K MEDICAL BILLING
BILLING EVERY SPECIALTY, EVERY SIZE

Health First Urgent Care

PRACTICE ANALYSIS

PRACTICE SNAPSHOT

AVERAGE BILLING & PAYMENT OF LAST 6 MONTH (Mar 1st 2022 to Aug 31st 2022):

We reviewed last 6 month of data and found below information

- Average Billing Charges: **$1,210,386.75**
- Average Payment : **$904,596.56**
- Patient Payment Average: $44,677.90
- Insurance Payment Average: $859,918.65

PRACTICE AGING (Jan 1st 2021 to Aug 31st 2022):

- Total Practice aging is: $ 1,843,371.33
- Insurance Aging: $ 1,621,061.82
- Patient Aging: $ 222,309.51

PRACTICE SNAPSHOT

CHARGES TO PAYMENTS COMPARISON (Sep 1st 2021 to Aug 31st 2022):

There are irregularities in the charges to payments comparison, we found a lot of claims that were billed three or four months ago and their payments are being posted after 60 to 90 days.

Billing Month	Claims Submitted	Billed Amount	Paid Claims	Payment Amount
Sep-21	2614	$ 1,419,467.05	1774	$ 432,607.55
Oct-21	2980	$ 1,685,519.30	1798	$ 462,086.98
Nov-21	2133	$ 1,366,385.36	1862	$ 482,619.91
Dec-21	2629	$ 1,576,894.63	2330	$ 699,834.48
Jan-22	5730	$ 3,064,049.00	1938	$ 594,380.73
Feb-22	2965	$ 1,642,502.00	1427	$ 384,977.82
Mar-22	1773	$ 997,407.04	4942	$ 1,289,810.61
Apr-22	1514	$ 938,477.00	4657	$ 1,193,590.67
May-22	2161	$ 1,412,324.00	1991	$ 642,901.05
Jun-22	2315	$ 1,366,517.50	1927	$ 632,293.14
Jul-22	2291	$ 1,323,912.00	3050	$ 787,373.64
Aug-22	2143	$ 1,163,263.00	1986	$ 614,598.63
TOTALS	31248	$ 17,956,717.88	29682	$ 8,217,075.21

* **CLAIMS SUBMITTED COLUMN**: It means how many claims were submitted in the respective billing month irrespective of the DOS

** **PAID CLAIMS COLUMN:** It means how many claims got paid in the respective billing month irrespective of the claims submitted during that month

PRACTICE SNAPSHOT

LIST OF TOP 10 PAYERS (Jan 1st 2022 to Aug 31st 2022):

List for the top 10 Payers with highest number of reimbursements from the past 8 months:

Insurance Name	Payment
Blue Cross of Washington Premera	$ 2,653,969.56
Molina Health Care Washington Provider	$ 722,903.18
Kaiser Foundation of Washington	$ 689,856.86
Community Health Plan of WA	$ 411,659.40
Medicare B Washington	$ 405,771.11
Coordinated Care of WA - Ambetter	$ 273,198.62
Aetna	$ 186,667.22
Washington LNI	$ 151,645.63
Amerigroup Apple Care	$ 110,281.85
Cigna	$ 110,275.60

PROBLEM & IMPROVEMENT AREAS

AR NUMBERS ARE HIGHER THAN THE INDUSTRY STANDARDS

INSURANCE AGING SUMMARY - 01/01/2021 to 08/31/2022								
Aging Slots	Primary Insurance Aging		Secondary Insurance Aging		Total Aging			
AR Days	P Claims	P Balances	S Claims	S Balances	Total Claims	Amount	Total %age	Comments
0-30	739	$ 410,936.27	40	$ 3,221.84	779	$ 414,158.11	25.55%	
31-60	396	$ 224,223.14	33	$ 4,303.64	429	$ 228,526.78	14.10%	
61-90	280	$ 152,537.94	25	$ 8,013.87	305	$ 160,551.81	9.90%	
91-120	246	$ 131,354.72	22	$ 2,615.05	268	$ 133,969.77	8.26%	
>120	1402	$ 671,811.91	78	$ 12,043.44	1480	$ 683,855.35	42.19%	Critical – Losing Collection
	3063	$ 1,590,863.98	198	$ 30,197.84	3261	$ 1,621,061.82	100%	

- Based on the above data , aging in 120+ quite high compared to industry standards, it should be lesser than 7%. Practice might losing a good amount of revenue here.

DAYS IN AR IS HIGH

- Days in AR is also pretty, Days in AR will be improved if aging claims process faster and should not fall into higher buckets.

PROBLEM & IMPROVEMENT AREAS

INSURANCES WHICH ARE CRITICAL AND DOESN'T SEEM TO BE HANDLED PROPERLY ARE:

Top 10 Insurances wrt Aging	
Insurance Name	Balance
Molina Healthcare	$ 289,174.38
BCBS - Premera	$ 265,805.88
Coordinated Care of WA	$ 197,028.87
Medicare	$ 137,661.20
Covid HRSA	$ 104,682.85
Aetna	$ 92,396.97
Amerigroup Apple Care	$ 89,414.20
Washington LNI	$ 70,464.37
Kaiser Foundation	$ 68,731.71
Community Health Plan	$ 61,482.72

PATIENT UNAPPLIED AMOUNTS

Patient payments have not been applied in many accounts ($ 23129.48). This amount should be applied timely in order to have correct information and avoid incorrect patient billing.

PROBLEM & IMPROVEMENT AREAS

We fetched some targeted data to check stats on some Claim statuses:

Details are as follows:

Claim Statuses	No. of Claims	Remarks
ERA Payer Denied	423	120 plus days have 423 claims in ERA Payer Denied
Clearinghouse Accepted	31	120 plus days have 31 claims in Clearinghouse Accepted
Insurance Accepted	408	120 plus days have 408 claims in Insurance Accepted
Pending	25	30 plus days have 25 claims in Pending Status - all have status for no charge
OccMed Pending	3	100 plus days have 3 claims in OccMed Pending status and were never billed
Client List	167	There are 167 claims in Client List Status either because of the following reasons: 1. Unsubmitted COVID HRSA Claims 4801, 5423, 5591, 5594, 5602, 5746, 6011 - the Subscriber ID is entered as 0000 2. Some claims state that waiting for Labs to appeal the payer processing decision - e.g. 11634, 13056 etc 3. Some claims (Occ Health Appointment) are sitting unsubmitted with no notes e.g. 15718, 20158, 15384, 15724 etc
Submitted	677	There are about 677 claims in the Submitted status since Jan 1st 2021 to Aug 31st 2022

PROBLEM & IMPROVEMENT AREAS

MAJOR DENIALS:

- **ELIGIBILITY NOT VERIFIED:**

  Multiple denials are found where patients' eligibility is not being verified prior to claims submission.

- **MEDICAL RECORDS ARE REQUIRED:**

  Many claims have been denied with the reason "Additional Information Required or Pending Further Review"

- **TIMELY FILING LIMIT EXPIRED**

  Some of the claims have been denied with the reason "The time limit for filing has expired."

- **BUNDLED SERVICES**

  We saw some services in claims that are denied with reasons "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

- **MEDICAL NECESSITY**

  Some of the procedures are denied as "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

DENIALS RECEIVED DURING THE MONTH OF AUGUST 2022

DENIAL CODE	DESCRIPTION	COUNT
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	701
133	The disposition of the claim/service is pending further review.	430
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	223
252	An attachment/other documentation is required to adjudicate this claim/service.	193
22	Secondary payment cannot be considered without the identity of, or payment information from, the primary payer. (COB)	192
24	Charges covered under a capitation agreement or managed care plan.	107
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	101
27	Expenses incurred after coverage terminated.	76
140	You received this RUC, because the patient's name and Medicare number/Medicare Beneficiary Identifier (MBI) on your claim do not match the name and number on the patient's Medicare card.	53
109	Claim/service not covered by this payer/contractor.	44
26	Expenses incurred prior to coverage.	35
29	The time limit for filing has expired.	24

PROBLEM & IMPROVEMENT AREAS

Based on the reviewed information, it seems that:

- A/R is not being worked out on a regular basis due to which the aging is rising.
- Another issue found in the resubmitted claims, comments are not updated in all claims about the action taken. This will create a lot of effort when the same claims will be worked again. It appears that duplication of work will be needed to work on the aging claims.
- According to the current practice trend, a normal claim is followed up on about 73 days after the claim has been submitted to the insurance. There are 749 claims in Insurance Accepted bucket & 1047 claims in ERA payer denied status since Jan 1st 2021 to August 31st, 2022.
- ERAs are not being posted in eCW on priority. We found ERAs as old as 08/04/2022 have bot been posted in the system as of yet.