Consider Before the Review

You do not need to answer these in advance. They can help your team focus the conversation.

- **Which facility or payer concerns you most?**

- When did the AR, denial or pending-balance issue begin?

- Is the issue getting worse, staying flat or improving?

- Which balances have been discussed repeatedly without resolution?

- Are Medicare Advantage authorizations, concurrent reviews or denials contributing to the problem?

- Is there a business-office staffing, ownership or handoff issue?

- What does your current billing vendor say is causing the issue?

- What decision are you trying to make after the review?

What We Will Work Through Together

During the review, we will use the information available to identify practical areas for further investigation. Depending on the reports you provide, the conversation may cover:

- AR concentration by facility, payer and aging bucket.
- Medicaid-pending cases without clear ownership or next action.
- Denial patterns that appear related to payer rules, authorization, eligibility, timely filing, documentation or internal handoffs.

- Held claims that require a defined owner and resolution path.
- Resident-liability changes or credit balances that may need further review.
- Reporting gaps that prevent leadership from seeing why cash is delayed.
- Questions to take back to your internal business office or current billing partner.

The outcome is a clearer view of what may be happening, what should be validated and what practical next step makes sense.

Secure Sharing Reminder

Do not send protected health information through standard email or an unsecured website form.

If you plan to share reports containing PHI, use the secure upload method or instructions provided by LTCPro. Before sharing, remove unnecessary personal identifiers where possible and share only the information needed for the discussion.

What This Review Does Not Do

The review does not:

- Complete a full claims audit.
- Determine reimbursement entitlement.
- Provide legal, compliance or coding advice.
- Make a payer coverage determination.
- Guarantee recovered revenue, reduced AR or a specific financial outcome.
- Replace the need for facility leadership, counsel, compliance professionals, payer guidance or qualified reimbursement advisers.

After the Review, Turn the Findings Into a Plan

If your review surfaces a workflow, staffing, reporting or vendor-accountability issue that needs more than an internal fix, LTCPro can help you determine the next practical step.

LTCPro supports U.S. skilled nursing and assisted living facilities with 50 beds or more across billing and accounts receivable, revenue cycle management, prior authorization, accounts payable, general ledger and payroll.

If you want to discuss the findings, evaluate a transition or explore ongoing long-term care billing support, schedule a conversation with an LTCPro specialist.

Talk With an LTCPro Long-Term Care Billing Specialist

[Contact Page Link](#)

Important Note

This guide and the associated review are for general operational discussion only. They are not legal, coding, reimbursement, compliance, audit or payer-specific advice.