Belle Curve Insights

REAL PILOT DATA

Full Practice Findings

FIVE PAGES · 1 JUNE – 31 JULY 2026

A single-doctor Florida practice · 445 patients across 44 clinic days · prepared by Sandra Stokke

55.1%

of every dollar this practice was **entitled to collect on insured claims** actually arrived. The benchmark is 95–99%.

82.8%	$25,868	$11,129	$31,273
PATIENT RECEIVABLE PAST 120 DAYS · BENCHMARK 10–15%	RECEIVED AND NEVER APPLIED TO AN ACCOUNT	OWED BACK TO PATIENTS · AT MINIMUM	INSURED CLAIMS COLLECTIBLE AND STILL UNPAID

Read the 55.1% correctly. It is not a measure of how hard anyone is working. It covers insured claims only, and it measures collections against what the insurer and patient were *contractually obliged* to pay once the contractual discount was off — so a low figure means money genuinely owed has not arrived. A practice-wide rate cannot be computed from this data: one adjustment code holds $32,157 with no reason recorded against it.

THE FIVE NUMBERS THAT MATTER

Measure	This practice	Benchmark	What it is measured against
Net collection rate, insured claims	**55.1%**	95–99%	$38,403 collected of $69,676 collectible
Insurance collection rate	**71.3%**	—	$31,340 of $43,956 of insurer responsibility
Patient receivable past 120 days	**82.8%**	10–15%	$351,648 of $424,798 in ageing buckets
Cash received but never applied	**$25,868**	near zero	Held across 122 patient accounts
Collected per attended visit	**$49.02**	—	$74,458 across 1,519 attended visits

Every rate carries its own denominator on purpose. The three usual ways to overstate a collection problem are to divide by billed charges, to mix self-pay into an insurance rate, and to quote a figure without the date it was measured. None is done here.

WHERE TO START — IN ORDER

1. **Split the catch-all write-off code into four.** Contractual reduction, cash-pay discount, courtesy adjustment, bad debt. A configuration change, not a project — and without it no collection rate here can be defended, including this one.
2. **Post the $17,630 of held cash that has charges waiting for it.** No patient contact, no collection effort; the receivable falls as you go.
3. **Work the $31,273 of insured claims that are collectible and unpaid,** starting with the seven commercial and Medicare plans rather than the auto carriers, which are simply waiting on settlement.
4. **Separate the 40 credit accounts into refunds owed and prepaid care,** then ask the vendor for a listing of accounts holding money with no open charge — the ageing report cannot see them.

1 · WHERE EVERY DOLLAR WENT

1 The practice cannot currently measure its own collection rate

Of the **$87,649** written off in June and July, $43,032 carries code CO-45 — a contractual reduction, correctly excluded from any collection rate. But **$32,157 sits in one code, OA-CT-WO, across 636 transactions**, and the description field records the procedure rather than the reason.

The posting pattern says what the code will not. **75.9% of it posts within thirty days of the visit and 37% the same day** — before any insurer has adjudicated anything — and **80.4% lands on exact multiples of $5** ($30 a hundred and twenty-four times, $80 a hundred and nine, $40 a hundred and seven). That is a cash-pay price list applied at the front desk and filed as a loss. Only **14.2% posts at sixty-one days or later**, the shape genuine bad debt actually has. (All four shares are of the $32,157, counted by posting date.)

> **Split OA-CT-WO into four codes — contractual, cash discount, courtesy, bad debt. From the next quarter forward a defensible net collection rate exists, and roughly $26,000 a quarter stops reading as money lost when it was money discounted on purpose. It is a settings change, not a project.**

2 55 cents of every collectible insured dollar arrived

On insured claims the practice billed $121,150 and the contractual discount took off $51,474, leaving **$69,676 that the insurer and the patient were obliged to pay**. $38,403 came in. The remaining **$31,273 is collectible and unpaid** — $22,196 still owed by insurers, $9,077 by patients. Some of it will yet adjudicate; none of it has been written off.

> **This is the number to work, and it is not the same thing as the receivable. It is two months of claims, and it is specific enough to assign.**

WHERE EVERY INSURED DOLLAR WENT · 1 JUNE – 31 JULY 2026

Disposition of every dollar billed to insurance	Amount	Share
Contractually written off — never collectible by anyone	**$51,473.87**	42.5%
Paid by the insurer	**$26,859.98**	22.2%
Still open with the insurer	**$22,195.82**	18.3%
Moved to patient responsibility	**$20,620.17**	17.0%
Charged to insurance	**$121,149.84**	**100%**

Of the $20,620 moved to the patient, $11,543 has been paid and $9,077 is still owed — add the $22,196 open with insurers and **$31,273 remains collectible and unpaid**. **Self-pay sits outside this table:** $87,290 charged, $36,055 collected, no separable contractual line.

WHAT THE $87,649 OF JUNE–JULY WRITE-OFFS ACTUALLY IS

Adjustment code	Transactions	Amount	Share	Reason recorded?
CO-45 · charge exceeds allowable	1,016	**$43,032.42**	49.1%	Yes — contractual
OA-CT-WO · generic write-off	636	**$32,156.81**	36.7%	**No**
OA-CTPPOA · migration adjustment	196	**$11,653.52**	13.3%	Cutover artefact
All other codes	292	$806.18	0.9%	Yes
Posted 1 June – 31 July 2026	**2,140**	**$87,648.93**	**100%**	

Counted by posting date. On a date-of-service basis the two months carry $52,483, of which $24,876 is still the unexplained code — the conclusion holds either way.

And it reached the bank. The practice-management system recorded **$86,708.48** in payments over the two months; **$84,528.27** reached the bank — a 2.5% gap consistent with settlement timing, not leakage. Those are two genuinely separate systems, and it is the step most audits skip. The profit-and-loss books that same $84,528.27, because income here is recorded from deposits rather than from services rendered: the P&L confirms the bookkeeping is internally consistent, it does not independently corroborate the deposits, and it is why the balance sheet carries no accounts-receivable line.

2 · MONEY ALREADY IN HAND

3 $25,868 was received and never applied to an account

Across **122 patient accounts**, money has arrived and nobody told the software which charge it belonged to. **$17,630 of it has charges waiting on the very same account** — nothing to collect, only to post. The consequence is not lost revenue; it is that patients who paid receive statements, staff chase money already in the bank, and the receivable shows debt nobody owes.

> **Post the $17,630 oldest-first. Until it is cleared, no collection rate computed from this receivable means anything.**

4 $11,129 is owed back — and the ageing report cannot show all of it

Forty accounts hold **$8,238 more than the patient owes**. These are not prepaid plans: patients paid cash at the desk for care their insurance covered in full, one front-desk habit repeated. Worse, the ageing report lists only accounts with an open charge, so **a further 42 payers and patients holding $2,891 appear nowhere in it at all**. The floor on refund exposure is $11,129; the true figure is unknown today.

> **Ask the vendor for a listing of accounts holding unapplied money with no open charge, then separate genuine refunds from prepaid care. Only the practice knows which is which.**

WHAT THE RECEIVABLE REPORTS · AS AT 10 SEPTEMBER 2026

Unapplied cash held on patient accounts	Accounts	Amount	Share
Posts against charges on the same account	82	**$17,630.25**	68%
Exceeds anything the patient owes — a credit balance	40	**$8,238.08**	32%
Reported as unapplied	**122**	**$25,868.33**	**100%**

WHAT THE RECEIVABLE CANNOT SEE · PAYMENT DETAIL, 1 MAY – 30 JUNE 2026

Unapplied payments taken in the period	Entries	Amount	Why it is missing
On accounts with no open charge	42	**$2,890.95**	Ageing report lists open charges only
Institutional money never assigned to anyone	2	**$3,460.50**	$3,125 since May; $335.50 Medicare Part B
Unapplied in the period	**87**	**$10,504.88**	Rest posts, or is the credit above

These are two lenses on overlapping money, not two halves of one total, which is why they are not added together. The refund floor is the credit balances plus the invisible accounts: **$8,238 + $2,891 = $11,129**. It is a floor because no report available today can list every account holding money it does not owe.

THE RECEIVABLE THIS SITS INSIDE

Accounts receivable as at 10 September 2026	Amount	Note
Patient charges outstanding	**$424,798.18**	1,340 accounts, sum of ageing buckets
Of which past 120 days	**$351,648.32**	**82.8% — benchmark is 10–15%**
Of which current, 0–30 days	**$28,168.61**	6.6%
Payer receivable, same date	**$167,027.38**	57.7% past 120 days

An 82.8% figure at 121+ days is not a collections problem alone. A receivable this old on a book this size usually means charges are sitting that were never going to be collected and have never been written off — which is the write-off code problem seen from the other end.

5 $12,616 of insurer responsibility went uncollected — but three quarters of it is auto

Insurers owed **$43,956** on charges first billed in June and July; **$31,340** arrived, a 71.3% collection rate. Of the $12,616 shortfall, **$9,611 is held by nine auto and personal-injury carriers**, where non-payment inside sixty days is normal and settlement, not follow-up, releases the money. The genuinely actionable balance is **$3,915 across seven commercial, network and Medicare Advantage plans**.

> **Work the seven health plans below. Track the auto carriers on a settlement calendar instead — chasing them weekly produces activity, not cash.**

6 Medicare Part B paid 109.7% of what it owed

Part B was responsible for $9,392 on the window's charges and paid **$10,302** — $910 more. Most of that is timing: payments landing in this window against claims billed earlier. But $335.50 of Part B money is also sitting unapplied on no patient account at all, and an overpayment that turns out to be real is a refund obligation to a federal payer.

> **Reconcile the Part B remittances against the claims they were sent for, and post or return the $335.50.**

EVERY PAYER WITH A SHORTFALL · CHARGES FIRST BILLED 1 JUNE – 31 JULY 2026

Payer	Type	Responsibility	Collected	Shortfall	Rate
STATE FARM	Auto	$4,137.03	$1,841.66	**$2,295.37**	44.5%
National General Auto	Auto	$1,578.00	—	**$1,578.00**	0.0%
USAA	Auto	$1,515.00	—	**$1,515.00**	0.0%
AAA Auto Insurance	Auto	$1,510.00	—	**$1,510.00**	0.0%
GEICO	Auto	$1,576.42	$387.56	**$1,188.86**	24.6%
TRAVELERS OF FLORIDA	Auto	$2,715.12	$1,685.12	**$1,030.00**	62.1%
ALIVI Health	**Network**	$1,025.00	—	**$1,025.00**	0.0%
BCBS FL	**Commercial**	$953.54	$155.54	**$798.00**	16.3%
AETNA	**Commercial**	$5,431.20	$4,719.20	**$712.00**	86.9%
UMR	**Commercial**	$871.00	$371.00	**$500.00**	42.6%
UHC Medicare Advantage	**Medicare**	$1,145.00	$755.00	**$390.00**	65.9%
UHC	**Commercial**	$1,666.00	$1,331.00	**$335.00**	79.9%
UnitedHealth Shared Services	**Commercial**	$205.00	$50.00	**$155.00**	24.4%
ALLSTATE, TRAVELERS, PROGRESSIVE	Auto	$7,908.42	$7,414.37	**$494.05**	93.8%
MEDICARE PART B	Medicare	$9,391.50	$10,301.81	**−$910.31**	109.7%
Ten payers collected in full		$2,327.68	$2,327.68	—	100.0%
All 27 payers		**$43,955.91**	**$31,339.94**	**$12,615.97**	**71.3%**

Two cautions that belong with this table. The report counts only charges *first billed* inside the window and shows the primary policy only, excluding secondary billings — so the true insurance rate is somewhat better than 71.3%. And the same window pulled on 30 August gave 65.1%: responsibility fell $3,765 as claims adjudicated while collections rose just $253. The rate moved six points and almost none of it was money. Any collection rate quoted without the date it was measured is not a number.

4 · WHAT THE PRACTICE ACTUALLY EARNS

7 One code carries half the practice

The spinal manipulation code 98941 is 1,232 of 3,097 units and **$36,167 of $74,458 collected — 48.6% of everything that came in**, at $29.36 per unit. The five largest codes together are 80.4% of collections. That concentration is not a fault; it is the fact that any pricing, contracting or scheduling decision has to be tested against first.

> **Before renegotiating anything, model the effect on 98941 alone. A one-dollar move on that code is worth more than most whole service lines.**

8 $2,341 of retail sales is posted to no provider and no location

Twenty-seven units — pillows, braces, orthotics, topicals — are booked against an unassigned provider at an unassigned location. It is a small sum, but it means retail is invisible in every provider and location report the practice runs, and the true service total is $210,780 rather than $208,439.

> **Assign a location and a provider to retail items so the category can be measured at all.**

WHAT EACH SERVICE COLLECTS · TOP TEN BY COLLECTIONS

Code	Service	Units	Charged	Collected	Per unit
98941	Spinal manipulation, 3–4 regions	1,232	$98,619.76	**$36,166.69**	$29.36
99203	New patient, detailed, 30 min	63	$14,490.00	**$7,062.28**	$112.10
97012	Intersegmental traction	507	$25,184.80	**$6,550.84**	$12.92
97124	Massage, 60 min, self-pay	92	$8,385.00	**$6,103.08**	$66.34
97014	Electrical stimulation, unattended	352	$8,864.12	**$3,963.95**	$11.26
97110	Therapeutic exercise, 15 min	153	$13,770.00	**$2,687.87**	$17.57
97039	Laser	37	$2,405.00	**$2,090.00**	$56.49
99213	Re-exam, expanded, 30 min	58	$9,816.74	**$1,772.66**	$30.56
98940	Spinal manipulation, 1–2 regions	87	$4,755.00	**$1,561.18**	$17.94
G0283	Electrical stimulation, Medicare/UHC	173	$4,325.00	**$1,545.35**	$8.93
All services, 1 June – 31 July 2026		**3,097**	**$208,439.42**	**$74,457.91**	**$24.04**

Per-unit figures blend reimbursement with deliberate write-offs and are not a fee schedule. **97110 is the clearest case:** billed here for taping and written off in full for cash patients, so its $17.57 mixes two different decisions. Codes below twenty units are excluded from the ranking.

THE PRACTICE IN FOUR NUMBERS

1 June – 31 July 2026	Value	Basis
Attended appointments	**1,519**	34.5 per clinic day across 44 days
Distinct patients seen	**445**	3.4 visits each; 211 had no insurance claim
Charged per attended visit	**$137.22**	2.0 billable units per visit
Collected per attended visit	**$49.02**	$167.32 per patient over the two months

157 appointments were cancelled or missed — 9.2% of everything scheduled. Self-pay is 211 of the 445 patients.

See what this looks like on your own numbers.

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