

Sample — fictional practice, illustrative figures. Not client results.

A sample audit report.

What the written report looks like after a free audit call, shown for Northfield Family Medicine, a fictional practice.

Every name, encounter ID and figure on this page is made up. The figures show how the report is laid out. They don't describe any real practice, and they aren't results Highview has achieved.

A real report uses your own billing data, reviewed under a signed business associate agreement (BAA), and covers the areas agreed on the free audit call. We walk you through it section by section.

About this report

Practice

Northfield Family Medicine (fictional)

Specialty

Family medicine

Providers

3

Period reviewed

12 months

Visits

8,177

Claims billed

8,060

A fictional practice. All names, encounter IDs and figures are synthetic.

1 Claims by status

Every claim billed in the period, by where it stands today.

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Claims by status, 12 months

Status	Claims	Billed charges	Open balance
Paid in full	6,877	\$1,472,602	\$0
Paid, patient balance due	424	\$89,627	\$28,950
Open with insurer	618	\$130,605	\$130,605
Denied, not yet resolved	141	\$31,061	\$31,061
Total	8,060	\$1,723,895	\$190,616

Open balances are shown at billed charges. What a payer allows is usually lower. Visits that were never billed aren't claims yet; they're in section 5.

2 Open balances

The open balance from section 1, split three ways so it's clear what needs follow-up: recent insurer claims, older insurer balances, and what patients owe.

Recent insurer claims

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Insurer claims open 0–45 days

Age	Claims	Balance at billed charges	No payer acknowledgement	Already denied
0–45 days	561	\$119,159	55	22

What needs follow-up: Most of these are within normal payer processing time and need no action yet. Follow up now on the 55 with no payer acknowledgement and the 22 already denied.

Older insurer balances, by age

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Insurer balances older than 45 days, by age

Age band	Claims	Balance at billed charges	Of which denied	Next step
46–90 days	55	\$11,287	30	Past typical payer processing time. Check each claim's status and work any denials.
91–180 days	62	\$13,664	43	Needs a status check and, where a claim was denied, a corrected claim or an appeal.
181–365 days	81	\$17,556	46	Check each claim against the payer's filing limit first; some may no longer be collectible.
Total	198	\$42,507	119	

What needs follow-up: 66 of these claims are already past the payer's filing limit. They stay in the bands above so the totals reconcile, but they may not be collectible unless there is proof the claim was filed in time.

Patient responsibility

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Patient balances after the insurer has paid

Age	Claims	Patient balance
0–45 days	63	\$4,815
Over 45 days	361	\$24,135
Total	424	\$28,950

What needs follow-up: Copays, coinsurance and deductibles the insurer has already processed. These are collected through patient statements, not payer follow-up, so they are kept separate.

3 Claims nearing filing deadlines

Insurer claims that still need a clean claim on file, with 30 days or fewer left before the payer's filing limit. These are worked first.

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Claims within 30 days of the filing limit, by payer

Payer	Filing limit used (days)	Claims	Billed charges
Medicare	365	3	\$430
Medicaid plan A	180	2	\$555
Commercial payer A	90	5	\$985
Commercial payer B	180	3	\$640
Total		13	\$2,610

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Soonest deadlines

Encounter	Payer	Issue	Days since visit	Filing limit	Days remaining	Charge
S-006373	Commercial payer A	Not on file with payer	82	90	8	\$160
S-006401	Commercial payer A	Not on file with payer	81	90	9	\$160
S-000234	Medicare	Not on file with payer	354	365	11	\$110
S-004504	Medicaid plan A	Denied: missing or invalid information	165	180	15	\$265
S-004508	Commercial payer B	Denied: eligibility or coverage	165	180	15	\$160
S-004543	Commercial payer B	Denied: eligibility or coverage	164	180	16	\$235
S-004547	Commercial payer B	Not on file with payer	163	180	17	\$245
S-006627	Commercial payer A	Denied: missing or invalid information	72	90	18	\$160
S-000433	Medicare	Not on file with payer	346	365	19	\$160
S-006695	Commercial payer A	Not on file with payer	68	90	22	\$270

Filing limits vary by payer and by contract. The limits here are illustrative; a real report uses the limits in the practice's own payer contracts.

4 Denial patterns

Denied claims not yet resolved, grouped by the reason the payer gave. Patterns point to fixes upstream, at registration, authorization or charge entry.

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Unresolved denials by reason

Reason	CARC	Claims	Billed charges	Next step
Missing or invalid information	16	42	\$9,071	Correct the claim and resubmit.
Eligibility or coverage	27	28	\$6,381	Verify coverage and bill the right payer.
Bundling (included in another service)	97	21	\$4,663	Check whether a modifier is supported; if not, write off.
Prior authorization missing	197	19	\$4,368	Look for an authorization on file; appeal if one exists.
Medical necessity	50	18	\$3,633	Review documentation and diagnosis coding before appealing.
Duplicate claim	18	7	\$1,578	Confirm the original was paid; usually no action.
Timely filing	29	6	\$1,367	Appeal only with proof of timely submission.
Total		141	\$31,061	

CARC is the standard claim adjustment reason code on the payer's remittance. Each category shows the most common code.

5 Unbilled visits

Visits in the schedule with no claim sent: 117 visits, \$24,432 in charges at the practice's own rates.

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Unbilled visits by reason

Reason	Visits	Older than 14 days	Charges
Visit note not yet signed	63	53	\$13,341
Charge not entered	38	37	\$7,555
Held for missing insurance details	16	16	\$3,536
Total	117	106	\$24,432

Visits from the last two weeks are often still being documented. Older unbilled visits need a decision: bill them before the payer's filing limit, or record why they won't be billed.

6 Coding review, in both directions

12 office visits reviewed against their documentation: 5 billed above what the documentation supports, 2 billed below it, and 5 that match.

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Coding review sample

Encounter	Provider	Code billed	Documentation supports	Direction	Finding
S-004269	Provider C	99214	99213	Above documentation	Decision-making documented as low, not moderate.
S-004500	Provider B	99214	99213	Above documentation	Decision-making documented as moderate, not high.
S-004734	Provider A	99213	99213	Matches	Documentation supports the code billed.
S-005392	Provider C	99213	99213	Matches	Documentation supports the code billed.
S-005462	Provider A	99214	99213	Above documentation	Decision-making documented as low, not moderate.
S-005481	Provider C	99214	99214	Matches	Documentation supports the code billed.
S-005662	Provider B	99214	99213	Above documentation	Total time documented falls short of the billed level.
S-006378	Provider B	99214	99213	Above documentation	Decision-making documented as moderate, not high.
S-006532	Provider B	99213	99213	Matches	Documentation supports the code billed.
S-006544	Provider C	99213	99214	Below documentation	Total time documented supports the higher level.
S-006596	Provider B	99214	99214	Matches	Documentation supports the code billed.
S-006623	Provider B	99213	99214	Below documentation	Total time documented supports the higher level.

Over-coding carries a repayment obligation. Where the documentation supports a lower code than was billed, the practice may have been paid more than it was owed and may have a repayment obligation to the payer. The report flags these for correction just as clearly as visits billed below the documentation.

A small sample shows the format. It is not a coding error rate.

7 Payer participation

Enrollment status with each payer, for the practice as a group and for each provider individually.

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Participation status by payer

Payer	Group (practice)	Provider A	Provider B	Provider C	Next step
Medicare	Participating	Participating	Participating	Participating	No action needed.
Medicaid plan A	Not enrolled	Needs verification	Participating	Participating	Start enrollment before sending this payer claims for anyone not enrolled.
Medicaid plan B	Participating	Participating	Needs verification	Participating	Confirm status with the payer before the next claims go out.
Commercial payer A	Needs verification	Not enrolled	Participating	Participating	Start enrollment before sending this payer claims for anyone not enrolled.
Commercial payer B	Not enrolled	Participating	Participating	Participating	Start enrollment before sending this payer claims for anyone not enrolled.

Payer	Group (practice)	Provider A	Provider B	Provider C	Next step
Commercial payer C	Participating	Participating	Participating	Participating	No action needed.

Group enrollment and each provider’s individual enrollment are checked separately: a practice can be in network while one of its providers is not.

What this report can’t tell you

- Whether a balance can still be collected depends on each claim’s history and the payer’s rules. Open balances here are listed so they can be worked, not counted as money owed.
- Figures in a real report are estimates from the data reviewed. They are not guarantees of what will be collected.
- A coding review looks at a sample of visits. It shows patterns to check, in both directions, not a precise error rate.