

Revenue your dashboard cannot see.

We switched billing platforms in the spring. Nothing errored. Collections fell by a third. This is what we found, what it was worth, and what we would tell another practice owner.

David Donohue, MD — physician-owner, primary care, Wilmington, Delaware · September 2026 · Figures rounded; vendors, payers, and patients not named.

Visits that never became a claim

1 in 9

for four months after the cutover

Program billing rows that never reached the billing system

3 in 4

in one month's upload

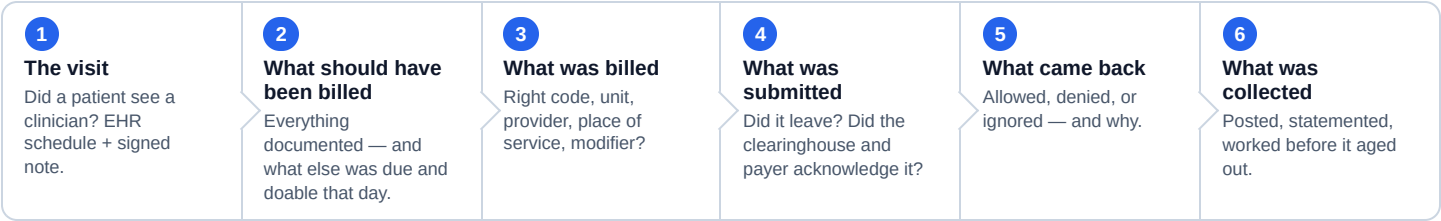
Payable, found in one pass

\$482k

4,848 claims · \$676k in charges rebuilt, corrected, or released

The idea that found it: start from the visit, not the claim

Every billing report we owned started with the claim. If a visit never became a claim, the report showed nothing — not a denial, not a zero. **Zeros do not trend.** So we started at the other end: every encounter in the EHR became a row, and we followed each one forward through every hand it passed through.



Hop 2 is the step most reconciliations skip: was everything that happened billed, and what else could reasonably have happened — the wellness visit owed, the program the patient qualified for, the screening one question away. That second list is bigger than the leak, and it is a plan, not a repair.

The scorecard the same view a practice would look at every Monday · three questions, a few measures each, a queue with an owner

Did every visit become a claim?				Hops 1 → 3
MEASURE	AT DISCOVERY · SEP 1		AFTER THE PASS · SEP 16	FIXED BY
Visits with a matching claim, per provider per week	89% ✖ Critical		100% ✓ Met	788 claims built from the chart and submitted
Program roster rows that reached the billing system	25% ✖ Critical		100% ↳ Biller re-importing	1,906 rows, two months, re-import lists
Claims parked in "needs review" older than 7 days	99 ! Serious		0 ✓ Met	Default rendering provider repaired, released

Did every claim get paid what the contract allows?				Hops 4 → 5
MEASURE	AT DISCOVERY · SEP 1		AFTER THE PASS · SEP 16	FIXED BY
Paid claims allowed under a tenth of charge	591 ✖ Critical		0 new ↳ Corrected claims in flight	Unit error found; corrected claims resubmitted
Identity and wrong-payer denials (member not found, home plan)	917 ✖ Critical		0 new ↳ Resubmitted	Ids corrected from the chart; rerouted by member prefix
Same denial, same code, same payer, every month	265 ! Serious		Rule written ✓ Met	Modifier removed before submission
Provider-enrollment denials on one NPI	282 ! Serious		Enrollment filed ↳ Payer	Enrollment, then resubmit

Did the money arrive?			Hop 6 · and the question the next pass answers
MEASURE	AT DISCOVERY · SEP 1	AFTER THE PASS · SEP 16	FIXED BY
Payable identified, collected to date	\$0 of \$482k × Unseen	\$35k of \$482k • 14–45 day payer turnaround	Updated as remittances post
Due, doable, and not done (ledger two)	— – Not measured	— – Next pass	Same join, read against the chart

What we found Charges = what was billed · Payable = what the payers' own fee schedules allow, from what they actually allowed on our paid claims of the same kind this year

Gap found	Claims	Charges	Payable (est.)	How it was fixed
Visits that never became claims	788	\$217k	\$146k	Claims built from the chart and submitted
Program rows never imported (two months)	1,906	\$135k	\$109k	Re-import lists handed to the biller
Program claims billed at pennies	591	\$38k	\$31k	Corrected claims
Wrong patient identifiers or payer	625	\$68k	\$46k	Corrected in place, biller resubmits
Parked at a review gate on a default provider	99	\$29k	\$19k	Rendering provider repaired, released
A modifier the payer never accepts	265	\$51k	\$38k	Modifier removed, corrected claims
Out-of-area members sent to the local plan	292	\$68k	\$46k	Reroute by member prefix
New clinician not yet enrolled	282	\$70k	\$47k	Enrollment, then resubmit
Total	4,848	\$676k	\$482k	About a fifth of the visit figure is patient responsibility

The gotchas and the comparison that sees each one

1. **Visits that never became claims.** One in nine, four months. *EHR visits vs billing claims, per provider per week.*
2. **Program billing uploaded by hand, partially.** A quarter of a month's rows; another month uploaded three times after a spreadsheet mangled ids. *Roster rows vs claims for the month.*
3. **A charge unit error the payer honored.** Hundreds paid at pennies. *Allowed amount far under fee schedule on paid claims.*
4. **Patient identifiers lost in the move.** "Member not found" by the hundreds; fixable in bulk from the chart. *Identity denials clustered after the cutover.*
5. **A default rendering provider.** One NPI on every claim the feed could not resolve, parked at a review gate. *"Needs review" older than a week.*
6. **A modifier the payer never accepts.** Same denial, same code, same payer, every month. *Denials by payer, procedure, reason.*
7. **Payer policy changed quietly.** A common add-on went from under a third denied to nearly all. *Denial rate by code and payer, month over month.*
8. **Out-of-area Blue members sent to the local plan.** Bounced with "submit to home plan." *A denial reason that appears only after the switch.*
9. **A new clinician billing before enrollment finished.** Three months of provider denials on one NPI. *Provider-information denials by NPI.*
10. **The payer's "complete" report was not.** Hundreds of adjudicated claims missing from it. *Reconciling the reconciliation.*

Check your own practice this week

- ☐ **Visits vs claims**, per provider per week. More than 3% short is a dropped feed.
- ☐ **Roster vs claims** for each program month. Should match within a handful.
- ☐ **Paid under a tenth of charge.** Unit errors and wrong codes live there.
- ☐ **"Needs review" older than seven days.** Read the oldest ten.
- ☐ **Same denial, same payer, every month.** That is a rule, not a mistake. Fix it once.
- ☐ **Had a transition?** Run all five with the cutover date as the split.