DATA DRIVEN DOCTOR

Northgate Health Partners

Monthly review — December, year 2. Eight providers, three sites, twenty-four months of reconciled clinical, revenue-cycle, and patient-contact data.

PERIOD	PROVIDERS	SITES	SYSTEMS READ
Dec, year 2	8	3	6

Illustrative sample. Northgate Health Partners is a fictional practice created to demonstrate the Data Driven Doctor monthly review. No real patient or practice data appears in this document.

Four decisions for this month.

Ranked by the dollars at stake, not by how easy they are. Every figure traces back to a chart later in this report.

01 **Reopen the Ironwood Select and Cascade HMO contracts** — **$168k** PER YEAR

Both payers pay under their own contracted rate — 11.8% and 8.6% respectively, across 4,750 claims. The variance is consistent by code, which points at their fee schedule load rather than at your coding.

02 **Put a prior-authorisation check on two plans at the front desk** — **$152k** PER YEAR

Prior authorisation is the largest denial reason at $214k over twelve months, and 71% of it comes from two plans. A check at booking removes most of it before a claim is ever built.

03 **Move two Friday afternoon sessions to Tuesday morning** — **$24k** PER YEAR

Friday afternoon runs 41–63% full while Tuesday morning is effectively closed at 96%. The same clinical hours produce roughly 340 more encounters a year.

04 **Shift 5% of acute same-day capacity into scheduled chronic care** — **$186k** PER YEAR

Chronic care management returns $130 of margin per encounter against $58 for acute same-day. The shift is a scheduling-template change, not a hiring decision.

How to read the numbers. Annual values assume December volumes hold. Where a decision depends on a payer agreeing to something, we state the exposure rather than the certain gain, and we say so in the section it comes from.

What moved this month

- **Margin per encounter reached $71**, up $4 on November and up 87% across the window.
- **Net collected fell 4.6% to $243k** on nine fewer clinical days. Per-day collection rose.
- **Days in A/R fell to 34.2**, inside the peer band for the first time in the window.
- **Denial rate reached 4.1%**, less than half where it started.

- **Missed calls fell to 206**, the lowest month recorded.

The month at a glance

December against November, and each measure against its own twelve-month path.

NET COLLECTED	MARGIN / ENC.	DAYS IN A/R	DENIAL RATE	MISSED CALLS
$243k	$71	34.2	4.1%	206
▼ 4.6%	▲ $4	▲ 0.7 d	▲ 0.1 pp	▲ 8

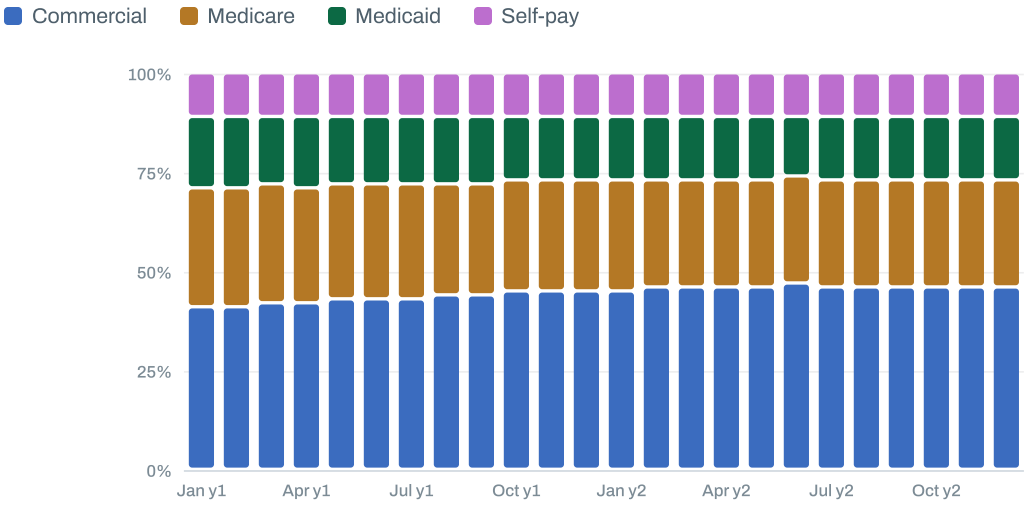
Contribution margin per encounter

24 months · dollars · operational events marked

Up 87% across the window, from $38 to $71. Two thirds of the gain lands after the coding review in Mar y2. Encounters grew only 18% over the same period, so this is a pricing and mix result.

Net revenue by payer

24 months · share of collected dollars



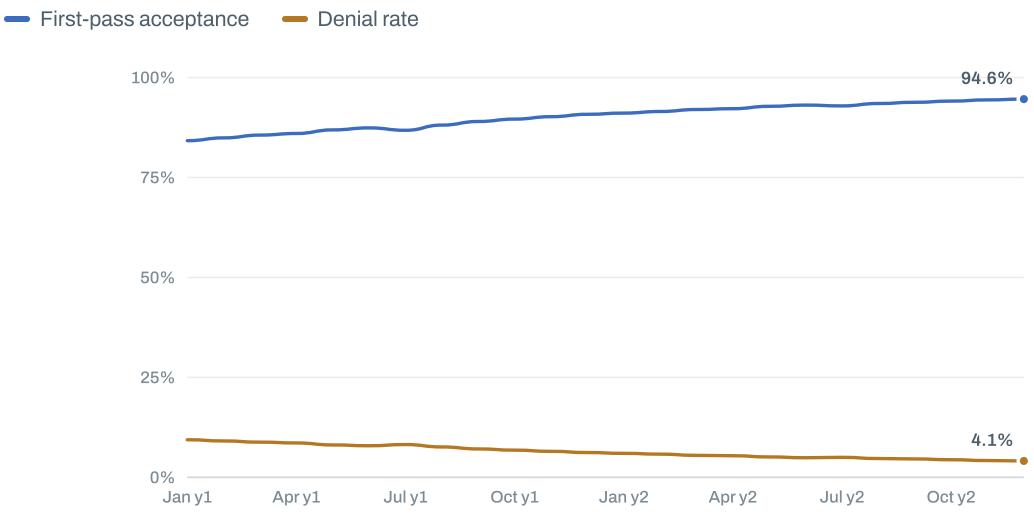
Commercial share moved from 41% to 46% while Medicaid fell two points. The mix shift alone is worth about $96k a year at current volumes.

Revenue integrity

The gap between what the practice earned and what it collected narrowed by $412k on an annualised basis. Most of that came from submitting cleaner claims, not from appealing harder.

Denial rate and first-pass acceptance

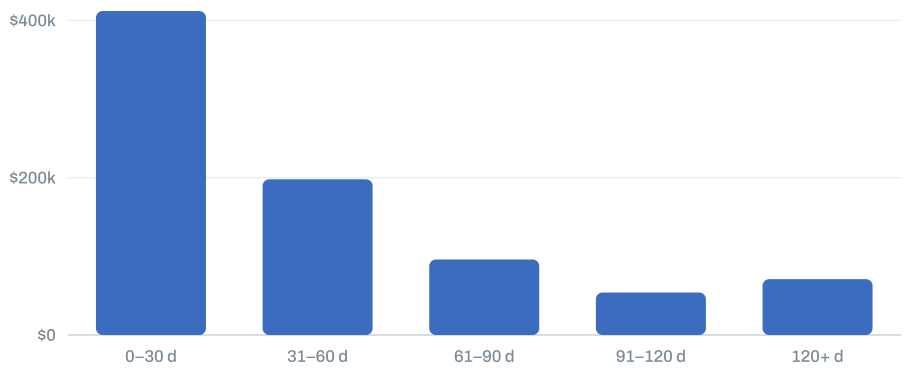
24 months · percent of claims



The two lines moved together, which tells you the gain came from cleaner submission rather than from harder appeals.

Accounts receivable by age

End of Dec y2 · dollars outstanding



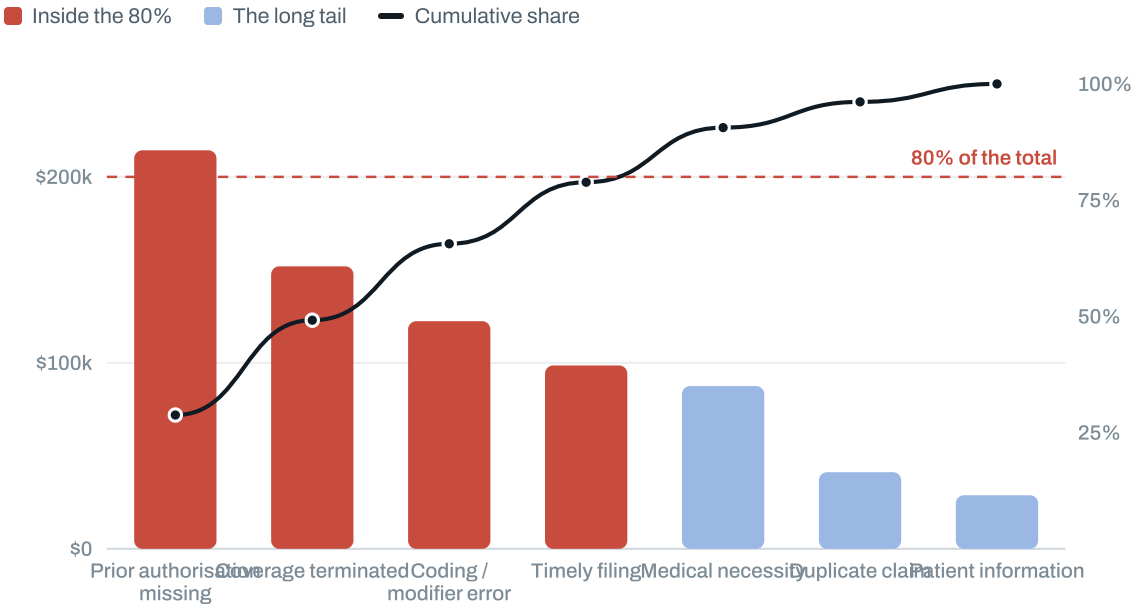
Balances over ninety days hold $125k, 15% of the book. Nine accounts are half of that.

Where the denials come from

Three reasons carry most of the loss. Both of the largest are checkable at the front desk before a claim is ever built.

Denials by reason, with the cumulative share

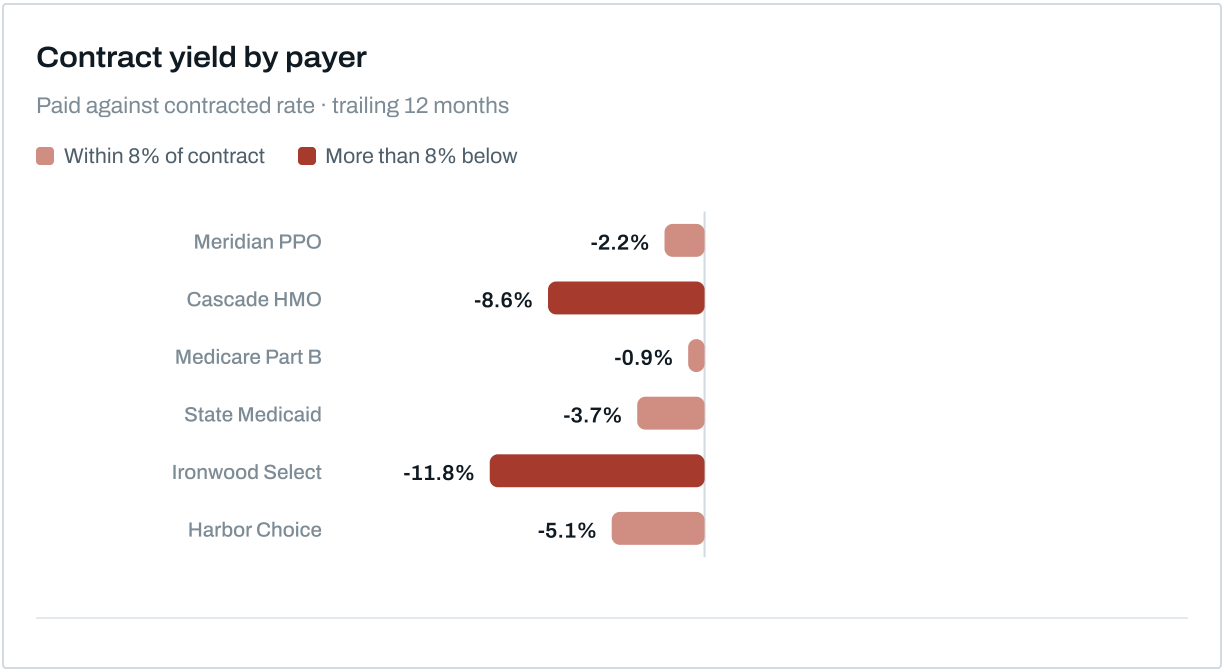
Trailing 12 months · dollars denied



Three reasons carry 68% of everything denied. Prior authorisation and coverage termination together are $366k a year, and both are checkable at the front desk before a claim exists.

Payer performance

Two payers pay materially under their own contracts. This is the evidence to take into a renegotiation, and it is reproducible claim by claim.



Payer	Claims	Paid vs contract	Annual exposure	Action
Ironwood Select	1,640	−11.8%	$94,200	Renegotiate
Cascade HMO	3,110	−8.6%	$73,800	Renegotiate
Harbor Choice	1,180	−5.1%	$21,400	Audit sample
State Medicaid	2,870	−3.7%	$18,900	Monitor
Meridian PPO	4,820	−2.2%	$14,600	Monitor
Medicare Part B	6,240	−0.9%	$7,100	No action

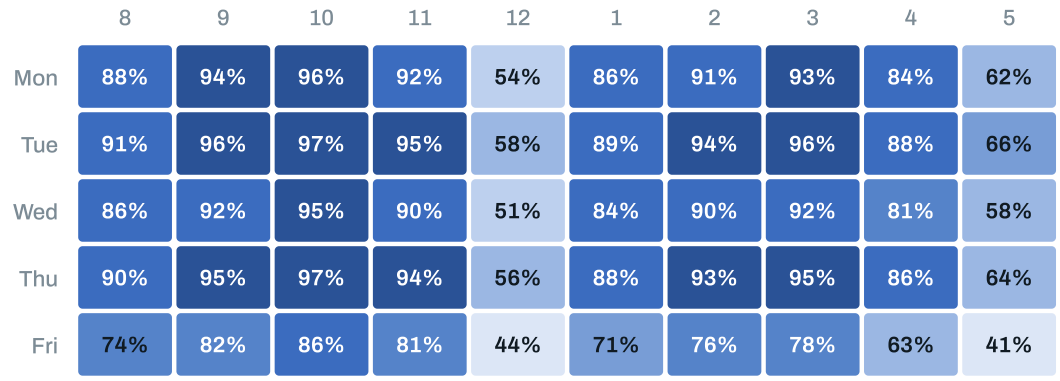
On the Ironwood variance. The shortfall is flat across CPT families rather than concentrated in one, which is the signature of a fee schedule loaded at the wrong year rather than a coding problem on your side. We can supply the claim-level extract to accompany a written request.

Capacity and access

Access improved for every provider. What remains is uneven, and the unevenness is structural rather than a matter of effort.

Slot utilisation by day and hour

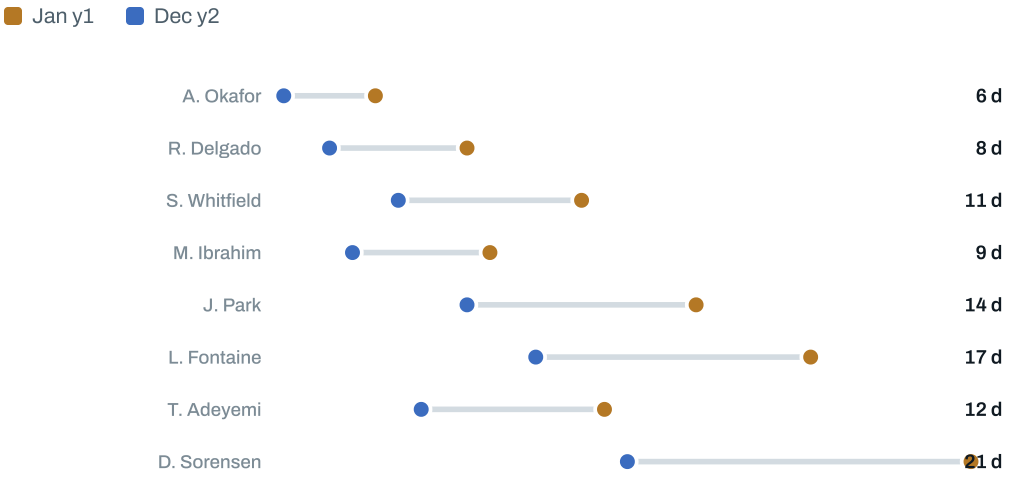
Trailing 12 months · percent filled



Friday afternoon runs 41–63% full while Tuesday morning is closed at 96%. Two sessions moved adds roughly 340 encounters a year.

Third next available appointment

By provider · days · start of window against now



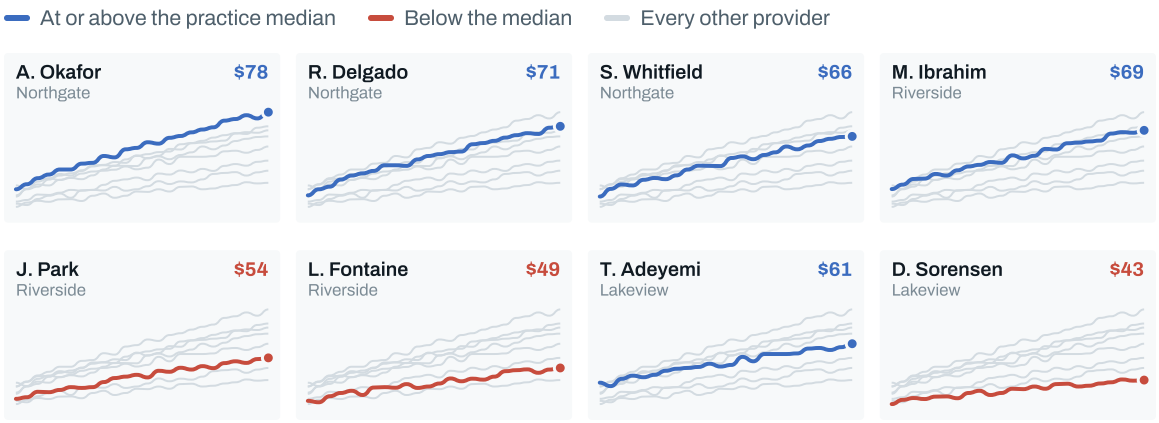
Access improved for every provider. D. Sorensen still sits at 21 days against a practice median of 11.

Every provider against the whole group

Reading a provider against the set rather than against a target changes the conclusion more often than not.

Margin per encounter, every provider against the whole group

24 months · one provider in colour, the other seven in grey



Six of eight sit at or above the practice median. The two below both run large paediatric panels, which is what a paediatric panel looks like and is not a performance finding.

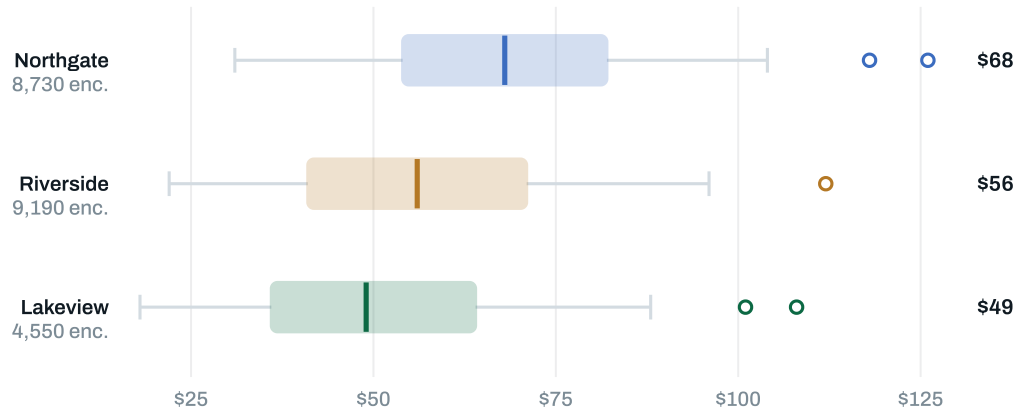
Provider detail

Volume, work, panel and margin side by side. Read the rows against each other, not against a single target — case mix drives most of the spread.

Provider	Site	Encounters	wRVU	Panel	Margin / enc.	No-show	3rd next avail.
A. Okafor	Northgate	3,140	5,820	1,980	$78	5.1%	6 d
R. Delgado	Northgate	2,980	5,410	1,870	$71	6.4%	8 d
S. Whitfield	Northgate	2,610	4,960	1,740	$66	7.2%	11 d
M. Ibrahim	Riverside	2,790	5,240	1,820	$69	6.8%	9 d
J. Park	Riverside	3,320	4,380	2,140	$54	9.6%	14 d
L. Fontaine	Riverside	3,080	4,110	2,020	$49	11.2%	17 d
T. Adeyemi	Lakeview	2,440	4,720	1,610	$61	7.9%	12 d
D. Sorensen	Lakeview	2,110	3,980	1,380	$43	12.8%	21 d

Margin per encounter by site

Trailing 12 months · box is the middle half, line is the median



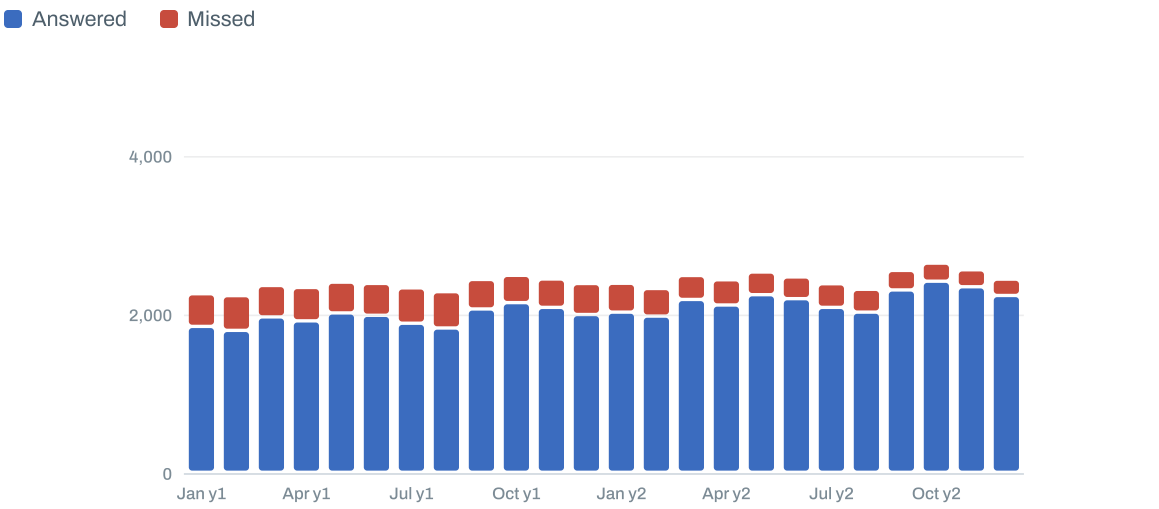
The spread inside each site is wider than the gap between sites, so case mix inside a location matters more than which location a patient walks into.

The patient layer

This is the layer most practices cannot see. It is also where the largest single leak in the practice sits: people who reached you and did not book.

Inbound calls, answered and missed

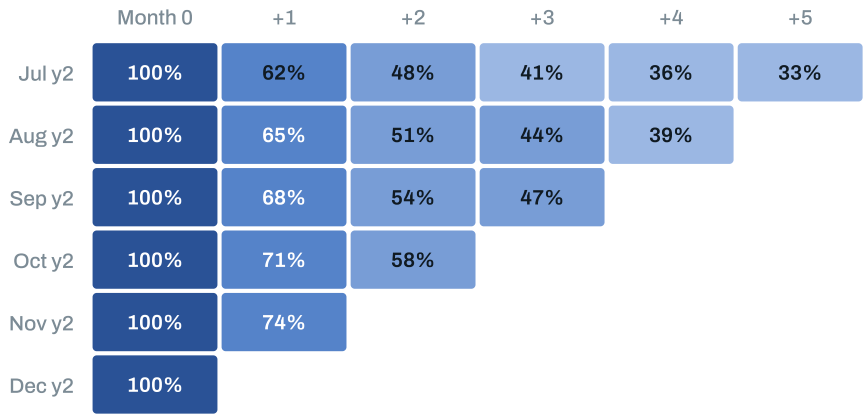
24 months · call volume



Missed calls fell by half after the voice agent went live in Mar y2 while total volume rose 21%.

Recall return rate by cohort

Share of each month's patients seen again



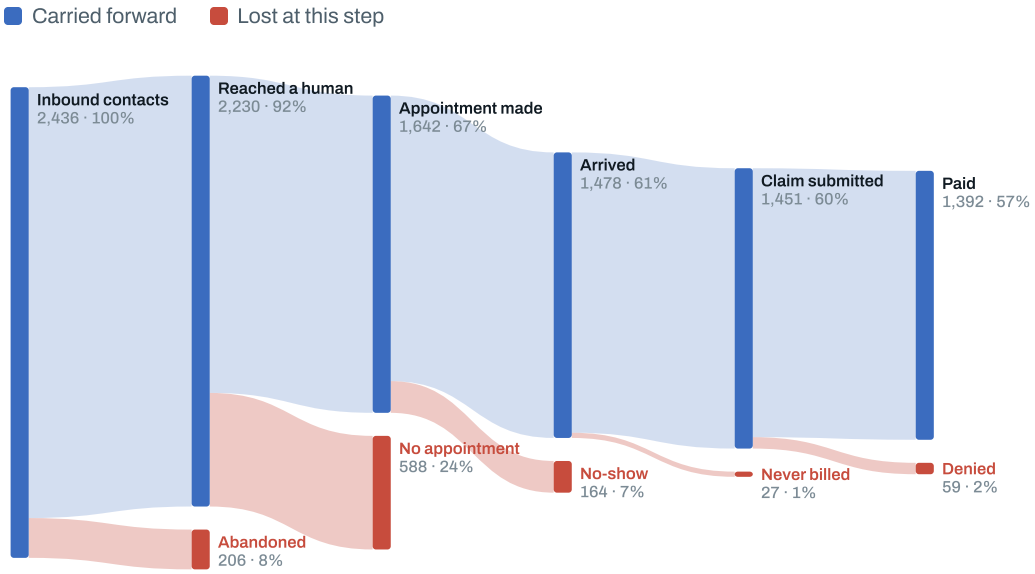
Each cohort returns better than the one before it, 62% to 74% at one month, tracking the switch from letters to text.

Where demand leaks

Every inbound contact followed to a paid claim, or to the point at which it stopped being one.

Where demand leaks, contact by contact

Dec y2 · every inbound contact followed to a paid claim or to the point it was lost



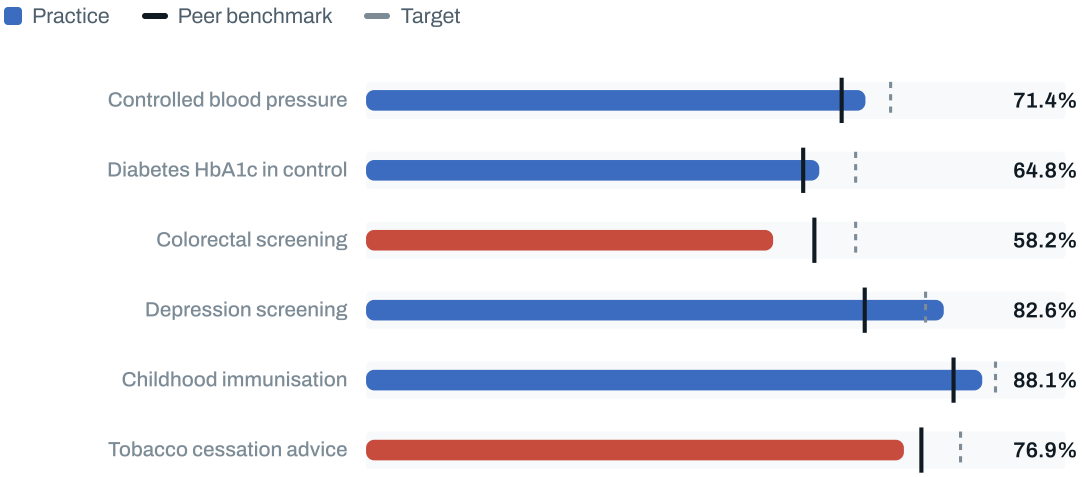
Of 2,436 contacts, 1,392 became a paid claim — 57%. The loss is concentrated in one step: 588 people reached a human and did not book, worth $41.7k in the month.

Quality and service mix

Quality measures beside the margin of the work that produces them, so the two conversations stay in one room.

Quality measures against peer benchmark

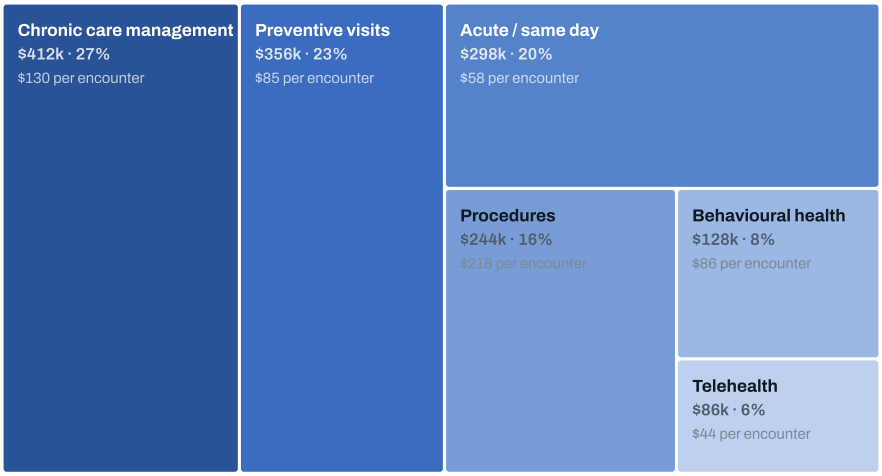
Trailing 12 months · percent of eligible patients



Four of six beat the benchmark. Colorectal screening trails by 5.9 points and tobacco cessation by 2.5; both are documentation gaps rather than care gaps.

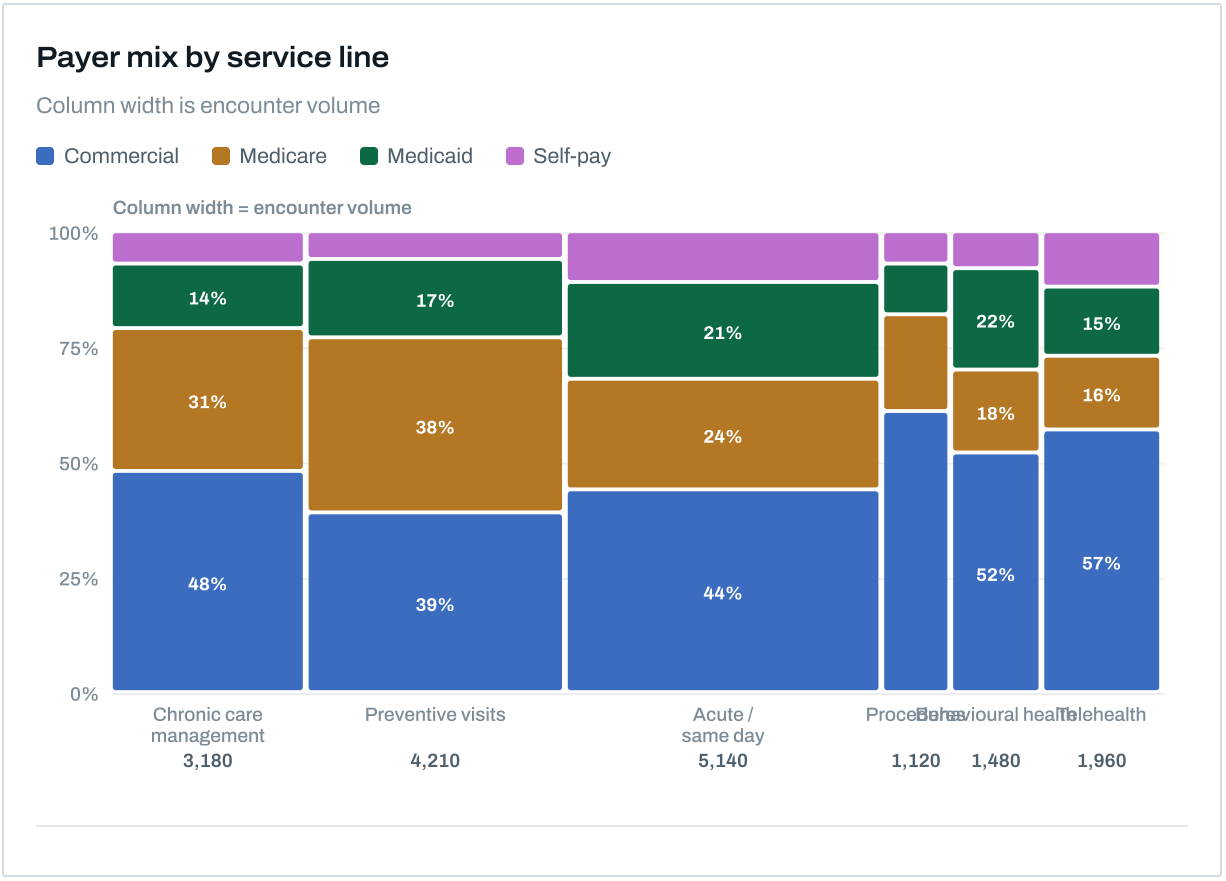
Contribution margin by service line

Trailing 12 months · area is margin



Payer mix by service line

Column width is encounter volume, so the chart shows exposure rather than share alone.



How these numbers were produced

Every figure in this report is reproducible from the source systems. Where we estimate, we say so and we show the assumption.

Systems read this period

System	Layer	Records	Refresh	Access
Electronic health record	Clinical	34,180 encounters	Nightly	Read-only
Practice management	Clinical	36,940 appointments	Nightly	Read-only
Clearinghouse	Money	33,412 claims	Nightly	Read-only
Remittance / ERA	Money	31,880 remits	Nightly	Read-only
Payment platform	Money	18,240 transactions	Daily	Read-only
Patient contact / voice	Patient	52,610 contacts	Hourly	Read-only

Definitions used

- **Contribution margin per encounter** — collected revenue less direct variable cost, divided by completed encounters. Overhead is excluded.
- **Days in A/R** — ending receivable divided by average daily charges over the trailing 90 days.
- **Denial rate** — claim lines denied at first adjudication, divided by claim lines submitted.
- **Third next available** — days until the third open appointment of the relevant type, sampled weekly.
- **Missed-call value** — missed calls × historic call-to-booking rate × margin per encounter. This is an estimate, and it is the only estimate on which a decision in this report depends.

Where the systems disagreed

Across the period, 412 encounters existed in the practice management system with no matching claim, and 96 remits arrived against claims the clearinghouse had marked void. We flag both rather than resolve them silently; the reconciliation list is attached to this report as a spreadsheet.

> **Questions on any figure.** Every chart here can be traced to the underlying rows. Ask us for the extract behind any number and we will send it with the query that produced it.