SAMPLE REPORT

Revenue cycle audit

Prepared for a three-provider internal medicine practice · 90 days of claims data reviewed · Report issued six business days after read-only access was granted.

> **This is a sample.**
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> Every figure in this document is invented. It exists so you can see the shape of what you receive before you hand over access to anything. Your report follows this structure using your own data, takes about a week, costs nothing, and is yours to keep and take to any billing company you like — including the one you already use.

Headline findings

91.4%	11.8%	58	$83,200
Net collection rate	Denial rate	Days in A/R	Identified as recoverable

Net collection rate is payments divided by the amount your contracts allowed, and it is the number that captures every leak at once. At 91.4% against an allowed volume of roughly $1.42M annualised, the gap to a 95% target is about $51,000 a year. That is not the whole opportunity — it excludes aged receivables already written down, which are handled separately in section 4.

Your clean claim rate, by contrast, is 96.1%. Both numbers are accurate. Only one of them is about money, and the difference between them is the substance of this report.

1 · Where the revenue is going

Finding	Annual impact	Difficulty
Eligibility-origin denials not traced back to registration	$19,400	Low — process change at the front desk
Established patient visits coded conservatively (99213 where documentation supports 99214)	$24,800	Low — coder feedback loop
Contractual underpayments posting without a variance check	$11,600	Low — posting rule change
Chronic care management never billed for an eligible panel	$18,900	Medium — requires workflow and consent
Claims lost to timely filing in the review period	$8,500	Already lost — prevention only

The final row is not recoverable. It is included because it is the clearest indicator of how the A/R queue is being worked, and because a practice should know when it happens rather than see it absorbed into an adjustment code.

2 · Denials by origin

Denials below are grouped by the stage of your revenue cycle that produced them rather than by payer or by CARC code. Grouping by payer tells you who denied. Grouping by origin tells you what to change so it stops.

Origin	Share	Leading reason	Where the fix belongs
Eligibility	34%	Coverage terminated or plan changed	Front desk — verify 48–72h ahead
Coding / modifier	26%	Modifier 25 missing on same-day E/M	Coder feedback loop
Authorisation	21%	Precertification absent (CO-197)	Scheduling — check at booking
Timely filing	9%	Filed past payer window	A/R prioritisation method
Payer error	6%	Incorrect contract rate applied	Escalate as a pattern, not per claim
Other	4%	Assorted, no pattern identified	—

The observation that matters

Fifty-five percent of your denials originate before a claim is ever created — at eligibility and at authorisation. No billing company can fix that from inside the billing function alone. Any proposal that does not involve changing something at your front desk is treating symptoms.

3 · Coding accuracy sample

Forty charts reviewed against documentation, in both directions. Most audits look only for overcoding, because that is where the penalties are. Undercoding carries no penalty and costs more.

Result	Charts	Note
Coded correctly	31	No action
Undercoded — documentation supported a higher level	7	Chiefly 99213 where MDM supported 99214
Overcoded — documentation did not support the level	1	Single instance, no pattern identified
Documentation insufficient to determine	1	Query sent to rendering provider

A 7-to-1 ratio of undercoding to overcoding is common and is not a compliance finding. It reflects clinicians rounding down out of caution, which is a rational response to how compliance is usually taught. It is also, at your volume, worth about $24,800 a year.

4 · Accounts receivable

Bucket	Balance	Assessment
0–30 days	$41,200	Normal
31–60 days	$26,800	Normal
61–90 days	$14,300	Slightly heavy; follow-up appears to begin around day 45
91–120 days	$9,100	Two claims approach filing deadlines within 30 days
120+ days	$21,600	Largely unworked. See below.

What is in the 120+ bucket

Of the $21,600 sitting past 120 days, we assess roughly $12,900 as realistically collectible and $8,700 as effectively dead — past filing deadlines, or balances small enough that pursuit costs more than recovery. We are telling you the second number because most reports do not. It usually appears later as an adjustment nobody explains.

The pattern in this bucket suggests A/R is being worked oldest-first. That is the intuitive method and close to the worst one: it spends attention on claims with no deadline pressure while newer claims approach their filing windows unattended. Sequencing by filing deadline first and recoverable value second is the single highest-yield change available to you.

5 · Credentialing

Item	Status	Action
Provider A — commercial payers	Current	None
Provider B — commercial payers	Current	None
Provider C — one commercial payer	Not enrolled	Claims for this payer are unbillable until enrolled
CAQH attestations	Two overdue	Attest before the next re-credentialing cycle
Licence and DEA expirables	All current	Calendar with 90-day lead time

6 · Recommended sequence

In order of return per unit of effort. The first two require no new systems and no new staff.

	Action	Expected annual effect
1	Move eligibility verification to 48–72 hours before the appointment, with patient responsibility returned to the front desk in a usable format	$19,400
2	Introduce a coder feedback loop on E/M level selection, reviewed monthly at provider level	$24,800
3	Add a contractual variance check at payment posting so underpayments stop posting as normal payments	$11,600
4	Re-sequence A/R by filing deadline, then by recoverable value	Prevents recurrence of the $8,500
5	Work the collectible portion of aged A/R as a discrete project	$12,900 one-off
6	Evaluate chronic care management for the eligible panel	$18,900

What happens next

Nothing, unless you want it to. This report is yours. If you would like us to implement any part of it, our pricing is published at arslanmedicalbilling.com/pricing and our service commitments — including the fee credits that apply when we miss them — are on the same page. If you would rather hand this to your current biller and ask them to work through it, that is a legitimate and completely reasonable use of it.

Scope and limitations. This review covered 90 days of claims data and a 40-chart documentation sample. It is an operational assessment, not a compliance audit, a legal opinion or a coding certification. Figures are estimates based on the period reviewed and assume payer behaviour and contracted rates remain broadly stable. Recoverability assessments on aged receivables are judgements, not guarantees. Every number in this sample document is invented.