

What a practice cannot see from inside its billing system.

Start from the visit, not the claim; follow every one through six hops to the bank; ask what else each visit was owed. What that finds in a representative practice.

September 2026 · Representative-practice figures are illustrative ranges, not predictions.

Leaks unseen in an ordinary year

3–7%

no transition, competent billing team

Claims denied on first pass

1 in 10

about two thirds never reworked

At \$4M in collections

\$120–280k

\$60–140k at \$2M

Six hops, and what leaks at each

A billing dashboard counts what reached the billing system. It cannot see the visit that never became a claim or the claim the payer never received. Those are zeros, and zeros do not trend. Starting from the EHR encounter makes the count exhaustive.

1

The visit

Eligibility unchecked · wrong plan on chart · missing auth

2

Should have been billed

No charge · add-ons omitted · level unsupported · wellness visit or program due, not offered

3

Was billed

Wrong NPI · not enrolled · bad modifier · id mismatch · roster rows dropped

4

Was submitted

Rejections unread · accepted but never forwarded · timely filing missed

5

Came back

Wrong payer · policy changes · underpayment · payer records incomplete

6

Was collected

Remits unposted · denials aged out · balances unstatemented

Two ledgers from one join

Ledger one · earned and lost

Care delivered and documented, and the dollars that never arrived for it. Recovery work: a list for the billing team with a fix on every row, mostly collectible within one or two payer cycles.

Ledger two · due, doable, and not done

Care the chart says the patient was owed — wellness visit, care-management enrollment, a screening — deliverable with a change the practice can actually make. Planning work: a roster, a staffing implication, a recurring monthly number.
Kept honest by three rules: appropriate per the chart, not a benchmark · doable with a named change · documentation supports it, both directions.

A representative practice, first look

four clinicians · ~\$4M collections · ~8,000 active patients · ~30% Medicare · estimated

Ledger one · what was earned and not collected			est. 2–4% of annual collections on a first pass
GAP	HOW IT SHOWS UP	PAYABLE (EST.)	STATUS
Visits that never became a claim	~1.5% of ~24,000 visits/yr with no matching charge	\$35–45k	! Serious
Denials aged past the appeal window	~10% denied first pass · two thirds never worked · half recoverable	\$40–55k	× Critical
Underpayment vs contract	Allowed below fee schedule on paid claims, one or two payers	\$8–15k	! Warning
Program months enrolled but not billed	Roster vs claims mismatch, a handful a month	\$4–10k	! Warning
Timely-filing losses booked as write-offs	Accepted but never forwarded · rejections unread	\$4–8k	! Warning
First pass, total	Then \$8–15k/month caught while still days old by the same checks running weekly	≈ \$90–130k	

Ledger two · what was due, doable, and not done				
same practice · gross of added staff · rows exist only where the chart supports them				
SERVICE	ELIGIBLE (EST.)	DONE TODAY (EST.)	DOABLE IN 12 MONTHS	GROSS ANNUAL (EST.)
Annual wellness visit	~2,400 Medicare patients	About half ! Half done	+20 points with a slot and a script	\$60–75k
Advanced primary care management (APCM)	~1,500 with two or more chronic conditions	Few or none × Not started	Enroll a quarter, with one care navigator	\$200–250k
Behavioral health integration	About half of APCM enrollees	Few or none × Not started	~190 patients, same navigator	\$85–100k
Preventive and quality services	All Medicare patients	Inconsistent ! Serious	Capture at the wellness visit	\$40–80k
Ledger two, total	One care navigator (~\$65k) carries ~500 enrolled; net of that, year one runs roughly half of gross. Ledger one funds ledger two: recover \$100k in the first quarter and the navigator is paid for.			≈ \$385–505k

When the risk is highest if you have had one of these in the last 12 months

Event	Expect
Billing platform or RCM vendor switch	Dropped feeds · identifier loss · default providers · payer routing and enrollment not carried over
EHR migration	Visit and bill history split · rosters rebuilt by hand · chart ids renumbered
Clearinghouse or submitter-id change	Rejections nobody reads · ERA and EFT lapses · accepted but never forwarded
New clinician, site, or tax id	Claims out before enrollment · wrong place of service · wrong billing provider
New program: care management, RPM, behavioral health	Roster-to-claim gaps · code and modifier habits set once, never revisited
Payer policy change · billing staff turnover	Last year's paying code stops paying · unowned queues · denials aged past appeal

Why this kind of analysis fits the problem

- **Exhaustive, not sampled.** Every visit matched to a bill, every bill to a claim, every claim to a payment. A one-in-nine dropout is invisible in a spot check and obvious in a full join.
- **Reads across systems.** The EHR knows the visit, the billing platform the claim, the payer what it received. Only a layer reading all three sees the visit that never became a claim.
- **Reads the chart, not just the claim.** Eligibility, gaps, and documentation live in the note. That is what makes ledger two possible.
- **Auditable, and it stays on.** Every finding carries the two records that disagree; the biller approves each fix. Run weekly, the next dropped feed shows within days, not months.

What a full pass asks of a practice

- **A business associate agreement, signed first.** No data moves before it.
- **Read-only exports:** EHR encounters and notes; billing charges, claims, remits; clearinghouse and payer records.
- **About two hours** of the billing lead's time.
- **What we never do:** change a claim, a charge, or a chart.
- **You keep** every list and the scorecard. **We keep** nothing at close, unless you ask us to keep watching.

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. Fix it once.

Something surprising? Thirty minutes with us is enough to judge whether a full pass applies.