



**(Part-A)**

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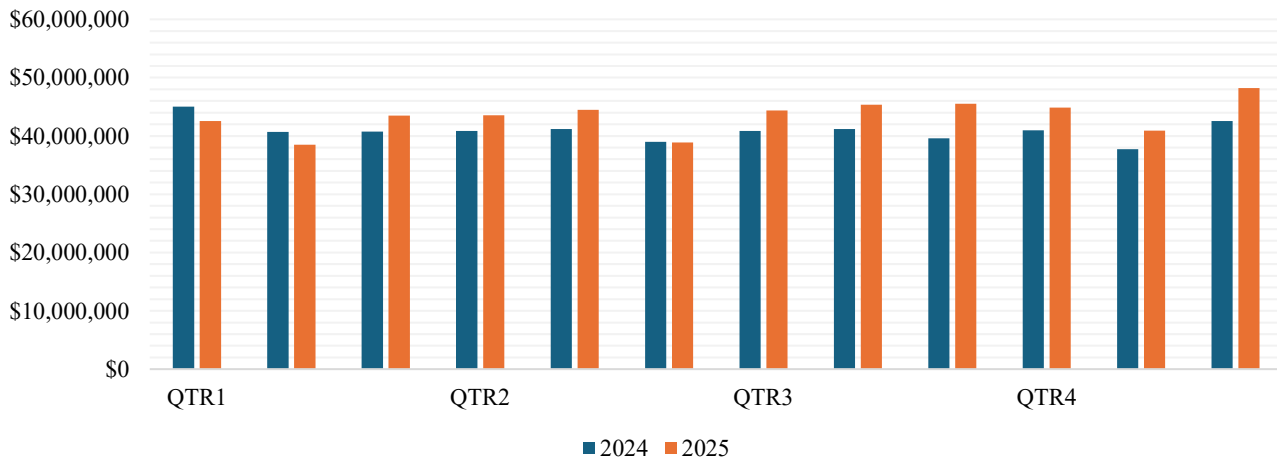
## 1. Charges Analysis

### 1.1. Month wise Charge Summary Comparison

The below table show the month wise charge comparison for the year 2024 and 2025.

Charges Trend 2024					Charges Trend 2025				
QTR	Month	Charges	Percentage	Total	QTR	Month	Charges	Percentage	Total
QTR1	24-Jan	\$45,050,893	9.2%	25.8%	QTR1	25-Jan	\$42,582,928	8.0%	23.0%
	24-Feb	\$40,699,596	8.3%			25-Feb	\$38,495,014	7.0%	
	24-Mar	\$40,748,728	8.3%			25-Mar	\$43,462,313	8.0%	
QTR2	24-Apr	\$40,866,573	8.3%	24.7%	QTR2	25-Apr	\$43,537,468	8.0%	24.0%
	24-May	\$41,197,357	8.4%			25-May	\$44,467,016	9.0%	
	24-Jun	\$38,996,199	8.0%			25-Jun	\$38,888,365	7.0%	
QTR3	24-Jul	\$40,879,996	8.3%	24.8%	QTR3	25-Jul	\$44,355,692	9.0%	27.0%
	24-Aug	\$41,165,800	8.4%			25-Aug	\$45,340,046	9.0%	
	24-Sep	\$39,588,968	8.1%			25-Sep	\$45,525,338	9.0%	
QTR4	24-Oct	\$40,967,244	8.4%	24.7%	QTR4	25-Oct	\$44,872,731	9.0%	26.0%
	24-Nov	\$37,738,354	7.7%			25-Nov	\$40,928,757	8.0%	
	24-Dec	\$42,538,537	8.7%			25-Dec	\$48,229,263	9.0%	
<b>Total</b>		<b>\$490,438,244</b>	<b>100%</b>	<b>100%</b>	<b>Total</b>		<b>\$520,684,931</b>	<b>100%</b>	<b>100%</b>

### Charge Comparison



### Overview

Total charges increased from \$490.4M (2024) to \$520.7M (2025), reflecting an approximate 6% year-over-year growth. Monthly charge distribution remains relatively even across both years, indicating stable charge capture patterns.

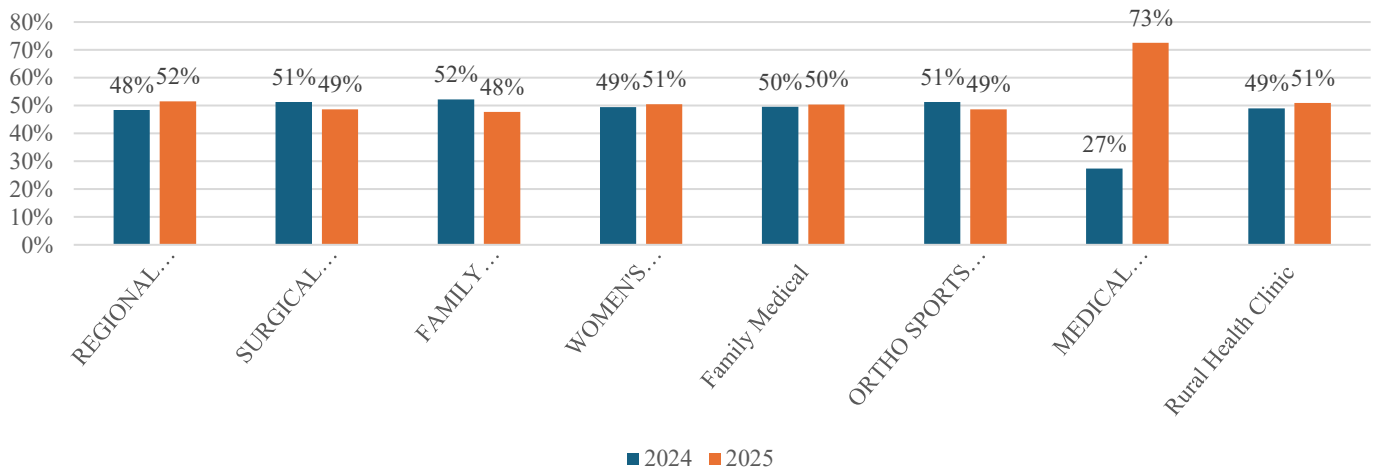


### 1.2. Overall Facility Wise Charges

This table summarizes facility-level charge performance for calendar years 2024 and 2025, including proportional contribution and year-over-year change.

Facility	2024	%	2025	%	Total	Difference	%
REGIONAL MEDICAL CENTER	\$466,284,461	95%	\$496,223,130	95%	\$962,507,591	\$29,938,669	3%
SURGICAL ASSOCIATES	\$7,789,668	1.6%	\$7,381,401	1.4%	\$15,171,069	(408,268)	-3%
FAMILY PHYSICIANS	\$6,240,197	1.3%	\$5,702,563	1.1%	\$11,942,760	(537,634)	-5%
WOMEN'S SERVICES	\$3,249,593	0.7%	\$3,316,827	0.6%	\$6,566,420	67,234	1%
FAMILY MEDICAL	\$2,616,508	0.5%	\$2,660,571	0.5%	\$5,277,079	44,064	1%
ORTHO SPORTS MED AND SURGERY	\$2,804,999	0.6%	\$2,660,006	0.5%	\$5,465,005	(144,993)	-3%
MEDICAL ASSOCIATES	\$763,355	0.2%	\$2,022,821	0.4%	\$2,786,176	1,259,466	45%
RURAL HEALTH CLINIC	\$689,463	0.1%	\$717,613	0.1%	\$1,407,076	28,149	2%
<b>Total</b>	<b>\$490,438,244</b>	<b>100%</b>	<b>\$520,684,931</b>	<b>100%</b>	<b>\$1,011,123,176</b>	<b>\$30,246,687</b>	<b>3%</b>

Facility Wise Charges



#### Facility Wise Charges Overview

The charge analysis indicates that Regional Medical Center accounts for 95% of total charges, reflecting heavy reliance on a single facility. Several outpatient and specialty facilities experienced year-over-year declines, including Surgical Associates (-3%), Family Physicians (-5%), and Ortho Sports Med and Surgery (-3%). Smaller facilities showed only marginal growth of 1–2%, contributing minimally to overall revenue increases. Notably, Medical Associates reported a 45% increase, which warrants verification for accuracy and potential operational or coding anomalies.

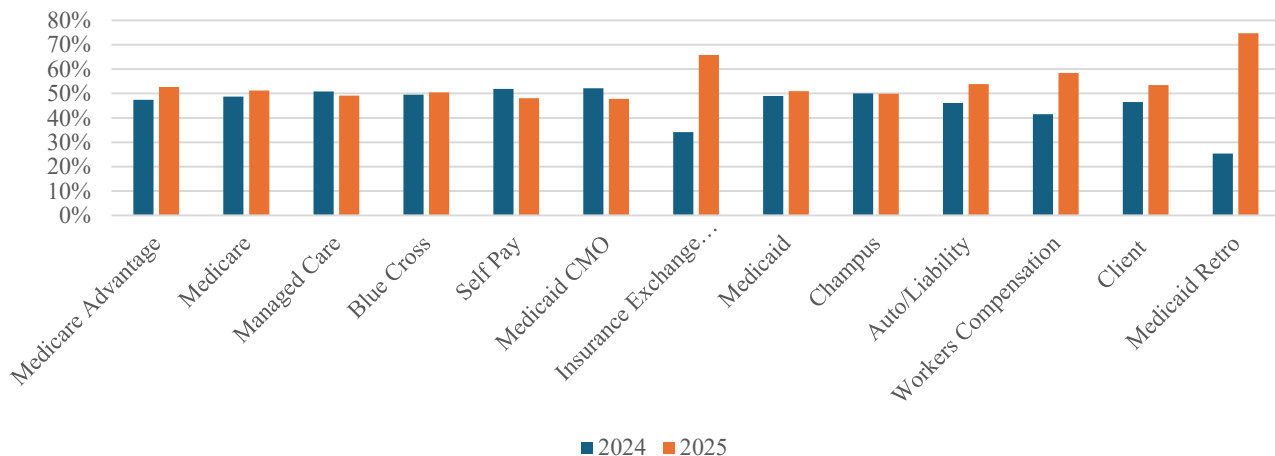


### 1.3. Payer Wise charge Comparison

This table summarizes Payer Wise charge performance for calendar years 2024 and 2025, including proportional contribution and year-over-year change.

Insurance	2024	%	2025	%	Total	Difference	%
Medicare Advantage	\$144,786,804	30%	\$160,835,895	31%	\$305,622,699	16,049,091	5%
Medicare	\$77,092,558	16%	\$80,887,480	16%	\$157,980,039	3,794,922	2%
Managed Care	\$60,644,789	12%	\$58,584,801	11%	\$119,229,590	(2,059,989)	-2%
Blue Cross	\$55,823,734	11%	\$56,907,087	11%	\$112,730,821	1,083,353	1%
Self-Pay	\$46,948,767	10%	\$43,422,733	8%	\$90,371,500	(3,526,034)	-4%
Medicaid CMO	\$42,346,315	9%	\$38,860,380	7%	\$81,206,695	(3,485,934)	-4%
Insurance Exchange	\$16,762,942	3%	\$32,282,652	6%	\$49,045,595	15,519,710	32%
Medicaid	\$27,590,318	6%	\$28,667,040	6%	\$56,257,358	1,076,723	2%
Champus	\$9,334,431	1.9%	\$9,314,440	1.8%	\$18,648,872	(19,991)	0%
Auto/Liability	\$7,309,915	1.5%	\$8,545,511	1.6%	\$15,855,426	1,235,596	8%
Workers Compensation	\$999,438	0.2%	\$1,404,894	0.3%	\$2,404,331	405,456	17%
Client	\$768,682	0.2%	\$884,861	0.2%	\$1,653,543	116,179	7%
Medicaid Retro	\$29,550	0.0%	\$87,156	0.0%	\$116,706	57,605	49%
<b>Total</b>	<b>\$490,438,244</b>	<b>100%</b>	<b>\$520,684,931</b>	<b>100%</b>	<b>\$1,011,123,175</b>	<b>\$30,246,687</b>	<b>3%</b>

Payer Wise Charges



### Payer wise Charge Overview

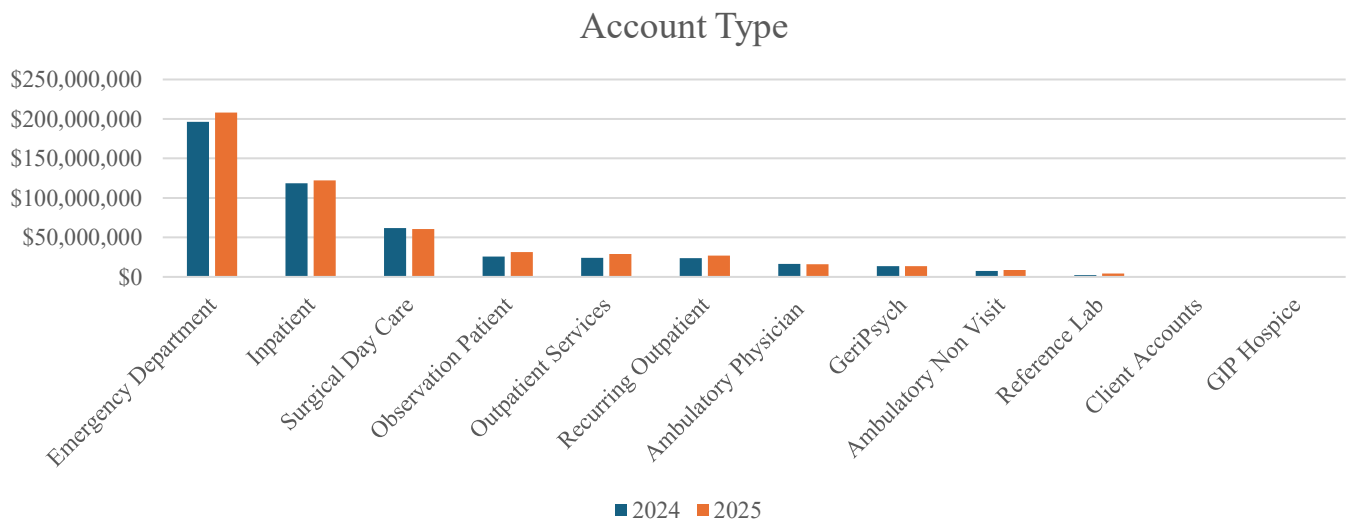
The insurance-wise charge analysis for 2024 and 2025 indicates that total charges increased modestly from \$490.4M to \$520.7M (3% growth). However, revenue is heavily concentrated among a few major payers, with Medicare Advantage (31%) and Medicare (16%) accounting for nearly half of total charges. Several key payers, including Managed Care (-2%), Self Pay (-4%), and Medicaid CMO (-4%), showed declines, or reduced patient volumes. While the Insurance Exchange Group experienced significant growth (32%), this unusual increase warrants verification to confirm accuracy and sustainability.



### 1.4. Account Type Wise Charge Comparison

This table summarizes Account type Wise charge performance for calendar years 2024 and 2025, including proportional contribution and year-over-year change.

Account Type	2024	%	2025	%	Total	Difference	%
Emergency Department	\$196,468,128	40%	\$208,195,283	40%	\$404,663,411	11,727,154	3%
Inpatient	\$118,402,263	24%	\$122,077,078	23%	\$240,479,341	3,674,816	2%
Surgical Day Care	\$61,792,211	13%	\$60,521,192	12%	\$122,313,403	(1,271,018)	-1%
Observation Patient	\$25,623,376	5%	\$31,555,520	6%	\$57,178,896	5,932,145	10%
Outpatient Services	\$24,133,975	5%	\$29,021,603	6%	\$53,155,578	4,887,628	9%
Recurring Outpatient	\$23,643,414	5%	\$27,069,776	5%	\$50,713,190	3,426,362	7%
Ambulatory Physician	\$16,585,487	3%	\$15,871,361	3%	\$32,456,848	(714,126)	-2%
Geriatr Psych	\$13,769,810	2.8%	\$13,610,056	2.6%	\$27,379,866	(159,754)	-1%
Ambulatory non-visit	\$7,568,297	1.5%	\$8,591,325	1.7%	\$16,159,622	1,023,028	6%
Reference Lab	\$2,324,714	0.5%	\$4,132,961	0.8%	\$6,457,675	1,808,248	28%
Client Accounts	\$114,914	0.0%	\$38,776	0.0%	\$153,690	(76,138)	-50%
GIP Hospice	\$11,657	0.0%	\$0	0.0%	\$11,657	(11,657)	-100%
<b>Total</b>	<b>\$490,438,244</b>	<b>100%</b>	<b>\$520,684,931</b>	<b>100%</b>	<b>\$1,011,123,175</b>	<b>\$30,246,687</b>	<b>3%</b>



### Account Type Wise Overview

The account-type analysis for 2024 and 2025 highlights significant revenue concentration and underperformance in key service lines. The Emergency Department dominates charges at 40%, reflecting heavy reliance on high-volume acute services. Several areas show declining or minimal growth, including Surgical Day Care (-1%), Ambulatory Physician (-2%), Geriatr Psych (-1%), Client Accounts (-50%), and GIP Hospice (-100%), indicating operational inefficiencies, reduced patient volume, or potential coding and billing gaps. While Observation Patient (+10%), Outpatient Services (+9%), Recurring Outpatient (+7%), and Reference Lab (+28%) recorded growth, these increases are insufficient to offset declines in other service lines.



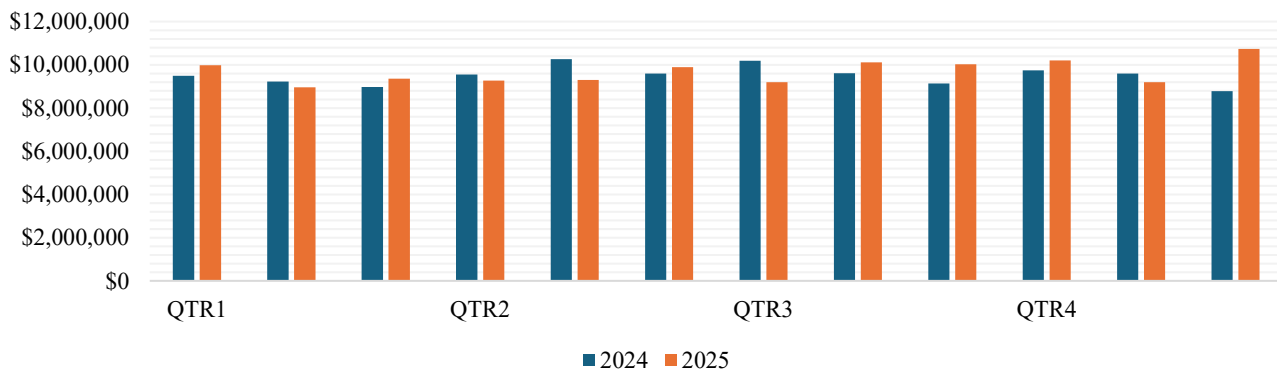
## 2. Payment Analysis

### 2.1. Month wise Payment Summary Comparison

The below table show the month wise Payment comparison for the year 2024 and 2025.

Payment Trends 2024					Payment Trends 2025				
QTR	Month	Payment	Percentage	Total	QTR	Month	Payment	Percentage	Total
QTR1	24-Jan	\$9,497,748	8.3%	24.3%	QTR1	25-Jan	\$9,973,627	8.6%	24.3%
	24-Feb	\$9,219,395	8.1%			25-Feb	\$8,950,459	7.7%	
	24-Mar	\$8,968,063	7.9%			25-Mar	\$9,354,612	8.1%	
QTR2	24-Apr	\$9,554,806	8.4%	25.8%	QTR2	25-Apr	\$9,262,968	8.0%	24.5%
	24-May	\$10,262,158	9.0%			25-May	\$9,298,590	8.0%	
	24-Jun	\$9,601,824	8.4%			25-Jun	\$9,896,234	8.5%	
QTR3	24-Jul	\$10,187,668	8.9%	25.3%	QTR3	25-Jul	\$9,187,578	7.9%	25.2%
	24-Aug	\$9,604,986	8.4%			25-Aug	\$10,109,620	8.7%	
	24-Sep	\$9,138,049	8.0%			25-Sep	\$10,020,268	8.6%	
QTR4	24-Oct	\$9,735,875	8.5%	24.6%	QTR4	25-Oct	\$10,195,854	8.8%	25.9%
	24-Nov	\$9,591,704	8.4%			25-Nov	\$9,196,911	7.9%	
	24-Dec	\$8,780,134	7.7%			25-Dec	\$10,729,800	9.2%	
<b>Total</b>		<b>\$114,142,411</b>	<b>100%</b>	<b>100%</b>	<b>Total</b>		<b>\$116,176,522</b>	<b>100%</b>	<b>100%</b>

### Payment Comparison



### Month Wise Payment Overview

The monthly revenue analysis indicates limited overall growth, with total amounts increasing marginally from \$114.1M in 2024 to \$116.2M in 2025 (2% increase). Several months in 2025, including February (\$8.95M), May (\$9.30M), and July (\$9.19M), show declines compared to the same months in 2024, suggesting inconsistencies in billing, claim submission, or payer collections. Despite spikes in December 2025 (\$10.73M), which may reflect catch-up collections, the fluctuations across multiple months indicate instability in revenue flow, raising concerns about operational efficiency, seasonality impact, and the effectiveness of ongoing follow-up processes.

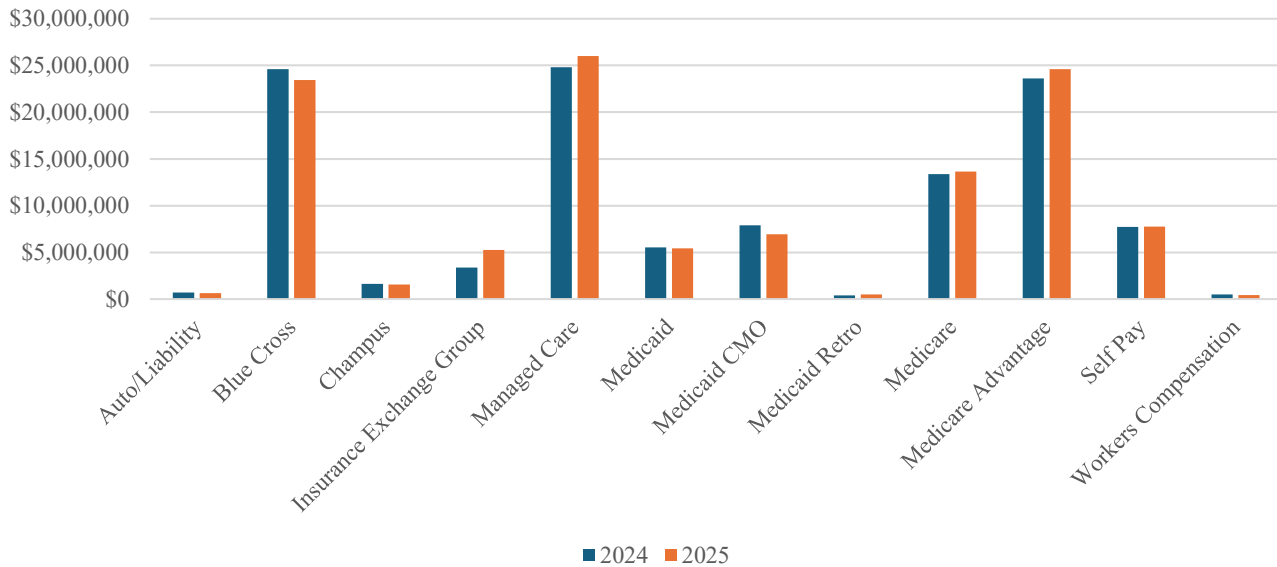


## 2.2. Payer Wise Payment Comparison

This report provides a comparison of total payments received from various payers for the reporting periods 2024 and 2025, highlighting overall growth and variance across payer categories.

Payer	2024	%	2025	%	Total	Difference	%
Auto/Liability	\$690,415	1%	\$623,371	1%	\$1,313,786	(67,043.58)	-5%
Blue Cross	\$24,597,116	22%	\$23,457,562	20%	\$48,054,678	(1,139,553.71)	-2%
Champus	\$1,634,554	1%	\$1,550,031	1%	\$3,184,586	(84,523.08)	-3%
Insurance Exchange Group	\$3,389,474	3%	\$5,264,227	5%	\$8,653,701	1,874,753.20	22%
Managed Care	\$24,803,964	22%	\$26,001,177	22%	\$50,805,141	1,197,212.31	2%
Medicaid	\$5,542,286	5%	\$5,415,918	5%	\$10,958,203	(126,367.96)	-1%
Medicaid CMO	\$7,886,468	7%	\$6,936,785	6%	\$14,823,252	(949,683.01)	-6%
Medicaid Retro	\$388,630	0.3%	\$485,731	0.4%	\$874,361	97,100.88	11%
Medicare	\$13,380,736	12%	\$13,640,239	12%	\$27,020,975	259,503.26	1%
Medicare Advantage	\$23,628,967	21%	\$24,609,725	21%	\$48,238,691	980,757.59	2%
Self-Pay	\$7,717,092	7%	\$7,747,359	7%	\$15,464,451	30,266.37	0.20%
Workers Compensation	\$482,709	0.4%	\$444,397	0.4%	\$927,106	(38,311.71)	-4%
<b>Total</b>	<b>\$114,142,411</b>	<b>100%</b>	<b>\$116,176,522</b>	<b>100%</b>	<b>\$230,318,933</b>	<b>2,034,110.56</b>	<b>1%</b>

Payer Wise Comparison



## Payer Wise Payment Overview

The payer analysis highlights several areas of concern despite modest overall growth of 1% (from \$114.1M to \$116.2M).

### Key observations include

- **Declining contributions from major payers**
  - Blue Cross decreased by \$1.14M (-2%)
  - Medicaid CMO decreased by \$949K (-6%)
  - Auto/Liability decreased by \$67K (-5%)

These declines may indicate issues in claims submission, delayed adjudication, or payer-specific collection inefficiencies.

- **Minimal growth from high-volume payers**
  - Medicare Advantage and Managed Care grew only 2%, while Medicare grew just 1%, suggesting stagnation in revenue streams from key payers.
- **Self-pay stagnation**
  - Self-pay increased by only \$30K (0.2%), reflecting ineffective patient collection efforts.
- **Offsetting gains from smaller payers**
  - Insurance Exchange Group grew 22%, and Medicaid Retro grew 11%, but their absolute dollar contributions are small, insufficient to offset declines in major payers.
- **Overall risk**
  - The combination of declining major payer contributions and reliance on minor payers' growth highlights potential instability in cash flow and collection effectiveness.
  - Payer-specific follow-ups, billing accuracy audits, and monitoring of slow-paying accounts are recommended to mitigate revenue leakage.

### Remarks

The payer-wise review for 2024–25 indicates that overall collections increased marginally by 1%, totaling \$116.18M in 2025 compared to \$114.14M in 2024. However, several key payers experienced declines that could impact cash flow and collection efficiency. Auto/Liability, Blue Cross, Champus, Medicaid, Medicaid CMO, and Workers Compensation all show reductions ranging from 1% to 6%, suggesting potential issues with delayed claim submissions, underpayments, or slower adjudication processes. While some payers such as Medicare, Medicare Advantage, and Managed Care showed minimal growth, these increases are not substantial enough to offset the declines. Self-Pay collections remain essentially flat, highlighting ongoing risks with patient balances and potential aging receivables. Overall, the data reflects a need for targeted follow-up and enhanced collection strategies, particularly for payers with declining trends, to mitigate revenue risk and improve cash flow predictability.

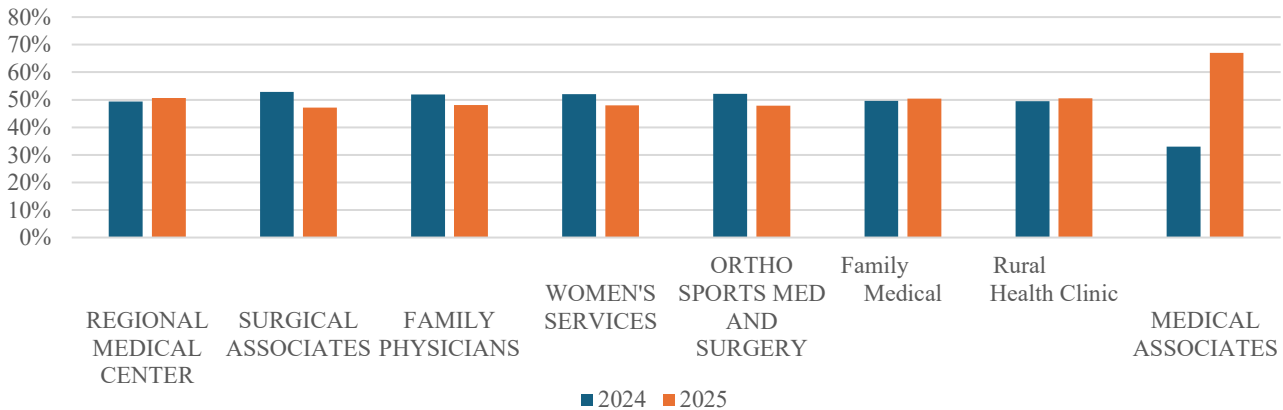


### 2.3. Overall Facility Wise Payment

This table summarizes facility-level Payment performance for calendar years 2024 and 2025, including proportional contribution and year-over-year change.

Facility	2024	%	2025	%	Total	Difference	%
REGIONAL MEDICAL CENTER	101,304,370	89%	104,062,278	90%	205,366,648	2,757,907.30	1%
SURGICAL ASSOCIATES	3,950,017	3%	3,522,122	3%	7,472,139	(427,894.81)	-6%
FAMILY PHYSICIANS	3,470,701	3%	3,210,463	3%	6,681,164	(260,237.30)	-4%
WOMEN'S SERVICES	1,958,644	2%	1,807,463	2%	3,766,107	(151,181.21)	-4%
ORTHO SPORTS MED AND SURGERY	1,507,198	1%	1,381,457	1%	2,888,655	(125,740.45)	-4%
FAMILY MEDICAL	1,356,345	1%	1,381,221	1%	2,737,566	24,876.22	1%
RURAL HEALTH CLINIC	392,675	0%	401,175	0%	793,850	8,499.70	1%
MEDICAL ASSOCIATES	202,461	0%	410,342	0%	612,804	207,881.11	34%
<b>Total</b>	<b>114,142,411</b>	<b>100%</b>	<b>116,176,522</b>	<b>100%</b>	<b>230,318,933</b>	<b>2,034,111</b>	<b>1%</b>

Facility Wise Payment Comparison



#### Facility Wise Payment Overview

The facility-wise analysis for 2024–25 shows that total collections increased slightly by 1%, from \$114.14M in 2024 to \$116.18M in 2025. However, several key facilities experienced declines that warrant attention. Surgical Associates (-6%), Family Physicians (-4%), Women’s Services (-4%), and Ortho Sports Med and Surgery (-4%) all show year-over-year reductions, indicating potential issues with patient volume, billing accuracy, or claim follow-up processes. While Regional Medical Center continues to dominate collections at 90% of the total, its modest 1% growth is insufficient to offset the declines in other facilities. Smaller facilities such as Medical Associates show notable growth (34%), but the absolute impact on total collections remains limited and may require verification for accuracy. Overall, the data highlights uneven performance across facilities, emphasizing the need for targeted operational and revenue-cycle interventions to address declining trends and improve overall collection efficiency.

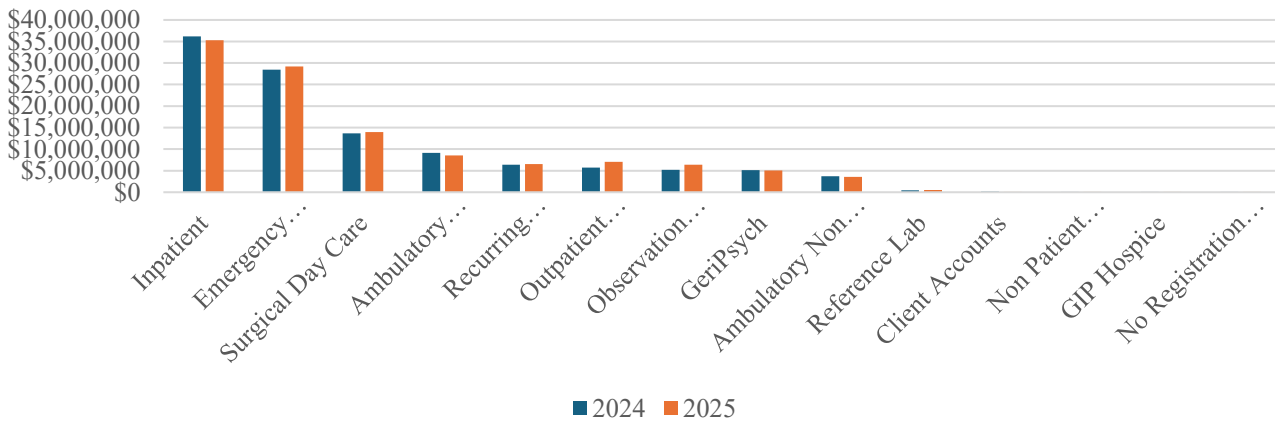


### 2.4. Account Type Wise Payment Comparison

This table summarizes Account type Wise Payment performance for calendar years 2024 and 2025, including proportional contribution and year-over-year change.

Payer	2024	%	2025	%	Total	Difference	%
Inpatient	\$36,204,393	32%	\$35,278,142	30%	\$71,482,536	(926,251.06)	-1%
Emergency Department	\$28,481,867	25%	\$29,223,089	25%	\$57,704,956	741,222.58	1%
Surgical Day Care	\$13,639,528	12%	\$13,970,257	12%	\$27,609,785	330,729.35	1%
Ambulatory Physician Billing	\$9,127,658	8%	\$8,521,598	7%	\$17,649,256	(606,060.10)	-3%
Recurring Outpatient	\$6,366,784	6%	\$6,520,108	6%	\$12,886,892	153,324.50	1%
Outpatient Services	\$5,703,983	5%	\$7,036,824	6%	\$12,740,808	1,332,840.86	10%
Observation Patient	\$5,211,472	5%	\$6,387,390	5%	\$11,598,862	1,175,917.38	10%
Geriatr Psych	\$5,119,681	4%	\$5,060,445	4%	\$10,180,125	(59,235.76)	-1%
Ambulatory non-visit	\$3,687,058	3%	\$3,567,522	3%	\$7,254,580	(119,535.64)	-2%
Reference Lab	\$408,282	0.36%	\$522,866	0.45%	\$931,147	114,584.14	12%
Client Accounts	\$143,051	0.13%	\$75,063	0.06%	\$218,113	(67,988.06)	-31%
Non-Patient Account	\$40,110	0.04%	\$8,645	0.01%	\$48,755	(31,464.33)	-65%
GIP Hospice	\$8,477	0.01%	\$4,238	0.00%	\$12,715	(4,238.30)	-33%
No Registration Class Listed	\$69	0.00%	\$334	0.00%	\$403	265.00	66%
<b>Total</b>	<b>\$114,144,435</b>	<b>100%</b>	<b>\$116,178,547</b>	<b>100%</b>	<b>\$230,322,982</b>	<b>\$2,034,112</b>	<b>1%</b>

Account Type Wise Comparison



### Account Type Wise Overview

The account-type analysis for 2024–25 indicates a marginal overall increase of 1% in total collections, from \$114.14M to \$116.18M. However, several key service lines show declining performance, raising concerns. Inpatient collections decreased by 1% (-\$926K), Ambulatory Physician Billing declined by 3% (-\$606K), Geriatr Psych dropped 1% (-\$59K), Ambulatory Non-Visit fell 2% (-\$120K), Client Accounts decreased sharply by 31% (-\$68K), Non-Patient Accounts declined by 65% (-\$31K), and GIP Hospice collections dropped 33% (-\$4K). These declines suggest potential issues in billing accuracy, claim follow-up, or patient volume for certain service lines. While Outpatient Services and Observation Patient categories experienced healthy growth (10%), the negative trends in critical inpatient and physician billing segments could adversely affect revenue stability.



### 3. Yearly Charges, Payments, and PC Ratio Analysis

The report presents monthly charges and payments for last two year from 2024 and 2025 highlighting collection efficiency through payment-to-charge ratios, with consolidated yearly totals and an overall ratio to track financial performance and reimbursement trends.

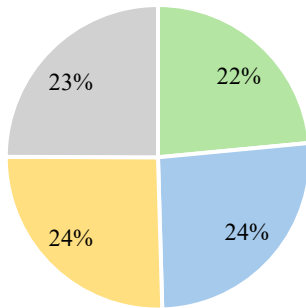
**PC Ratio For 2024**

QTR	Month	Charges	Payment	PC Ratio	Average
QTR1	Jan-24	\$45,050,893	\$9,497,748	21%	22%
	Feb-24	\$40,699,596	\$9,219,395	23%	
	Mar-24	\$40,748,728	\$8,968,063	22%	
QTR2	Apr-24	\$40,866,573	\$9,554,806	23%	24%
	May-24	\$41,197,357	\$10,262,158	25%	
	Jun-24	\$38,996,199	\$9,601,824	25%	
QTR3	Jul-24	\$40,879,996	\$10,187,668	25%	24%
	Aug-24	\$41,165,800	\$9,604,986	23%	
	Sep-24	\$39,588,968	\$9,138,049	23%	
QTR4	Oct-24	\$40,967,244	\$9,735,875	24%	23%
	Nov-24	\$37,738,354	\$9,591,704	25%	
	Dec-24	\$42,538,537	\$8,780,134	21%	
<b>Total</b>		<b>\$490,438,244</b>	<b>\$114,142,411</b>	<b>23%</b>	<b>23%</b>

**PC Ratio For 2025**

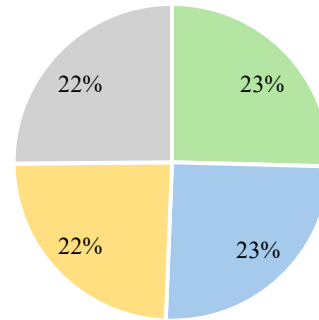
QTR	Month	Charges	Payment	PC Ratio	Average
QTR1	Jan-25	\$42,582,928	\$9,973,627	23%	23%
	Feb-25	\$38,495,014	\$8,950,459	23%	
	Mar-25	\$43,462,313	\$9,354,612	22%	
QTR2	Apr-25	\$43,537,468	\$9,262,968	21%	23%
	May-25	\$44,467,016	\$9,298,590	21%	
	Jun-25	\$38,888,365	\$9,896,234	25%	
QTR3	Jul-25	\$44,355,692	\$9,187,578	21%	22%
	Aug-25	\$45,340,046	\$10,109,620	22%	
	Sep-25	\$45,525,338	\$10,020,268	22%	
QTR4	Oct-25	\$44,872,731	\$10,195,854	23%	22%
	Nov-25	\$40,928,757	\$9,196,911	22%	
	Dec-25	\$48,229,263	\$10,729,800	22%	
<b>Total</b>		<b>\$520,684,931</b>	<b>\$116,176,522</b>	<b>22%</b>	<b>22%</b>

**PC Ratio**



■ QTR1 ■ QTR2 ■ QTR3 ■ QTR4

**PC Ratio**



■ QTR1 ■ QTR2 ■ QTR3 ■ QTR4



## Overall PC Ratio Trend

- Total PC ratio declined from 23% in 2024 to 22% in 2025 despite charges increasing from \$490.44M to \$520.68M.
- Indicates reduced collection efficiency relative to billed charges.

## Quarter-wise Analysis

- **Q1 2025**  
PC ratio stable at 22–23%, comparable to Q1 2024.
- **Q2 2025**  
PC ratio dropped to 21%, down from 24% in Q2 2024.
- **Q3 2025**  
Continued lower performance at 21–22% versus 24% in prior year, suggesting mid-year cash flow delays.
- **Q4 2025**  
Slight improvement at 22–23%, but still below prior year's 23–24%.

## Month-wise Observations

- **April, May, July, September 2025**  
Lower PC ratios (21–22%), reflecting slower payment realization.
- **December 2025**  
Despite high charges (\$48.23M), PC ratio only 22%, highlighting delayed year-end collections.

## Overview on PC Ratio

The PC ratio analysis for 2024–25 shows a slight decline in overall collections efficiency, with the total PC ratio decreasing from 23% in 2024 to 22% in 2025, despite an increase in total charges from \$490.44M to \$520.68M. Quarterly comparisons reveal weaker performance in Q2 and Q3 of 2025, with PC ratios dropping to 21–22% compared to 24–25% in the prior year, indicating slower payment realization despite higher billing volumes. Month-over-month trends also show inconsistencies, such as lower PC ratios in April, May, July, and September 2025, suggesting potential delays in claim submission, payer adjudication, or cash posting. While Q1 and Q4 maintain relatively stable ratios, the overall downward trend raises concerns regarding collection efficiency and the effectiveness of revenue cycle processes. Management should review billing follow-up, denial management, and payment posting procedures to improve PC ratios and ensure timely cash flow.



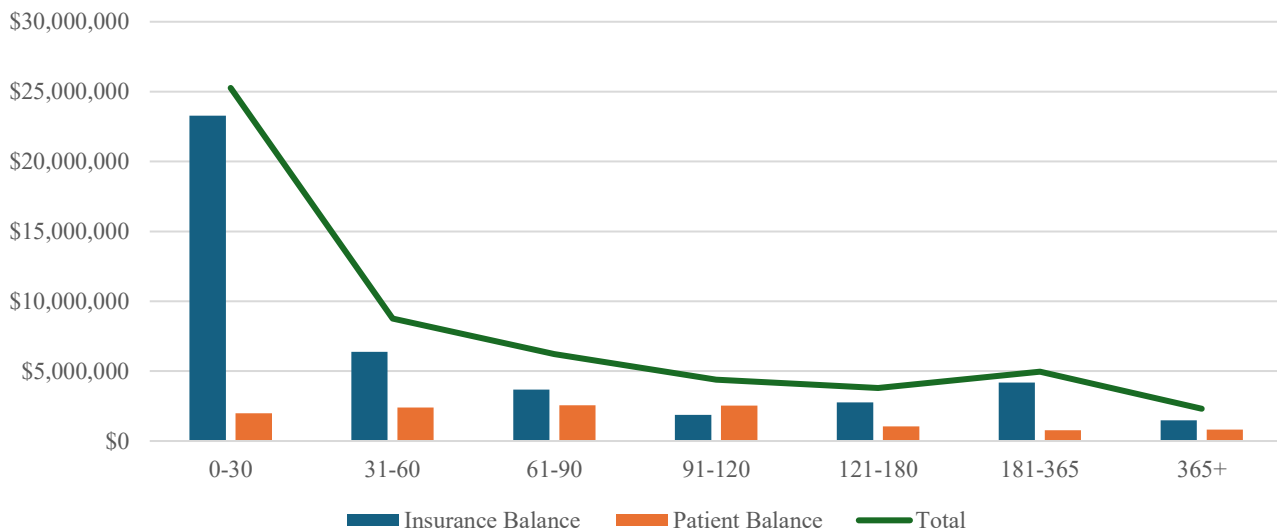
## 4. AR Analysis

### 4.1. Accounts Receivable Aging Report Summary

The table below presents an overview of outstanding account balances categorized by aging periods (in Bucket), showing the total balance, claim count, and the percentage each aging category represents of the total balance

Aging	0-30	31-60	61-90	91-120	121-180	181-365	365+	Grand Total
Insurance Balance	\$23,136,180	\$6,285,300	\$3,527,797	\$1,702,925	\$2,697,052	\$4,064,989	\$1,100,589	\$42,514,832
Patient Balance	\$1,783,739	\$2,357,471	\$2,524,038	\$2,513,906	\$984,639	\$641,503	\$595,148	\$11,400,444
<b>Total</b>	<b>\$24,919,918</b>	<b>\$8,642,771</b>	<b>\$6,051,836</b>	<b>\$4,216,830</b>	<b>\$3,681,691</b>	<b>\$4,706,491</b>	<b>\$1,695,737</b>	<b>\$53,915,276</b>
Percentage	46%	16%	11%	8%	7%	9%	3%	100%

Accounts Receivable



### Key Observations

- The 0–30-day aging bucket totals \$24.9 million (46%), indicating that nearly half of total receivables are current and recently billed, reflecting timely charge posting.
- The 31–60-day bucket represents \$8.6 million (16%), suggesting a moderate volume of balances requiring active follow-up to prevent further aging.
- The 61–90 day and 91–120-day buckets total \$6.0 million (11%) and \$4.2 million (8%), respectively, indicating a noticeable shift of balances into mid-aging categories.
- The 121–180 day and 181–365-day buckets together account for \$8.7 million (16%), reflecting delays in claim resolution and potential payer or patient follow-up gaps.
- The 365+ day bucket totals \$1.6 million (3%), representing long-outstanding balances with elevated risk of non-collection or write-off.
- Insurance balances dominate the early aging buckets, while patient balances are more evenly distributed across mid-to-late aging, increasing collection risk.

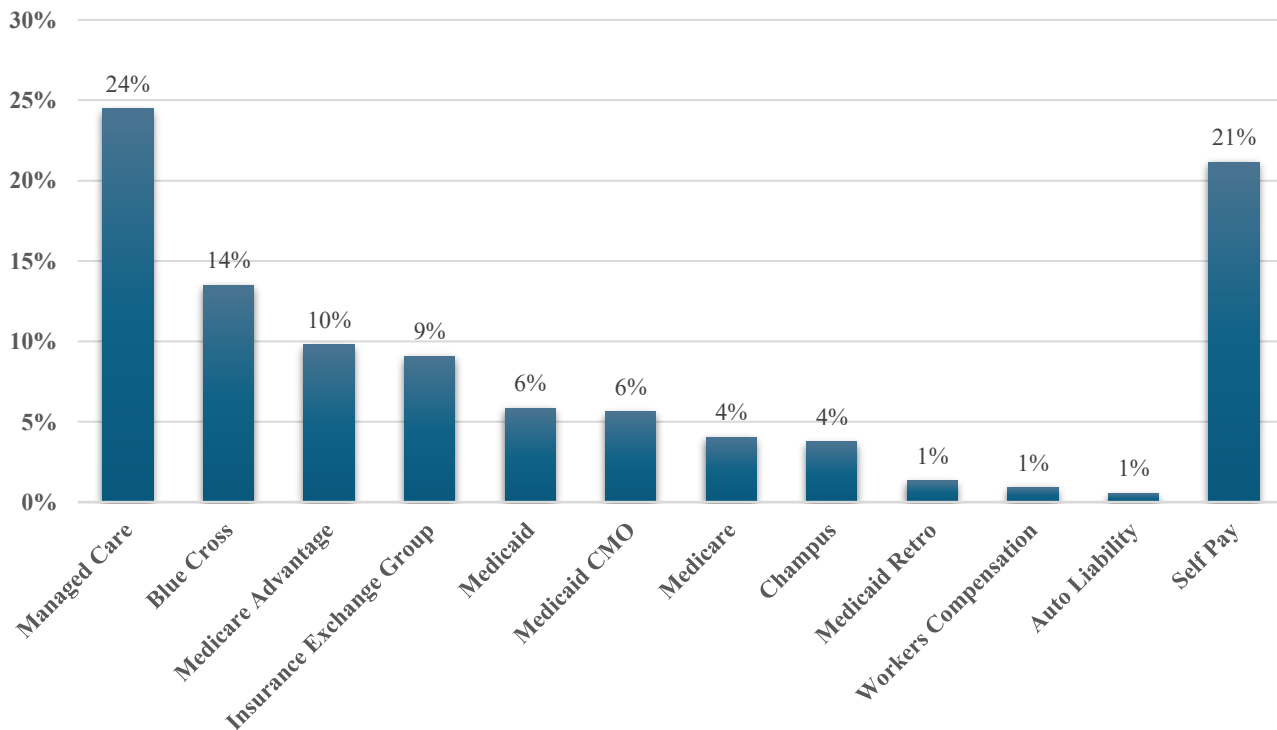


## 4.2. Accounts Receivable Aging Analysis by Payer

This report provides a comprehensive view of the aging of accounts receivable (A/R) balances by payer across five aging categories. It helps identify which payers contribute most to outstanding balances and where collection efforts should be focused.

Payer	0-30	31-60	61-90	91-120	121-180	181-365	365+	Grand Total
Managed Care	\$8,477,911	\$2,222,910	\$509,797	\$190,645	\$743,292	\$908,172	\$135,909	\$13,188,635
Blue Cross	\$3,198,414	\$1,043,435	\$754,405	\$462,850	\$731,624	\$822,444	\$269,404	\$7,282,576
Medicare Advantage	\$3,735,018	\$315,973	\$296,962	\$172,141	\$28,183	\$662,638	\$67,966	\$5,278,882
Insurance Exchange Group	\$2,679,589	\$640,115	\$594,719	\$122,030	\$164,956	\$491,584	\$197,352	\$4,890,345
Medicaid	\$1,352,408	\$516,522	\$249,655	\$171,068	\$373,883	\$412,827	\$76,695	\$3,153,059
Medicaid CMO	\$1,723,232	\$417,302	\$226,579	\$122,690	\$201,499	\$229,379	\$105,174	\$3,025,855
Medicare	\$639,290	\$484,799	\$652,868	\$239,252	\$186,029	-\$3,328	-\$18,021	\$2,180,889
Campus	\$847,428	\$405,444	\$113,539	\$173,146	\$178,136	\$124,134	\$189,521	\$2,021,873
Medicaid Retro	\$406,561	\$157,743	\$92,599	\$17,137	\$28,807	\$6,178	\$600	\$709,625
Workers Compensation	-\$87	\$296	\$784	\$9,240	\$21,710	\$404,074	\$55,320	\$491,336
Auto Liability	\$77,702	\$80,801	\$35,890	\$22,724	\$38,935	\$6,887	\$28,818	\$291,758
<b>Self-Pay</b>	<b>\$1,783,739</b>	<b>\$2,357,471</b>	<b>\$2,524,038</b>	<b>\$2,513,906</b>	<b>\$984,639</b>	<b>\$641,503</b>	<b>\$595,148</b>	<b>\$11,400,444</b>
<b>Grand Total</b>	<b>\$24,921,207</b>	<b>\$8,642,810</b>	<b>\$6,051,836</b>	<b>\$4,216,830</b>	<b>\$3,681,691</b>	<b>\$4,706,491</b>	<b>\$1,703,885</b>	<b>\$53,915,276</b>

Payer wise AR %



## Key Observations

- Managed care holds the largest overall A/R balance at \$13.1M, with \$8.5M (63%) in the 0–30-day bucket, indicating strong recent billing but \$2.0M aged beyond 120 days, signaling emerging follow-up risk.
- Self-Pay balances total \$11.4M, with a significant concentration in aging beyond 60 days; over \$7.2M (64%) is aged 61+ days, representing the highest collection risk among all payers.
- Medicare Advantage shows \$5.2M total A/R, with balances spread consistently across all aging buckets, including \$3.1M aged over 120 days, indicating chronic delays in adjudication or escalation.
- Blue Cross and Medicare each exceed \$7.2M in total A/R, with material balances in the 181–365 and 365+ buckets, reflecting unresolved claims and potential appeal or documentation gaps.
- Insurance Exchange Group and Medicaid CMO exhibit moderate total balances but elevated mid-to-late aging exposure, suggesting inconsistent follow-up effectiveness.
- Auto Liability displays an unusually high portion in 61–120-day buckets, consistent with extended adjudication timelines inherent to liability claims but still requiring close monitoring.
- Medicaid Retro shows a disproportionate share in the 181–365 and 365+ buckets, indicating delayed eligibility resolution and retroactive billing challenges.
- Workers Compensation and Champus balances are comparatively small but remain aged beyond standard timelines, reflecting low prioritization or payer-specific processing delays.

## Overall Summary

While a meaningful portion of payer balances remains current, several major payers—including Medicare Advantage, Managed Care, Blue Cross, and Self Pay carry substantial receivables aged beyond 120 days, increasing financial exposure and write-off risk. The Self Pay portfolio represents the most critical risk area due to heavy concentration in late aging. Targeted payer-specific follow-up strategies, enhanced escalation for aged insurance claims, and strengthened patient collection workflows are necessary to reduce long-term outstanding balances and improve cash flow reliability.

## Focus Areas for Collections Teams

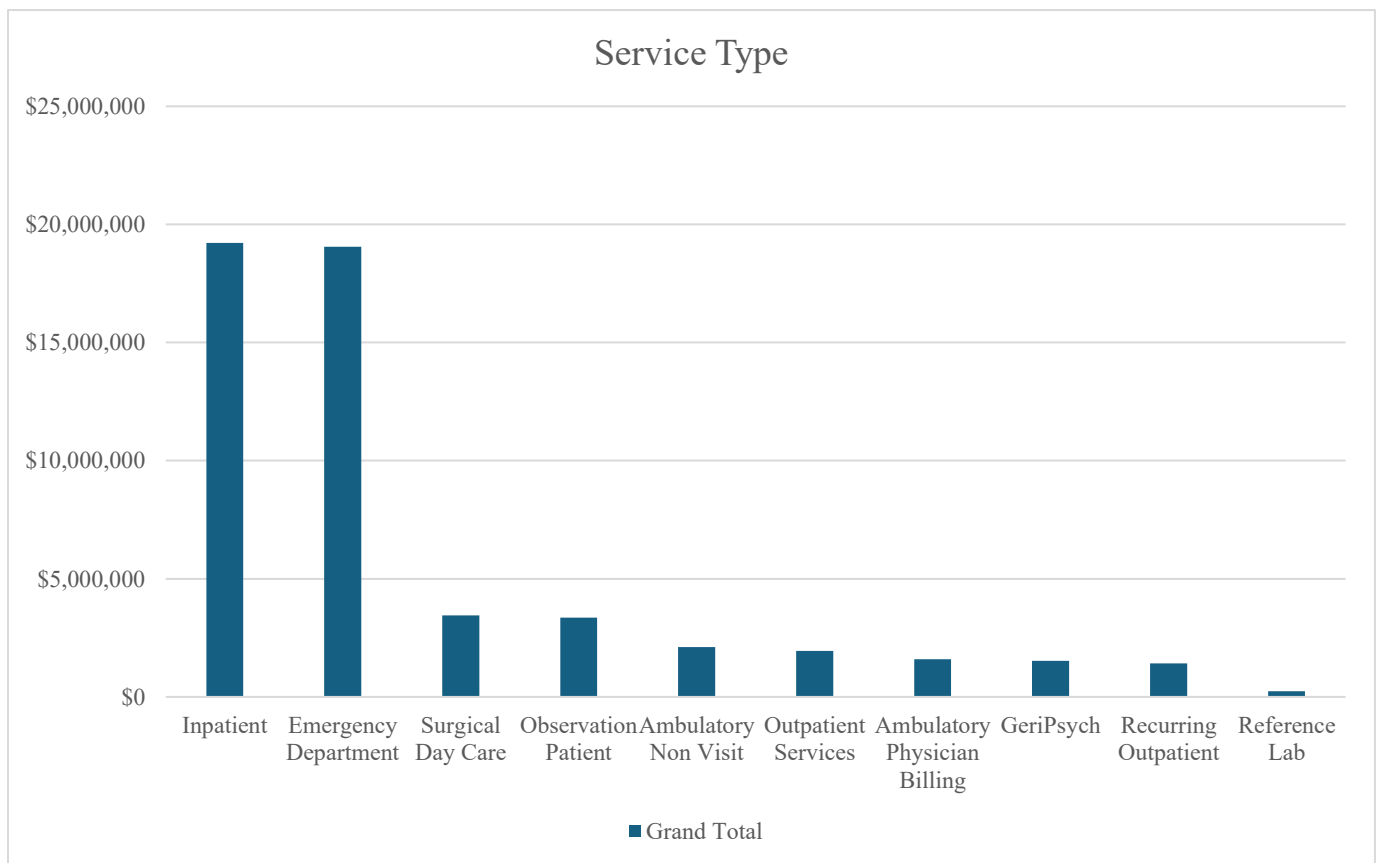
- **Prioritize 120+ Day Balances:** Immediately target high-risk aged balances, particularly within Self Pay, Medicare Advantage, Managed Care, and Blue Cross, to prevent further aging and potential write-offs.
- **Strengthen Self-Pay Collections:** Implement enhanced patient outreach, payment plans, and financial counseling, as Self Pay shows the highest concentration of balances aged beyond 60 days.
- **Payer-Specific Escalation:** Apply tailored follow-up strategies for payers with chronic aging patterns (e.g., Managed Care, Insurance Exchange Group, Medicaid CMO) to address recurring adjudication delays.
- **Monitor Liability and Workers' Comp Claims:** Track Auto Liability and Workers Compensation accounts closely due to extended resolution timelines and higher risk of prolonged outstanding balances.
- **Reduce Mid-Aging Slippage:** Proactively work 61–120-day balances to prevent migration into the 120+ day category through earlier intervention and consistent follow-up.



### 4.3. Service-Wise A/R Aging Summary

This table presents a breakdown of Accounts Receivable (A/R) by Service Type across Different aging buckets and balances for each.

Account Type	0-30	31-60	61-90	91-120	121-180	181-365	365+	Grand Total
Inpatient	\$9,160,798	\$3,372,458	\$1,648,408	\$1,086,126	\$1,374,247	\$2,112,765	\$467,691	\$19,222,493
Emergency Department	\$8,368,505	\$3,126,061	\$2,755,134	\$1,951,395	\$1,135,178	\$1,284,733	\$434,895	\$19,055,901
Surgical Day Care	\$2,121,413	\$254,927	\$346,387	\$127,226	\$200,334	\$268,053	\$135,695	\$3,454,036
Observation Patient	\$2,005,383	\$170,231	\$387,805	\$223,005	\$146,701	\$374,750	\$46,749	\$3,354,623
Ambulatory non-visit	\$665,803	\$377,785	\$293,139	\$213,949	\$186,276	\$193,914	\$179,029	\$2,109,895
Outpatient Services	\$1,177,213	\$200,312	\$191,985	\$122,941	\$100,893	\$112,725	\$35,334	\$1,941,404
Ambulatory Physician	\$612,157	\$189,974	\$113,838	\$104,838	\$170,109	\$163,442	\$243,424	\$1,597,782
Geri Psych	\$629,665	\$336,877	\$99,996	\$134,457	\$216,821	\$105,239	\$484	\$1,523,538
Recurring Outpatient	\$53,838	\$585,345	\$188,251	\$225,327	\$131,038	\$82,517	\$152,097	\$1,418,413
Reference Lab	\$125,142	\$28,801	\$26,893	\$27,566	\$20,095	\$8,354	\$339	\$237,190
<b>Grand Total</b>	<b>\$24,919,918</b>	<b>\$8,642,771</b>	<b>\$6,051,836</b>	<b>\$4,216,830</b>	<b>\$3,681,691</b>	<b>\$4,706,491</b>	<b>\$1,695,737</b>	<b>\$53,915,276</b>



## Accounts Receivable Aging Summary by Account Type

The total Accounts Receivable balance across all account types is **\$53,915,276**. A significant portion of the AR is concentrated in **Inpatient** and **Emergency Department accounts**, which together account for approximately **71% of the total balance** (\$19.22M + \$19.06M ≈ \$38.28M).

### Key Account Type Highlights

- **Emergency Department** has a total balance of **\$19,055,901**, with a sizable portion aged **61+ days (\$5.28M)**, indicating that enhanced follow-up and collection efforts may be required.
- **Inpatient accounts** total **\$19,222,493**, with **\$5.69M** in 61+ day buckets, requiring attention to aging receivables to ensure timely resolution.
- **Ambulatory Physician Billing** accounts total **\$1,597,782**, with most balances in the **0–60-day range (\$802,131)**, reflecting relatively healthy current receivables.
- **Observation Patient** and **Surgical Day Care** accounts show notable balances in the **181–365 and 365+ day aging buckets (\$421,499 and \$135,695, respectively)**, suggesting long-standing open claims that may require escalation or write-off review.
- **Recurring Outpatient** accounts have higher concentration in the **31–120-day range (\$998,923)**, indicating potential workflow or billing cycle delays.
- **Reference Lab** has a minimal total balance of **\$237,190**, with all amounts under 180 days, indicating low risk, though regular reconciliation should be maintained.

### Overall Observations:

1. **Inpatient and Emergency Department** have the highest exposure in 90+ day buckets, totaling over **\$9.8M**, representing **~18% of total AR**. These require immediate follow-up and potential payer escalation.
2. **Observation Patient** and **Surgical Day Care** have long-outstanding balances (>180 days), highlighting potential claim delays or process inefficiencies.
3. **Ambulatory Physician** 90+ day exposure is relatively low (~\$511K), reflecting strong collection practices in this segment.
4. Overall, **focus on 61+ day receivables**, particularly in Inpatient and Emergency Department accounts, is critical to improve cash flow and reduce aged AR risk.





## 5.2. Payer Rejected - Invalid Payer ID

Account No: U- [REDACTED] 2052,

DOS: 12/20/2025, 12/21/2025

Charge Amount: \$5,962.00

Claim Status: Payer Rejected

Similar Case: UT [REDACTED] 2000508

### Findings

- The claim for DOS 12/20/2025 was submitted on 12/26/2025.
- The claim is showing as rejected at the clearinghouse.
- The rejection reason was: **SDS is no longer processing claims for Payer ID 42561.**
- The claim requires correction of the payer ID, as it was rejected due to an inactive payer ID.
- No corrective or follow-up action was taken after the rejection.
- In the PMS, the claim is still showing as pending at the insurance end.

### Recommendation

It is recommended that the correct and active payer ID be identified and updated in the PMS and billing system for this claim. Once the payer information is corrected, the claim should be resubmitted through the clearinghouse and monitored to ensure successful acceptance by the payer. Additionally, the claim status in the PMS should be updated to accurately reflect the rejection and resubmission activity. Internal processes should be reinforced to ensure payer ID validation is completed prior to claim submission to prevent similar clearinghouse rejections in the future.

\*PFVOKW SDS IS NO LONGER PROCESSING CLAIMS FOR PAYER ID 42561

Document Number: [REDACTED]

Account Number: U- [REDACTED]

MRN: M0001 [REDACTED]

Field Name:

Claim Type/Ordinal: N [REDACTED]

Bill Type: 131

Claim Data ▾

Notes ▾

Tracking ▾

Print ▾

1. [REDACTED]		2. [REDACTED]		3a PAT. CNTL # [REDACTED]		4. BILL TYPE									
[REDACTED]		[REDACTED]		3b MED. REC. # [REDACTED]		131									
[REDACTED]		GA [REDACTED]		5. FED. TAX NO. [REDACTED]		6. STATEMENT COVERS PERIOD									
[REDACTED]		[REDACTED]		[REDACTED]		12/20/2025 12/21/2025									
8. PATIENT NAME			9. PATIENT ADDRESS			7. [REDACTED]									
a. [REDACTED]			b. [REDACTED]			c. [REDACTED] d. [REDACTED] e. [REDACTED]									
10. BIRTHDATE		11. SEX		ADMISSION		16. DHR		17. STAT		CONDITION CODES		29. ACDT STATE		30. [REDACTED]	
[REDACTED]		F		12. DATE 13. HR 14. TYP 15. SRC		1		01		[REDACTED]		[REDACTED]		[REDACTED]	
OCCURRENCE CODE		OCCURRENCE DATE		OCCURRENCE CODE		OCCURRENCE DATE		OCCURRENCE CODE		OCCURRENCE DATE		OCCURRENCE CODE		OCCURRENCE DATE	



### 5.3. Payer Rejected - Patient information Mismatch

Account No: [REDACTED]  
 DOS: 01/16/2026  
 Charge Amount: \$3,213.00  
 Claim Status: Payer Rejected

#### Findings

- The claim for DOS 01/16/2026 was submitted on 01/22/2026.
- The claim is showing as rejected at the clearinghouse.
- The rejection reason was: **The claim/encounter contains invalid information as specified in the status details (Status: Entity's name).**
- No corrective or follow-up action was taken after the rejection.
- In the PMS, the claim is still showing as pending at the insurance end.

#### Recommendation

It is recommended that the entity name details on the claim be thoroughly reviewed and corrected to ensure they match the payer's requirements and clearinghouse records. This includes validating the billing provider, rendering provider, and facility name fields for accuracy and consistency. Once the corrections are made, the claim should be resubmitted through the clearinghouse and closely monitored to confirm acceptance by the payer. Additionally, the PMS should be updated to reflect the rejection and resubmission status, and internal quality checks should be strengthened to verify critical demographic and provider information prior to claim submission to prevent similar rejections in the future.

The screenshot shows a software interface with a red error message box on the left: "as specified in the Status details and has been rejected. Status: Entity's name...". To the right, there are fields for Patient Name, Account Number, and Document Number. Below these are buttons for Claim Data, Notes, Tracking, and Print. At the bottom is a detailed form with the following sections:

3a PAT. CNTL. #		UP		4 BILL TYPE																
3b MED. REC. #		A		131																
5. FED. TAX NO.		6. STATEMENT COVERS PERIOD		7.																
01/16/2026		01/16/2026																		
8. PATIENT NAME			9. PATIENT ADDRESS																	
a.			a.																	
b.			b.																	
10. BIRTHDATE	11. SEX	ADMISSION		16. DHR	17. STAT	CONDITION CODES								29. ACDT STATE	30.					
	F	12. DATE	13. HR	14. TYP	15. SRC															
				1	1		01													



### 5.4. Payer Rejected - Entity Not Eligible

Account No: [REDACTED]  
 DOS: 01/16/2026  
 Charge Amount: \$4,744.00  
 Claim Status: Payer Rejected  
 Similar Case: UEDC [REDACTED] 12/0

#### Findings

- The claim for DOS 01/17/2026 was submitted on 01/23/2026.
- The claim is showing as rejected at the clearinghouse.
- The rejection reason was: **The claim/encounter has invalid information as specified in the Status details and has been rejected. Status: Entity not eligible**
- Eligibility verification was not completed prior to resubmission.
- In the PMS, the claim is still showing as pending at the insurance end.
- Need to confirm active insurance of the patient and then resubmit the claim to insurance

#### Recommendation

It is recommended that the patient’s insurance eligibility be verified to confirm active coverage for the date of service (01/17/2026). This includes validating the payer, member ID, coverage dates, and plan eligibility status. Once active insurance is confirmed and any required corrections are made in the PMS and billing system, the claim should be resubmitted through the clearinghouse and monitored to ensure acceptance by the payer. Additionally, the claim status in the PMS should be updated to accurately reflect the rejection and resubmission activity.

n as specified in the Status details and has been rejected. Status: Entity not eligi...

Patient Name: [REDACTED]  
 Account Number: UR [REDACTED]  
 MRN: M [REDACTED]  
 Field Name:

Document Number: C [REDACTED]  
 Claim Type/Ordinal: M [REDACTED]  
 Bill Type: 131

Claim Data ▾
Notes ▾
Tracking ▾
Print ▾

		2		3a PAT. CNTL #		UE [REDACTED]		4. BILL TYPE											
				3b MED. REC. #		MC [REDACTED]		131											
				5. FED. TAX NO.		6. STATEMENT COVERS PERIOD		7.											
				E [REDACTED]		01/17/2026 01/17/2026													
8. PATIENT NAME			a.		9. PATIENT ADDRESS					a.									
b.			j		b.					e.									
10. BIRTHDATE	11. SEX	ADMISSION			16. DHR	17. STAT	CONDITION CODES								29. ACDT STATE	30.			
		12. DATE	13. HR	14. TYP	15. SRC		18	19	20	21	22	23	24	25	26	27	28		
						01													

### 5.5. Partially Paid - Pre-Certification/Authorization

Account no: UDC  
 DOS: 01/21/2025 - 01/23/2025  
 Charge Amount: \$31,424.77  
 Claim Status Partially Paid

#### Findings

- The claim for 01/21/2025 - 01/23/2025 was submitted on 01/29/2025.
- Claim is Partially paid on 02/06/2025
- \$305.88 Allowed for this Claim and that was process under patient deductible
- CPT Code 49651 and 49650 Denied for the Reason **CO210 that is PAYMENT ADJUSTED BECAUSE PRE-CERTIFICATION/AUTHORIZATION NOT RECEIVED IN A TIMELY FASHION**
- In PMS for Denied CPT balance move to the BD Balance
- No Further Action was taken on the claim

#### Recommendation

It is recommended to review the denied CPT codes (49651 and 49650) to determine whether pre-certification or authorization can be obtained retroactively from the payer. If possible, submit a reconsideration or appeal for the denied amounts to recover revenue. All denied balances should be tracked and appropriately updated in the PMS to ensure accurate reporting and follow-up.

Payment Information									
Charge Amount:	31424.77	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:			
Covered:	31424.77	Deductible:	0.00	Interest:	0.00	DRG Amount:		0.00	
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	12144.38	DSH Amount:		0.00	
Denied:	18974.51	Copayment:	305.88	Allowed Amt:	305.88	MSP Pri Payer		0.00	

Claim Level Information									
Group & Reason Code	Amount	Units	Remark Codes						
No claim level information to display									

Line Level Information										
RCC	HCPCS/ Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
0272		1	01/23/2025	128.00	0.00	0.00		CO97	128.00	0
0278	C1781	2	01/23/2025	1554.00	305.88	0.00		CO45 PR3	1248.12 305.88	0 0
0360	49651	1	01/23/2025	7369.50	0.00	0.00		CO210	12649.67	0
0360	49650	1	01/23/2025	7369.50	0.00	0.00		OA94 CO45 CO210	-5280.17 1044.66 6324.84	0 0 0
CO210		18974.51	0	PAYMENT ADJUSTED BECAUSE PRE-CERTIFICATION/AUTHORIZATION NOT RECEIVED IN A TIMELY FASHION						
OA94		-5280.17	0	PROCESSED IN EXCESS OF CHARGES.						

Remark Code	Description
N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.



### 5.6. Denied - Incomplete/Invalid Consent Form.

Account no: [REDACTED]  
 DOS: 11/24/2025  
 Charge Amount: \$25,217.72  
 Claim Status: Denied

#### Findings

- The claim for DOS 11/24/2025 was submitted on 11/30/2025.
- The insurance processed and finalized the claim on 12/24/2025.
- The final status of the claim is completely denied under claim number 306823904600164.
- The denial reason was: **CO251, N228 – Incomplete/Invalid Consent Form.**
- The required consent form was submitted on 12/29/2025.
- No follow-up has been conducted since the consent form submission, and approximately two months have now passed.
- The claim is still showing as pending in AR at the insurance end.

#### Recommendation

It is recommended to immediately follow up with the payer to confirm receipt and review of the submitted consent form. If the documentation has not been processed, a formal reconsideration or appeal should be submitted along with proof of timely consent submission. Detailed follow-up notes should be documented in the PMS, and the claim should be monitored until final resolution.

Bill	Type	Status	Cutoff Date	Date Range	Age	Receivable Status	Charges	Balance
1	Final	Posted	11/29/25	11/21/25 - 11/24/25	79	AR	25,217.72	25,217.72

#### Provider Information



FYE: [REDACTED] EFT/Check#: [REDACTED]  
 Check Date: 12/24/2025 Payer Name: AMGP GEORGIA  
 NPI/Legacy #: [REDACTED] MANAGED CARE CO I

#### Patient Information

Patient Name: [REDACTED]  
 Patient Status: [REDACTED]  
 Claim Status: 01 - Processed as Primary  
 Bill Type: 131

PCN: [REDACTED]  
 MRN: [REDACTED]  
 ICN: [REDACTED]  
 Member ID#: [REDACTED]

Service Dates: 11/21/2025 - 11/24/2025

#### Payment Information

Charge Amount:	25217.72	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	25217.72	Deductible:	0.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	25217.72	DSH Amount:	0.00
Denied:	0.00	Copayment:	0.00	Allowed Amt:	0.00	MSP Pri Payer:	0.00

#### Reason/Remark Summation

Group/Reason Code	Amount	Units	Description
CO251	25217.72	0	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT).
Remark Code			Description
N228			INCOMPLETE/INVALID CONSENT FORM.



### 5.7. Denied - Lack of Information

Account no: UDA  
 DOS: 01/03/2026  
 Charge Amount: \$3,825.00  
 Claim Status: Denied  
 Similar Account: U

#### Findings

- The claim for DOS 01/03/2026 was submitted on 01/09/2026.
- The insurance processed and finalized the claim on 01/14/2026.
- The final status of the claim is completely denied under claim number 2601202B9600.
- The denial reason was: **You are required to code to the highest level of specificity.**
- No follow-up has been conducted after receiving the initial denial.
- The claim is still showing as pending in AR at the insurance end.

#### Recommendation

It is recommended that the diagnosis and/or procedure codes billed on the claim be reviewed against the medical documentation to ensure they reflect the highest level of specificity required by the payer. Any incomplete or unspecified codes should be corrected accordingly. Once the appropriate coding updates are made, the claim should be resubmitted or appealed as necessary. The claim should then be actively monitored until final resolution, and detailed follow-up notes should be documented in the PMS.

#### Payment Information

Charge Amount:	3825.00	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	3825.00	Deductible:	0.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	0.00	DSH Amount:	0.00
Denied:	3825.00	Copayment:	0.00	Allowed Amt:	0.00	MSP Pri Payer	0.00

#### Claim Level Information

Group & Reason Code	Amount	Units	Remark Codes
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No claim level information to display

#### Line Level Information

RCC	HCPCS/ Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
0300	87631	1	01/03/2026	2729.00	0.00	0.00	M81	CO16	2729.00	1
0450	99282	1	01/03/2026	1096.00	0.00	0.00	M81	CO16	1096.00	1

\*Claim was adjudicated by payer at Line Level

#### Reason/Remark Summation

Group/ Reason Code	Amount	Units	Description
CO16	3825.00	2	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF).

Remark Code	Description
M81	YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY.



### 5.8. Denied - Covered by Another Payer

Account no: U-  
 DOS: 01/06/2026 - 01/07/2026  
 Charge Amount: \$14,948.00  
 Claim Status: Denied  
 Similar Case: U-

#### Findings

- The claim for DOS 01/06/2026 – 01/07/2026 was submitted on 01/13/2026.
- The insurance processed and finalized the claim on 01/28/2026.
- The final status of the claim is completely denied under claim number 310037793100478.
- The denial reason was: This care may be covered by another payer per Coordination of Benefits (COB).
- No follow-up has been conducted after receiving the initial denial.
- The claim is still showing as pending in AR at the insurance end.

#### Recommendation

It is recommended that the patient’s Coordination of Benefits (COB) be reviewed to verify the correct primary and secondary payer order for the dates of service. Eligibility should be confirmed with all potential payers to determine coverage responsibility. If another payer is identified as primary, the claim should be submitted to the appropriate payer with supporting documentation, including the EOB from the current insurer if required. If the current payer remains primary, a reconsideration or appeal should be filed with documentation validating payer sequence. All follow-up actions should be documented in the PMS, and the claim should be actively monitored until final resolution to prevent further aging in AR.

#### Payment Information

Charge Amount:	14948.00	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	0.00	Deductible:	0.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	14948.00	Coinsurance:	0.00	Contractual Adj:	0.00	DSH Amount:	0.00
Denied:	0.00	Copayment:	0.00	Allowed Amt:	0.00	MSP Pri Payer	0.00

#### Claim Level Information

Group & Reason Code	Amount	Units	Remark Codes
No claim level information to display			

#### Line Level Information

RCC	HCPCS/Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
0301	80053	0	01/06/2026	389.00	0.00	0.00	MA04	CO22	389.00	0
0352	74177	0	01/06/2026	9315.00	0.00	0.00	MA04	CO22	9315.00	0
0450	99283/25	0	01/07/2026	2226.00	0.00	0.00	MA04	CO22	2226.00	0
0636	J1200/UD	0	01/06/2026	18.00	0.00	0.00	MA04	CO22	18.00	0
0636	J2919	0	01/06/2026	41.25	0.00	0.00	MA04	CO22	41.25	0
0636	Q9967/UD	0	01/06/2026	207.00	0.00	0.00	MA04	CO22	207.00	0
0636	J2270/UD	0	01/07/2026	17.50	0.00	0.00	MA04	CO22	17.50	0
0636	J2405/UD	0	01/07/2026	18.00	0.00	0.00	MA04	CO22	18.00	0
0250		0	01/07/2026	27.75	0.00	0.00	MA04	CO22	27.75	0
0258		0	01/06/2026	74.50	0.00	0.00	MA04	CO22	74.50	0
0260	96374/XU	0	01/06/2026	617.00	0.00	0.00	MA04	CO22	617.00	0
0260	96375	0	01/06/2026	451.00	0.00	0.00	MA04	CO22	451.00	0
0260	96375	0	01/07/2026	902.00	0.00	0.00	MA04	CO22	902.00	0
0300	81001/XU	0	01/06/2026	94.00	0.00	0.00	MA04	CO22	94.00	0
0300	83690	0	01/06/2026	210.00	0.00	0.00	MA04	CO22	210.00	0
0300	84703	0	01/06/2026	211.00	0.00	0.00	MA04	CO22	211.00	0
0300	85025	0	01/06/2026	129.00	0.00	0.00	MA04	CO22	129.00	0

\*Claim was adjudicated by payer at Line Level

#### Reason/Remark Summation

Group/Reason Code	Amount	Units	Description
CO22	14948.00	0	THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
Remark Code			Description
MA04			SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.



### 5.9. Denied - Additional Information Has Been Requested

Account no: UE 00086  
 DOS: 12/12/2025 - 12/12/2025  
 Charge Amount: \$1800.00  
 Claim Status: Denied

#### Findings

- The claim for DOS 12/12/2025 was submitted on 12/18/2025.
- The insurance processed and finalized the claim on 01/06/2026.
- The final status of the claim is completely denied under claim number UE 000245886.
- The denial reason was: **INFORMATION REQUESTED FROM THE PATIENT/INSURED/RESPONSIBLE PARTY WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.**
- No follow-up has been conducted after receiving the initial denial.
- The claim is still showing as pending in AR at the insurance end.

#### Recommendation

It is recommended to immediately contact the payer to identify the specific information required to process the claim. The patient or responsible party should be contacted promptly to obtain the missing or incomplete information. Once the required documentation is collected, it should be submitted to the payer along with a reconsideration or appeal request.

Payment Information							
Charge Amount:	1800.00	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	1800.00	Deductible:	0.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	378.00	DSH Amount:	0.00
Denied:	1422.00	Copayment:	0.00	Allowed Amt:	0.00	MSP Pri Payer	0.00

Claim Level Information			
Group & Reason Code	Amount	Units	Remark Codes
No claim level information to display			

Line Level Information										
RCC	HCPCS/Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
0610	72141		12/12/2025	1800.00	0.00	0.00	N179	CO45 PR227	378.00 1422.00	0 0

\*Claim was adjudicated by payer at Line Level

Reason/Remark Summation			
Group/Reason Code	Amount	Units	Description
CO45	378.00	0	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION. (USE ONLY WITH GROUP CODES PR OR CO DEPENDING UPON LIABILITY)
PR227	1422.00	0	INFORMATION REQUESTED FROM THE PATIENT/INSURED/RESPONSIBLE PARTY WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.)
Remark Code	Description		
N179	ADDITIONAL INFORMATION HAS BEEN REQUESTED FROM THE MEMBER. THE CHARGES WILL BE RECONSIDERED UPON RECEIPT OF THAT INFORMATION.		



### 5.10. Denied - Inconsistent Modifier

Account no: U[REDACTED]  
 DOS: 12/18/2025  
 Charge Amount: \$1285.00  
 Claim Status: Denied

#### Findings

- The claim for DOS 12/18/2025 was submitted on 12/30/2025.
- The insurance processed and finalized the claim on 01/06/2026.
- The final status of the claim is completely denied under claim number YC[REDACTED] 70.
- The denial reason was: **The procedure code is inconsistent with the modifier.**
- No follow-up has been conducted after receiving the initial denial.
- The claim is still showing as pending in AR at the insurance end.

#### Recommendation

It is recommended that the billed procedure code and associated modifier be thoroughly reviewed against the medical documentation and payer-specific billing guidelines to ensure proper coding compliance. Any incorrect or incompatible modifier should be corrected based on documentation support. Once the necessary corrections are made, the claim should be resubmitted or appealed as appropriate. The claim should then be actively monitored until final resolution, with all follow-up actions documented in the PMS.

Payment Information							
Charge Amount:	1285.00	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	1285.00	Deductible:	0.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	0.00	DSH Amount:	0.00
Denied:	1285.00	Copayment:	0.00	Allowed Amt:	0.00	MSP Pri Payer	0.00

Claim Level Information			
Group & Reason Code	Amount	Units	Remark Codes
No claim level information to display			

Line Level Information											
RCC	HCPCS/Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units	
0402	76642	1	12/18/2025	1285.00	0.00	0.00	N572	CO4	1285.00	0	

\*Claim was adjudicated by payer at Line Level

Reason/Remark Summation			
Group/Reason Code	Amount	Units	Description
CO4	1285.00	0	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT.
Remark Code	Description		
N572	THIS PROCEDURE IS NOT PAYABLE UNLESS APPROPRIATE NON-PAYABLE REPORTING CODES AND ASSOCIATED MODIFIERS ARE SUBMITTED.		



### 5.11. Incorrect Billing - Duplicate Submission

Account no: V [redacted]  
 DOS: 01/02/2026 to 01/19/2026  
 Charge Amount: \$143,438.37  
 Claim Status: Wrong Submission  
 Similar Case: V [redacted]

#### Findings

- The claim was submitted to the insurance twice: the first submission was on 01/27/2026, and the second submission was made the very next day.
- The claim generated from Meditech shows a charge amount of \$143,484.37.
- However, the claims submitted via Quadax show different amounts: one claim is \$137,979.69 and the other is \$141,355.69.
- Both amounts from Quadax do not match the original Meditech charge amount.

#### Recommendation

It is recommended to perform a thorough review and reconciliation between **Meditech** and **Quadax** claim data to identify the source of the discrepancies. Claims should only be submitted to insurance once with accurate charge amounts reflecting the original system of record. Any duplicate submissions should be investigated and corrected to prevent payment delays, denials, or potential compliance issues.

The screenshot displays a medical billing software interface with the following sections:

- Bills Summary:** A table with columns for Bill, Type, Status, Cutoff Date, Date Range, Age, Receivable Status, Charges, and Balance. A row shows Bill 2, Final, Posted, 01/27/26, 01/02/26 - 01/19/26, 24, AR, with Charges of 143,484.37 and Balance of 134,955.26.
- Insurance Payment Summary:** A table with columns for Insurance, Prorated, Adjustment Total, Expected Reimb, Payment Total, Payments Received, Payments Remaining, and Balance. It shows BLUE CROSS PPO with a prorated amount of 143,484.37 and an adjustment total of 2,004.11.
- Claim Details:** A table with columns for Claim, CSID, Edited Versions, Status, Age, Amount, Payment Total, and Adjustment Total. It lists three claims: 837 Blue Cr In Mom/Baby Inst (Amount: 143,454.37), 837 Prof BC Baby (Amount: 30.00), and 837 Prof Blue Cross (Amount: 30.00).
- Claim History Table:** A table with columns for Document Number, Client Code, Created By, Trans Type, Claim Type, Patient Acct #, Last Name, First Name, Bill Type, From Date, Archived Date, Total Charge, Ordinal, and Paid Amount. It shows two records: 1192832 (Total Charge: 137979.69) and 1192433 (Total Charge: 141355.69).



### 5.12. Incorrect Billing – Late charge Submission

Account no: ██████████  
 DOS: 10/20/2025 to 11/14/2025  
 Charge Amount: \$322,664.43  
 Claim Status: Wrong Submission

#### Findings

- The claim for DOS 10/20/2025 – 11/14/2025 was billed multiple times to the insurance.
- Claim wrongly filed to State Medicare who processed & denied under Capitation.
- The initial claim was submitted without verifying Medicare eligibility, which should always be our top priority for all the claims especially for high dollar claims where accuracy is critical.
- Incorrect filing even due to a minor oversight, can result in significant revenue delays and increases the risk of the claim exceeding the timely filing limit.
- After denial, the claim was resubmitted to the MA plan, and the MA plan processed and paid the claim.
- On 02/02/2026, the team increased the charge and resubmitted the claim again, which was more than three months after the initial submission.
- Try to ensure all charges are dropped from all the department before final submission and during Cut-off period, some exceptions are always applied. But late charge drop of over \$125K is exceptional and the correction may result the reversal of initial payment and subsequently increases the likelihood of denial

#### Recommendation

It is recommended to implement strict eligibility verification procedures before claim submission to prevent duplicate or improper billing. Claims should only be submitted once per DOS unless valid adjustments are required, and any changes in charge amounts must be thoroughly reviewed for accuracy and documentation. Internal controls should be strengthened to ensure timely submission and prevent duplicate billing or compliance risks.

Document Number	Client Code	Created By	Trans Type	Claim Type	Patient Acct #	Last Name	First Name	Bill Type	From Date	Archived Date	Total Charge	Ordinal	Paid Amount
				GAMC31				117	10/20/2025	02/02/2026	319545.33	P	0.00
				NACO32-60054				117	10/20/2025	02/02/2026	319545.33	P	0.00
				NACO32-60054				111	10/20/2025	11/11/2025	193948.82	P	0.00
				GAMC31				111	10/20/2025	11/26/2025	193414.82		0.00
				NACO32-60054				111	10/20/2025	11/20/2025	193414.82		34177.60
				GAMC31				111	10/20/2025	11/12/2025	193414.82	P	0.00
				NACO32-60054				111	10/20/2025	11/12/2025	193414.82	P	0.00
				NACO05-60054				111	10/20/2025	11/01/2025	253.00		142.27
				NACO05-60054					10/20/2025	10/23/2025	253.00	P	0.00
				NACO05-60054					10/20/2025	12/03/2025	92.95	P	0.00
				NACO05-60054				231	10/20/2025	12/06/2025	92.95		52.82
				NACO32-60054				211	10/20/2025	11/05/2025	56.00		15.16
				NACO05-60054					10/20/2025	10/31/2025	56.00	P	0.00



## 6. Coding Issue

A)

Account No: V [redacted] 25

### Findings

- The facility billed CPT 99281; however, documentation reflects more than minimal nursing and ancillary staff resources, including full triage assessment with complete vital signs, pulse oximetry interpretation, nursing evaluation, and documented discharge education, which exceeds the minimal intervention requirement for 99281 under ACEP facility guidelines.
- The record shows prescription medications (Tamiflu, Ondansetron, Ibuprofen 800 mg, and Brompheniramine-pseudoeph DM) were electronically prescribed, and discharge instructions included influenza education, droplet precautions, medication usage instructions, and return precautions, which indicate at least moderate discharge instruction complexity under ACEP facility coding standards.
- The documentation reflects patient assessment, evaluation of tachycardia (pulse 107), clinical review of prior ED visit, medication reconciliation, and provider-patient counseling regarding hydration, isolation, and symptom management, all of which demonstrate resource utilization beyond a straightforward visit.
- The denial reason N657 suggests the payer considers the services inconsistent with the billed level, and based on the documented nursing interventions and prescription-related discharge education, CPT 99281 appears undercoded relative to the documented facility resource intensity.

### Recommendation

- Submit a corrected facility claim with CPT 99283, as the documented nursing interventions and moderate discharge instruction involving prescription medication education align more appropriately with ACEP Type A moderate facility resource criteria.
- Ensure the nursing documentation clearly reflects medication reconciliation, discharge education time or detail, patient counseling regarding prescription use and droplet precautions, and any staff coordination performed during triage to strengthen medical necessity and resource utilization support.
- Include a concise appeal statement referencing ACEP ED Facility Coding Guidelines and emphasize that prescription medication management and moderate discharge teaching elevate the visit above minimal intervention level
- <https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines>

Rev	Service Dates	Qual	Code	Mods	APC	APG	Qty	Submit Chgs	Paid Chgs	Group	Code	Amount	LQ Remark
0450	12/19/25	HC	99281				1	750.00	0.00	CO	11	750.00	N657
<b>CAS Code</b> CO-11 Denied/ Mismatch Dx/Proc													
<b>LQ Remark</b> N657 This should be build with the appropriate code for these services													



B)

Account No: ██████████

**Findings**

- The claim was denied with CO16 and remark code M81 indicating that the diagnosis was not coded to the highest level of specificity, and based on the documentation, if a nonspecific code such as J06.9 (acute URI unspecified) or R09.81 (nasal congestion only) was submitted without reflecting the confirmed clinical impression, the payer may have considered it insufficiently specific for CPT 87631.
- CPT 87631 represents a comprehensive multiplex respiratory viral PCR panel, and medical necessity must be supported by a diagnosis reflecting suspected viral respiratory infection in a high-risk population (1-month-old infant with breathing concerns), rather than symptom-only coding such as “breathing problem” or isolated nasal congestion.
- The documentation clearly supports evaluation of respiratory distress concerns in a 1-month-old infant with initial abnormal triage vitals (tachycardia, low SpO2 reading later corrected), which justifies ED level 99282 facility coding; therefore, the denial appears related to diagnosis coding specificity rather than E/M level inappropriateness.
- The final clinical impression lists “Upper respiratory infection” and “Nasal congestion,” but if the claim did not reflect the most specific confirmed diagnosis after viral panel results (e.g., acute URI, viral infection ruled out, or documented suspected viral etiology), the payer may have rejected the respiratory panel due to lack of precise ICD-10 linkage.

**Recommendation**

- Review the ICD-10 codes submitted on the claim and update them to the highest level of specificity supported by documentation, such as J06.9 (acute upper respiratory infection) if confirmed, and ensure appropriate linkage to CPT 87631 rather than using symptom-only codes like R06.89 or R09.81 alone.
- Confirm that the primary diagnosis reflects the reason for ordering the respiratory PCR panel in a 1-month-old infant with breathing concerns, emphasizing age-related risk and evaluation for serious viral infection to support medical necessity.
- Submit a corrected claim with updated and properly sequenced diagnosis codes instead of filing a medical necessity appeal, since CO16 with M81 indicates a correctable billing specificity issue.
- Implement an internal coding review process to ensure that when multiplex PCR panels are billed, the final diagnosis coding reflects suspected or confirmed respiratory infection rather than generalized symptom codes to prevent future specificity denials.

NO claim level information to display

**Line Level Information**

RCC	HCPCS/Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
0300	87631	1	01/03/2026	2729.00	0.00	0.00	M81	CO16	2729.00	1
0450	99282	1	01/03/2026	1096.00	0.00	0.00	M81	CO16	1096.00	1

\*Claim was adjudicated by payer at Line Level

**Reason/Remark Summation**

Group/Reason Code	Amount	Units	Description
CO16	3825.00	2	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVISE REMARK CODE THAT IS NOT AN ALERT.) REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF).

Remark Code	Description
M81	YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY.



C)

Account No: Claim: [REDACTED]

**Finding**

- The documentation for the patient visit demonstrates a thorough history of present illness, review of systems, and physical exam, but lacks detailed justification for the selected level of E/M service (99282), including clear complexity of decision-making or risk stratification. The lab and diagnostic testing results were reported but not consistently linked to medical necessity or clinical decision-making in the notes, which may affect coverage and coding accuracy. Medication lists and prior history are comprehensive; however, the reconciliation process and rationale for medication management during the ED encounter are not clearly documented. Discharge instructions and follow-up plans are provided but could be enhanced with explicit education or counseling notes to support quality of care and compliance with documentation standards.

**Recommendation**

- Ensure that each ED encounter clearly documents the complexity of medical decision-making, risk, and resource utilization to support the billed E/M level, following AEP ED Facility Level Coding Guidelines (<https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines>). Explicitly link diagnostic testing and lab orders to medical necessity within the narrative to strengthen clinical and coding justification. Standardize medication reconciliation and clearly document rationale for any new prescriptions, adjustments, or patient counseling provided during the visit. Enhance discharge instructions and follow-up notes to reflect patient education, counseling, and specific return precautions to demonstrate adherence to quality standards and support coding compliance.

**Claim Level Information**

Group & Reason Code	Amount	Units	Remark Codes
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No claim level information to display

**Line Level Information**

RCC	HCPCS/ Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Rea Cod
0300	87426	0	12/27/2025	104.00	0.00	0.00	M15	CO97	
0300	87502	0	12/27/2025	463.00	0.00	0.00	M15	CO97	
0300	87651	0	12/27/2025	313.00	0.00	0.00	M15	CO97	
0450	99282	0	12/27/2025	1039.00	0.00	0.00	N381	CO45 CO204 OA94	

\*Claim was adjudica

**Reason/Remark Summation**

Group/ Reason Code	Amount	Units	Description
CO97	880.00	0	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT IF PRESENT.
CO45	1784.74	0	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEG ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNT CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJ



D)

Account No: [REDACTED]

**Findings**

- The principal diagnosis assignment of J44.1 Acute exacerbation of COPD is not supported as the condition chiefly responsible for admission, as the record consistently demonstrates acute respiratory failure with hypoxia and hypercapnia requiring intubation, mechanical ventilation, tracheostomy, and prolonged ventilator dependence, which meets UHDDS criteria for principal diagnosis selection.
- Documentation shows ileus, encephalopathy, and shock during the stay; however, the type of shock and specificity of encephalopathy are not consistently clarified, which affects severity capture and MCC/CC validation.

**Recommendation:**

- Recommend sequencing acute respiratory failure (J96.01 or J96.02 based on final documented specification) as the principal diagnosis, with COPD exacerbation reported as a secondary condition if clinically supported.
- Recommend physician clarification for shock type and encephalopathy type (e.g., metabolic, hypoxic, toxic) to ensure accurate severity adjustment and compliant code assignment.

E)

Account No: [REDACTED]

DRG 164 is correct for this case based on:

- Major percutaneous procedure (bilateral PE thrombectomy)
- MCC: RV strain and elevated troponin
- Complexity: Failed IVC filter retrieval, comorbid prostate cancer

Documentation supports coding and DRG assignment

Minor improvements suggested for explicit MCC statement and procedural clarity

Documentation Improvement / Query Suggestions

**Documentation is overall strong**, but for audit defensibility:

- **Explicit MCC statement:** “RV strain with elevated troponin due to acute bilateral PE, representing major complication.”
- **Procedural clarity:** Clearly state “bilateral pulmonary thrombectomy performed successfully, IVC filter insertion attempted but retrieval failed, adding complexity.”
- **Include lab trends** supporting cardiac involvement (troponin, PTT, platelet count).



**F)**

**Account No:** ██████████

This inpatient admission (01/01/26–01/09/26) involves ESRD on dialysis, possible acute CVA, possible Type II MI, and PFO closure. The record contains unresolved “rule out” diagnoses and discharge diagnosis omissions that impact principal diagnosis selection, CC/MCC capture, and DRG integrity. Internal CDI queries were appropriately initiated but require finalized provider clarification to support accurate code assignment and defensible DRG reporting.

### Findings

- The medical record contains conflicting documentation regarding acute cerebral infarction, as earlier imaging reports note no acute stroke while the discharge summary states MRI confirmed acute to subacute infarcts, and the condition is not clearly finalized in the discharge diagnoses.
- “Rule out Type II MI” is documented with elevated troponin and cardiology assessment of probable NSTEMI Type II, but the condition is not resolved in the discharge summary, leaving ambiguity in final diagnosis reporting.
- The discharge diagnosis list omits potentially reportable acute conditions that were evaluated, treated, and clinically monitored during the admission, creating uncertainty in principal diagnosis selection under UHDDS guidelines.
- There is inconsistency in congenital heart defect terminology (PFO vs ASD secundum) and CKD staging documentation (N18.9 listed with ESRD), which may result in inaccurate ICD-10-CM, PCS assignment, and DRG classification.

### Recommendations

- Obtain and incorporate formal addendum responses to both CDI queries clarifying whether acute CVA and Type II MI were ruled in, ruled out, or represent sequelae, including supporting clinical indicators and treatment rendered.
- Reconcile imaging documentation and hospital course narrative to clearly define the principal diagnosis in accordance with UHDDS guidelines.
- Align discharge diagnosis coding with confirmed CKD staging and ensure congenital heart defect terminology accurately reflects the defect treated during the procedure.
- Implement a discharge diagnosis reconciliation review process to ensure consultant-confirmed and clinically managed conditions are reflected in the final discharge summary prior to coding finalization.

### DRG Impact

- If acute CVA is ruled in and supported, the principal diagnosis may shift from chronic ESRD to an acute neurologic event, potentially impacting DRG assignment and relative weight.
- If Type II MI is ruled in and clinically supported, this may introduce a CC depending on payer logic and grouping outcome.
- If both conditions are ruled out, the current chronic condition-driven DRG would likely remain appropriate, assuming documentation is aligned.
- Final DRG validation is dependent on resolved query documentation.



## Clinical Validation Analysis

### Acute CVA:

There is conflicting imaging documentation (earlier imaging negative vs discharge MRI positive). Clinical indicators must support acute infarction during this admission (neurological deficits, imaging confirmation, treatment modification). Without clear provider confirmation, reporting would not meet clinical validation standards.

### Type II MI:

Elevated troponin and chest pain are documented, but EKG lacked acute ischemic changes. Cardiology documented probable Type II MI due to microvascular disease. A definitive provider statement confirming the diagnosis and clinical cause is required for compliant reporting.

### G)

Account No: [REDACTED]

### Findings

#### CO-97 Denials – Bundled Services

The claim was processed as a comprehensive outpatient surgical episode with bundled ancillary services. Payment structure appears consistent with payer outpatient reimbursement methodology.

#### Left Reverse Total Shoulder Arthroplasty

This supports billing of: CPT 23472 LT – Total shoulder arthroplasty

#### Diagnosis support is solid

M19.012 – Primary OA left shoulder

M12.812 – Rotator cuff arthropathy

Z96.612 – Presence of artificial shoulder joint

No documentation deficiencies for the primary procedure.

64415 XU (brachial plexus block)

#### Documentation

Patient had a block placed in the prep area and then taken to the operating room and placed under general anesthesia."

#### Recommendation

Under outpatient packaging methodology, regional blocks used as part of the anesthesia plan are typically bundled.

Appeal only if contract language explicitly allows separate reimbursement for postoperative pain blocks.



H)

Account No: 77

### Key Clinical Findings / Summary

The patient was admitted with a history of **angioedema**, requiring airway protection, and developed **acute hypoxic respiratory failure** secondary to **Pseudomonas pneumonia**, **sepsis**, and **acute kidney injury** requiring **hemodialysis**.

### Key inpatient events included

- Sedation, intubation, and ICU management for airway protection
- Recurrent episodes of angioedema related to ACE inhibitor use (lisinopril)
- Acute encephalopathy, likely metabolic
- Sepsis secondary to *Pseudomonas aeruginosa* (resistant to meropenem; treated with Zosyn)
- Acute hypoxic respiratory failure, ventilator support and subsequent tracheostomy
- AKI progressing to hemodialysis dependency
- PEG tube placement and ongoing nutritional support
- Cardiac history: atrial fibrillation with RVR, HFrEF, hypertension

### Hospital Course Highlights

- Intubated, sedated for airway protection due to angioedema.
- PEG tube and tracheostomy placed.
- Developed acute metabolic encephalopathy (likely multifactorial: uremia, metabolic acidosis).
- Required **intermittent hemodialysis** for AKI superimposed on CKD.
- Pneumonia due to ***Pseudomonas aeruginosa*** resistant to meropenem; treated with Zosyn.
- Cardiac history: sinus bradycardia, AFib with RVR, HFrEF; treated with amiodarone and Coreg.
- Complicated ICU course: agitation, sedation, delirium, intermittent hypoxia, apneic episodes, hypernatremia.
- Transitioned to **comfort care plan with ongoing active treatment**; patient alert, following commands by 1/17.

### Labs / Imaging / Diagnostics

- Hematology: anemia (Hgb 8.6), leukocytosis resolving, thrombocytopenia absent.
- Renal: BUN 84 → 142; Cr 5.8 → 6.5; GFR 12 → 9 (AKI on CKD).
- ABGs: fluctuating metabolic acidosis and respiratory changes.
- EKGs: multiple arrhythmias (AFib, sinus brady, PACs/PVCs), LVH, anterior infarct evidence.
- Cultures: Sputum positive for *Pseudomonas*; blood cultures negative.



### Active Problems at Discharge / Current

**Sepsis / Pseudomonas pneumonia** – acute

**Acute hypoxic respiratory failure** – status post trach/PEG, off ventilator

**AKI on CKD** – requiring intermittent hemodialysis

**Acute encephalopathy** – metabolic / infectious

**HFrEF** – ongoing management

**AFib with RVR** – rate controlled, on amiodarone/Coreg

**Ileus / PEG feedings** – ongoing nutritional management

**Hypertension / Diabetes type 2** – chronic comorbidities, adjustments in medications

**Angioedema** – resolved

### DRG Validation

- **DRG Entered:** 004 – **Tracheostomy with MCC**
- **Rationale:** The tracheostomy procedure triggers **MCC assignment** per IPPS/Medicare logic.
- All MCC comorbidities are captured (sepsis, AKI, acute respiratory failure).
- DRG assignment **aligned with inpatient clinical severity** and procedures performed.

### Key Audit Notes

- **PDX Accuracy:** While angioedema was the **initial reason for admission**, documentation of **acute hypoxic respiratory failure** as secondary diagnosis is appropriate and captured.
- **MCC Capture:** AKI requiring dialysis and sepsis are correctly documented, supporting DRG 004 assignment.
- **Procedure Capture:** Tracheostomy procedure is the **primary driver** for DRG 004.
- **Documentation Support:** ICU course, ventilation status, PEG, dialysis, and infectious complications are well-documented and support inpatient coding.
- **Financial/Compliance Implication:** Coding reflects **severity of illness** and **resource utilization**; DRG 004 assignment is justified.

### Conclusion / Recommendations

Current coding of **PDX, secondary diagnoses, and PCS** is **accurate** and **compliant** with inpatient coding guidelines.

DRG 004 assignment is **correct** based on clinical and procedural documentation.

Ensure **all secondary diagnoses and MCCs** remain clearly documented for future audits or payer review



## 7. Conclusion

### 1. Charges Analysis

Total charges increased from **\$490.4M in 2024 to \$520.7M** in 2025, reflecting overall growth. However, revenue remains heavily concentrated within the Regional Medical Center (**95%**), indicating dependency risk. Certain facilities and service lines experienced declines, including Surgical Associates, Family Physicians, and Ortho Sports Medicine. Payer mix shifts were noted, with growth in Medicare Advantage and Insurance Exchange, but declines in Managed Care, Self-Pay, and Medicaid CMO. While overall charge capture appears stable, reliance on limited service lines and payers create financial vulnerability.

### 2. Payment Analysis

Total collections increased marginally by **1–2%**, which is disproportionately low compared to the **6%** increase in charges. Major payers such as Blue Cross and Medicaid CMO showed declining payments, while Medicare and Managed Care exhibited minimal growth. Several facilities experienced reduced collections, particularly Surgical Associates and Family Physicians. Payment inconsistency across months suggests instability in billing, adjudication, or follow-up processes. Overall, revenue growth is not keeping pace with charge growth.

### 3. PC Ratio Analysis

The overall Payment-to-Charge (PC) ratio **declined from 23% in 2024 to 22% in 2025**, indicating reduced collection efficiency despite increased billing volume. Q2 and Q3 of 2025 showed the most significant performance drop. Although Q1 and Q4 remained relatively stable, the consistent dip mid-year highlights delays in cash realization and potential inefficiencies in denial management, follow-up, or payment posting processes. Immediate corrective strategies are required to improve collection yield.

### 4. Accounts Receivable (AR) Analysis

Total AR stands at **\$53.9M**, with **46%** in the 0–30-day bucket, reflecting timely billing activity. However, **27%** of receivables are aged beyond 90 days, increasing financial risk. Self-Pay balances represent the highest exposure, with a significant portion aged beyond 60 days. Major payers such as Managed Care, Medicare Advantage, and Blue Cross carry substantial aged balances, indicating delays in adjudication or insufficient follow-up. Emergency Department and Ambulatory Physician accounts contribute the largest share of outstanding AR, requiring focused intervention.

### 5. Billing Errors & Denial Management

Multiple clearinghouse rejections and denials were identified due to eligibility issues, invalid payer IDs, patient demographic mismatches, missing authorization, coding specificity errors, modifier inconsistencies, COB errors, and duplicate claim submissions. A recurring issue across cases is lack of timely follow-up and inadequate documentation in the PMS. These operational gaps increase AR aging, delay collections, and elevate write-off risk. Strengthening pre-submission validation, eligibility checks, authorization tracking, and denial follow-up workflows is critical to prevent recurring revenue leakage.



## 6. Overall RCM Performance – Final Conclusion

While **Regional Hospital** demonstrates charge growth and stable billing activity, collection performance is lagging behind. The decline in PC ratio, aging AR balances, payer-specific payment reductions, and recurring billing errors highlight weaknesses in revenue cycle execution. To improve financial stability and cash flow predictability, the organization should:

- **Strengthen eligibility and pre-authorization controls**
- **Implement aggressive AR follow-up for 90+ day balances**
- **Improve denial management and root cause analysis**
- **Enhance payer-specific performance monitoring**
- **Conduct reconciliation audits between billing systems**

Without corrective action, increased charge volumes may continue without proportional cash realization, leading to long-term financial inefficiencies.

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