

Camber

Practical Guide

Revenue Integrity Diligence: What Every PE Sponsor Should Assess Before Signing a Specialty Care Deal

A Camber Guide for Private Equity and Growth Equity Investors



Revenue integrity diligence is a distinct and necessary layer of pre-acquisition analysis for any ABA or specialty behavioral health deal.

This guide demonstrates why it belongs in every sponsor's process, explains what it reveals that a standard Quality of Earnings review cannot, and provides a practical framework for what to examine before you sign.

It is written for deal teams, operating partners, and portfolio leaders who are evaluating specialty care providers across ABA therapy, pediatric care, long-term care, and substance use disorder treatment, and want to understand whether a target's revenue is not just growing, but genuinely collectible, compliant, and scalable under new ownership.

The Acquisition Issue: Reported Revenue Is Not the Same as Reliable Revenue

A target's income statement shows you what was collected. It does not show you how that revenue was created, how much of what was earned remains uncollected, whether the collection process is repeatable under new ownership, or whether the reported figures mask structural exposure that will surface post-close.

This distinction between reported revenue and reliable revenue is the central problem with how most specialty care acquisitions are underwritten.

Standard financial diligence, including a Quality of Earnings analysis, is backward-looking by design.

It validates historical figures and confirms that recognized revenue was real. But what it does not do is model the fragility of the revenue-generation process itself: the payer mix concentration, the claim denial patterns, the authorization exposure, the credentialing gaps, the degree to which collections depend on specific individuals rather than repeatable systems.

The behavioral health and specialty care market has absorbed this lesson at significant expense. Scaled multi-site organizations have been acquired at premium multiples: ABA transactions in 2024 and 2025 traded in the range of 12–15x EBITDA for top-tier platform companies, a premium that reflects both the sector's growth profile and the strategic value of a strong foundation for future add-on acquisitions.

However, M&A advisors and operators active in this space consistently report a post-close pattern: collection rates that held during ownership by a founder or long-tenured billing team deteriorate after transition. Not because the underlying business changed, but because the people who held the process together are gone. What the QofE recorded as stable revenue was, in practice, dependent on individuals rather than systems. That distinction only becomes visible after close.

The market has taken notice. **M&A advisors active in behavioral health report that buyers are now "scrutinizing financials more rigorously than ever,"** with a specific focus on whether reported cash flow is genuinely sustainable.

Revenue integrity diligence is the structured answer to that scrutiny. And while ABA therapy is the sector where the evidence base is most developed, the same principles, and many of the same failure modes, apply across pediatric care, long-term care, and substance use disorder treatment.

What Revenue Integrity Actually Means

Revenue integrity is a straightforward concept: does all of your potential revenue have a clear, compliant, and repeatable path to collection?

The emphasis on potential is intentional. Most specialty care providers are not collecting everything they earn. The gap between what is authorized, delivered, billed, and actually paid is the primary source of hidden value, and hidden risk, in any specialty care acquisition.

Each of the following components carries its own failure mode, and standard financial diligence will not surface them.

Four components of revenue integrity:

CREATION

Is every billable session or service being identified, documented, and converted into a claim correctly? Documentation gaps, unsigned sessions, missed charges, and billing entry errors mean revenue disappears before it is ever submitted.

COMPLIANCE

Are claims being submitted in a way that is defensible to payers and to regulators? Billing for services at the wrong provider level, using incorrect codes or modifiers, exceeding authorized hours, or misclassifying place of service creates not just denial risk but audit and recoupment liability. This distinction matters enormously when Medicaid and Medicare are significant payers.

COLLECTION

What percentage of submitted claims are paid on the first pass, and how quickly? First-pass paid rate and days in A/R are the most direct measures of operational billing quality. Across specialty care, the industry benchmark for best-in-class performance is a denial rate below 5%, with top performers closer to 2–3%. Underperformance against this benchmark is not a minor administrative issue. It is a direct drag on cash conversion and EBITDA.

SCALABILITY

Will this revenue process hold under the operational changes that accompany a PE acquisition? System integrations, new payer contracts, staff transitions, and geographic expansion all stress-test billing infrastructure. A process that depends on institutional knowledge held by two or three individuals is a person-dependent workaround, not a reliable process.

The Risks a Standard QofE Will Not Surface

Revenue integrity gaps translate directly into investment risk across three dimensions:



Finance



Compliance



Operational

The specific failure modes vary by sector, but the underlying pattern is consistent. Revenue that looks solid in a QofE deteriorates after close because the process that created it was never examined.

Financial Risk: The gap between what is owed and what is collected

Denial rates are rising industry-wide. Across U.S. healthcare, initial claim denial rates reached 11.8% in 2024, up 15.7% from 2020, and in 2025 more than 41% of providers reported denial rates above 10%. In 2025, U.S. hospitals spent an estimated \$43 billion attempting to collect payments for care already delivered, including \$18 billion specifically fighting denied claims.

Long-term Care and Skilled Nursing

Skilled nursing facility (SNF) billing carries distinctive challenges layered on top of the broader denial environment. Most SNFs hold beds dually certified for both Medicare and Medicaid, meaning a single resident may move between payers within one stay. Each transition creates a billing reset point where missed eligibility changes can trigger retroactive denials that are difficult to recover.

ABA Therapy

Behavioral health services face an average in-network ACA marketplace plan denial rate of 20% across all services, with individual insurer rates ranging from 1% to 54%. Behavioral health and ABA claims are disproportionately affected by authorization-related denials. 9% of all in-network denial reasons in 2023 were attributed to lack of prior authorization or referral, a category that is almost entirely preventable with robust front-end billing processes.

Pediatric Care

Billing complexity is driven by high claim volume across vaccination schedules, developmental screenings, and acute visits, combined with the Medicaid and CHIP enrollment complexity that characterizes a pediatric payer mix. Age-specific CPT coding requirements and state-specific Medicaid rules mean that coding errors are a common source of denials.

Substance Use Disorder Treatment

Denial rates are elevated by complex multi-level-of-care authorization requirements. SUD treatment centers face particularly intensive payer scrutiny around medical necessity documentation, length-of-stay justification, and level-of-care transitions, each representing a point where underdocumented claims are routinely denied. Prior authorization is particularly prevalent in SUD care and has been directly linked to decreased provider willingness to treat and reduced patient access, with denial rates for prior authorization requests reaching as high as 40% in some Medicaid managed care plans.



Underpayment

Denial is not the only revenue leak. Even when claims are paid, they are not always paid correctly. Payments for inpatient behavioral health services were 34.3% below costs across all payers on average in 2023.

This figure illustrates a structural underpayment gap that extends beyond hospitals into outpatient and community-based specialty care settings. In ABA specifically, where payer-rate tools can surface systematic underpayments across thousands of claims, the aggregate exposure often surprises acquirers during a post-close audit.

The same dynamic applies in long-term care, where ancillary service charges are frequently missed or underbilled.



A/R aging

Days in accounts receivable vary meaningfully by specialty, payer mix, and billing infrastructure, but the direction of risk is consistent across sectors.

When aging buckets show significant balances at 90+ days, collectibility deteriorates sharply. Claims become harder to appeal, timely filing deadlines approach, and write-offs become inevitable.

An A/R aging schedule that looks manageable in aggregate often conceals concentrated payer exposure when broken down by payer and denial code.



Write-off Normalization

QofE reviews typically accept management's characterization of write-offs as contractual adjustments.

Revenue integrity diligence distinguishes between legitimate contractual write-offs, bad debt from uncollectible patient balances, and operational write-offs: revenue that was earned and owed but abandoned due to process failure.

The third category is invisible in a standard audit and can represent a material, recoverable revenue gap across all of these sectors.

Compliance Risk: What Past Billing Behavior Has Created

Some PE firms have acquired ABA providers with a pre-existing pattern of fraudulent billing practices that standard due diligence procedures failed to detect. One acquired entity had previously paid \$2.7 million to settle a case involving billing for excessive hours and misrepresenting provider identities to Tricare.

You do not need to be looking at fraud to face compliance exposure

Systemic modifier errors, credentialing gaps that caused claims to be submitted under the wrong provider NPI, consistent billing beyond authorized hours, or insufficient medical necessity documentation all create retroactive recoupment risk that can sit on a balance sheet for years without disclosure.

The compliance calculus varies by sector but the common thread is government payer exposure. Medicaid is a major payer in ABA, pediatric care, long-term care, and SUD treatment, and Medicaid conducts aggressive post-payment audits.

Tricare is significant in ABA and SUD. Medicare is the dominant payer in long-term care and skilled nursing. Any acquirer taking on a specialty care organization with meaningful government payer volume should treat RCM compliance review as mandatory pre-close diligence, not a post-close integration task.



Operational Risk: Revenue That Will Not Survive the Transition

The most overlooked category of risk is transition fragility. Revenue cycle performance in specialty care often depends on individuals: a billing manager with deep payer relationships, a small team with institutional knowledge of a particular Medicaid program's quirks, a clinician who manually tracks authorization expiration across a complex caseload.

When PE acquires a specialty care organization and begins integration, those individuals often leave, get reorganized, or get absorbed into larger administrative structures. The billing performance metrics that justified the acquisition multiple then deteriorate. Not because the business changed, but because the person-dependent workarounds that produced those metrics are gone.



Technology-automated billing processes are the only ones that survive ownership transitions reliably.

These are processes where the rules engine, payer-specific logic, and claims submission workflow are embedded in software rather than in people. Assessing the degree to which a target's revenue cycle is systematized versus person-dependent is a direct measure of whether the multiple you are paying is defensible.

Payer Mix Analysis and Concentration Risk

Map the target's payer mix in detail: the percentage of revenue from each payer, the contracted rates versus the rates actually received, and the historical trend in each payer's denial and payment behavior.

Concentration risk is sector-specific. In ABA, a platform company deriving more than 30–35% of revenue from a single commercial payer, or more than 50% from Medicaid across one or two states, carries exposure that is not visible in a standard revenue breakdown. In long-term care, the dominant question is Medicare versus Medicaid versus managed care mix, and the trend direction of each, given that Medicare Advantage plan initial denial rates rose 4.8% from 2023 to 2024 alone.

In SUD treatment, out-of-network versus in-network commercial mix is particularly significant: out-of-network providers face unpredictable cash flows and carry different M&A valuation dynamics.

Examine the payer-rate variance: the gap between contracted rates and actual payments. Systematic underpayments by specific payers, when identified at scale across thousands of claims, represent both a recovery opportunity and an indicator of weak contract management.

Illustrative payer mix – three acquisition targets

Revenue % by payer type

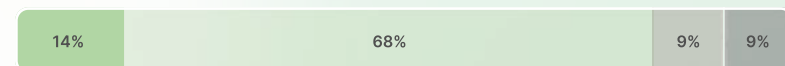
Target A

Well-diversified



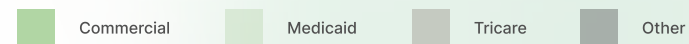
Target B

Medicaid-heavy – state policy risk



Target C

Single-payer concentration – high exposure



Figures are illustrative only. Actual payer mix varies significantly by organization, geography and service model. A pre-acquisition revenue integrity diagnostic maps real payer-level revenue, contracted rates, and realized rate variance for each target.

First-Pass Paid Rate and Denial Pattern Analysis

Pull at least 24 months of claims data and compute the first-pass paid rate by payer, by service type, and by location. Aggregate denial rates obscure the specific failure modes that drive revenue loss.

Look for:

DENIAL CODES CONCENTRATED IN SPECIFIC PAYERS

A high denial rate with one payer that management attributes to that payer's complexity often indicates a payer-specific rule the billing team has not automated.

AUTHORIZATION-RELATED DENIALS

In ABA, SUD, and pediatric care, denials for services exceeding authorized hours, or for services where prior authorization lapsed, are entirely preventable and reflect a process failure. In SUD, level-of-care authorization denials are a particularly significant revenue risk.

CREDENTIALING DENIALS

Claims denied because the rendering provider was not credentialed with the payer at the time of service indicate either a credentialing management failure or an undisclosed period of billing under the wrong NPI.

TIMELY FILING DENIALS

A claim denied because the filing deadline passed is a claim that was earned and is now gone. Timely filing denials, when they appear in volume, indicate that the billing cycle has significant lag. Claims are not being submitted within the required window.

ELIGIBILITY DENIALS

In long-term care and pediatric care especially, eligibility changes during a stay or enrollment period are common and frequently missed. In long-term care, a patient transitioning from Medicare to Medicaid mid-stay creates a billing transition point that results in retroactive denials if left unmanaged.

A/R Aging Quality Review

An A/R aging schedule should be reviewed for both the total balance and the quality of what is in each bucket.

The specific questions:

- What percentage of the 90+ day bucket is genuinely collectible versus effectively written off but not yet recognized?
- Is the aging schedule clean across payer types, or is aging concentrated in Medicaid, Medicare Advantage, or specific commercial payers?
- What is the write-off rate, and how is management classifying write-offs? Contractual, bad debt, and operational write-offs have very different implications.
- Is there a documented appeals process for denied claims, and what is the appeals success rate? Providers that do not pursue appeals systematically are abandoning revenue that was earned.

Authorization Management and Compliance Exposure

Prior authorization is a major upstream control point across all of these sectors. Most commercial payers and all Medicaid programs require prior authorization before ABA and SUD services begin, and authorization must be renewed for ongoing care, typically every three to six months.

In pediatric care, authorization requirements vary significantly by payer and service type. In long-term care, admission authorization and continued-stay authorization are critical revenue checkpoints.

Review the target's authorization management process in detail:

- Are authorizations being tracked in real time, or managed through spreadsheets and manual reminders?
- Are there patterns of services delivered beyond authorized hours or beyond the authorized level of care? This creates both denial exposure and potential recoupment liability if audited.
- Are authorization renewals being initiated early enough to avoid gaps in billable coverage?
- Are there outstanding Medicaid, Medicare, or Tricare audits, or any historical recoupment demands?

Revenue Cycle Infrastructure: Systemized vs Person-Dependent

This is the assessment that most directly predicts whether the revenue cycle will hold post-acquisition.

The core question is this: if the two or three most experienced members of the revenue cycle team left in month three after close, what would happen to collections?

Indicators Of A Systematized Revenue Cycle Infrastructure

Claims submission is automated and frequent, not batch-processed weekly by a revenue cycle team.

Payer-specific rules are encoded in a rules engine, not in the institutional memory of individual billing staff.

Denial management workflows are automated, with escalation triggers and documented appeal processes.

The KPI dashboard provides real-time visibility into claim status, denial codes, and A/R aging without requiring manual reporting from the billing team.

Onboarding new providers and new payer contracts does not require individual customization because the system handles it.

Indicators of a person-dependent billing infrastructure

Manual claim submission, often through the EHR interface, on a weekly or bi-weekly cycle.

Denial management is reactive. Denials are worked when the billing team has capacity.

Reporting on billing performance is not available in real time and requires a specific person to pull it.

Institutional knowledge of payer-specific rules lives with one or two people and is not documented.

Revenue Scalability Assessment

For an acquisition intended to serve as a platform company, revenue integrity diligence must also assess whether the billing infrastructure can scale.

The specific question is not whether the current billing process works for the current volume. It is whether it will work at 2x, 3x, or 5x the current volume without a proportional increase in billing headcount.

Technology-driven RCM scales where human-driven RCM cannot. A specialty care organization that automates 80–90% of the claims lifecycle can add locations, providers, and payer contracts without hiring new billing staff for each one. One that relies on manual processes needs to staff up proportionally, eroding the operational leverage that justified the acquisition.

Ask the target: what happened to billing headcount and billing error rates the last time the organization expanded by 20%? The answer is more revealing than any pro forma.

The Camber Pre-Acquisition Diagnostic

Camber provides a structured 72-hour assessment that produces specific, investment-grade findings on each of the areas described above.

The diagnostic draws on over \$2.5 billion in ABA, SLP, OT, and PT claims in the U.S., with payer-level data across commercial, Medicaid, and Tricare payers in every major geography.

That claims data provides the payer-level benchmark context that turns raw performance figures into actionable findings: denial rates, collection timelines, and underpayment patterns assessed against what Camber observes across comparable payers and geographies.

The output of a Camber pre-acquisition diagnostic is not a qualitative assessment. It is a structured findings document covering:

- 01 | Payer mix concentration and contracted rate vs. realized rate variance by payer
- 02 | First-pass paid rate by payer, service type, and location, with denial code analysis
- 03 | A/R aging quality assessment, including collectibility scoring of the 90+ day bucket
- 04 | Authorization management gap analysis and estimated compliance exposure
- 05 | Billing infrastructure classification (systematized versus person-dependent) with specific evidence
- 06 | Revenue scalability assessment and headcount leverage projection
- 07 | Identified revenue recovery opportunities, sized and prioritized

The diagnostic is designed to give your deal team a clear, defensible answer to the question that the QofE does not answer: is this revenue not only growing, but collectible, explainable, and scalable?

Camber runs pre-acquisition diagnostics within a 72-hour window, designed to fit your diligence timeline.

Contact Camber before your next specialty care deal closes.

Run a Camber diagnostic