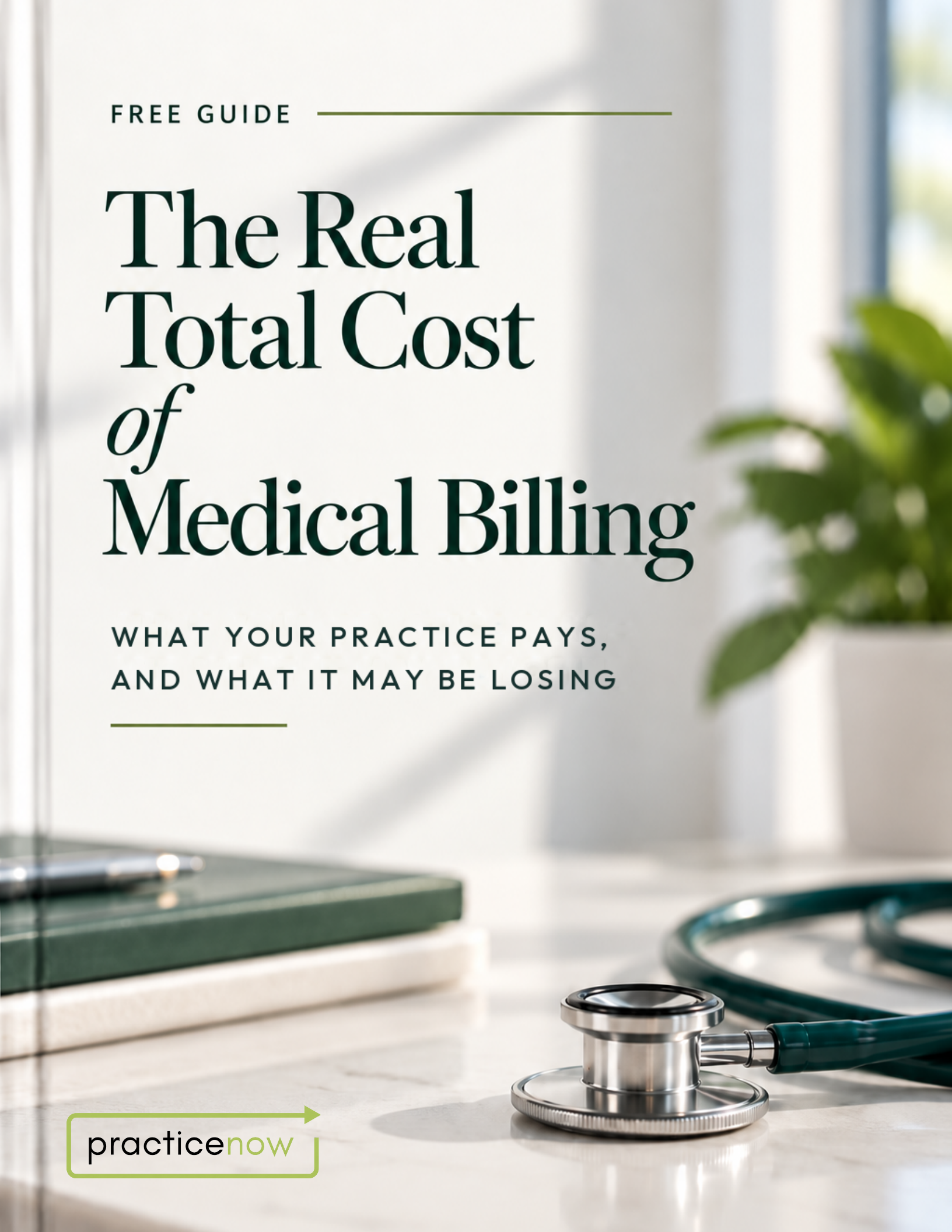


FREE GUIDE

The Real Total Cost *of* Medical Billing

WHAT YOUR PRACTICE PAYS,
AND WHAT IT MAY BE LOSING

A stethoscope with a green tube and silver chest piece lies on a white surface. To the left, a green folder or book is partially visible. In the background, a potted plant with green leaves is out of focus.

practicenow

Your billing invoice is not your billing cost.

One practice found a billing company that charged a fraction of its old fee. On paper, it was an easy call: a big saving, every year.

But the new company only sent out claims. Coding, denials and collections quietly came back to the practice's own staff. No one owned the whole process, and write-offs started to climb. Within a year, the practice's all-in cost of billing went from about 14 percent to over 40. The pressure showed up in payroll.

The invoice went down. The cost went up. Nothing on the invoice warned them.

Anonymized example. Figures are approximate.

Ask most physician owners what billing costs and you'll hear the vendor's rate: 4%, 6%, maybe 8% of collections. That number is real. It's also usually a fraction of what the practice actually spends to get paid. The rest is spread across places no single report shows: outside collections, contract management, the front desk, coders, the denials team and, largest of all, revenue the practice earned under its contracts and then wrote off.

Counted all-in, billing can reach 30 to 40% of what a practice is owed. A well-run practice can bring it under 15%. **On a \$10M practice, that gap can be worth \$1.5 to \$2.5M a year, for care you've already delivered.**

Five things to take from this guide

- 1 Count billing all-in, not just the vendor fee.
- 2 Measure it against what you're owed under contract, not what you collected. Otherwise write-offs vanish from the math.
- 3 Write-offs are usually the largest and least visible part of the cost. A clean A/R report can hide them.
- 4 Everyone who touches billing is measured on something different, so each one sees only part of the picture. Owners are often the only ones who can see all of it, if they ask.
- 5 The goal isn't the cheapest invoice. It's the lowest total cost.

Before you start: grab 12 months of summary reports. Your billing invoices or billing payroll, your outside contracts, and your totals for payments and write-offs.

The question isn't what you pay your billing company. It's how much of what you earned you actually keep.

The total cost of medical billing, line by line

The total cost of medical billing (TCMB) is our all-in measure of what it costs a practice to get paid: everything billing touches, plus the revenue that never arrives. Here is how the reported number and the real one can differ in a typical independent practice.

Cost item	Usually reported	Usually missed
Billing company contract	8%	
Outside collections contract		8%
Insurance contract management		4%
Front desk and medical assistant time collecting payments		1%
In-house coding		2%
In-house denial management		2%
Write-offs: denials never worked, underpayments accepted, balances never collected		15%
Total cost of medical billing	8%	40%

Illustrative example, shown as a share of gross annual revenue. Not a specific practice. Other costs, such as software and leadership time, could be added.

What the invoice shows

Vendor fee only



Every cost billing touches

Fee + outside contracts + in-house time



Total cost of medical billing

All of that, plus write-offs



Why the numbers you've seen are smaller

You may have seen industry figures for "cost to collect" in the single digits. Those figures usually stop at the first bar or the second, and they divide by collections, the money that actually came in. A dollar that's written off never reaches collections, so measured that way it simply disappears.

We measure against gross annual revenue instead: what the practice is owed for 12 months of care under its contracts, before anything is written off. That keeps every lost dollar in view as a cost, because it is one. **Same practice, same year: the number just stops hiding the biggest line.**

YOUR TURN

Take stock before you add it up

Check what you can answer today. Each unchecked line is a cost you may not be counting.

- ☐ I know our billing company's rate, and exactly which steps it covers.
- ☐ I can name every outside contract billing depends on, such as collections, contract management or coding help.
- ☐ I know roughly how many staff hours go to billing work each week, across the front desk, coding and denials.
- ☐ I know our software and clearinghouse costs.

Your first guess: all-in, what share of gross annual revenue does billing cost you? Write it down now. The worksheet in section 6 will show how close you were.

_____ %

2 • THE COST NOBODY REPORTS

Why owners need to watch write-offs

It's 4:55 on a Friday. Your billing lead has a \$400 denial that would take an hour to appeal. She writes it off, and her report looks better for it on Monday. Nobody did anything wrong. And \$400 you earned is gone.

Not every reduction is a loss. A **contractual adjustment** is the expected gap between your list price and what an insurer agreed to pay. It's normal and planned. A **write-off** is different: it's revenue you earned under the contract that was removed from your books because nobody collected it. Denials that were never reworked. Underpayments that were accepted. Patient balances that were never pursued.

How a clean A/R can hide a growing problem

Accounts receivable (A/R) shows only what's still waiting to be paid. The moment a balance is written off, it leaves A/R. So a billing team or company that writes off hard-to-collect claims quickly can report an A/R that looks excellent while the practice quietly loses revenue it earned.

That isn't usually bad intent. It's how the job is measured. If the scorecard is days in A/R and the age of balances, writing off a difficult claim improves the scorecard the same day. Working it costs time and may not pay off for months. Without someone asking about write-offs, the incentive points one way.

When A/R looks great, ask what was written off to get it there.

What owners typically see, and don't

Usually on the report	Usually missing
Total collections	Write-offs by reason, each month
Days in A/R	What was owed under contract (the allowed amount) versus what arrived
Aging buckets (30, 60, 90+ days)	Care delivered in the exam room that never reached a claim
The billing company's fee	The in-house time and outside contracts billing depends on

In assessments we've done, owners are often surprised by how large the write-off line is, in some cases a sizable share of all the work the practice performed. You can't see that number without starting from what you're owed under contract.

Hold your billing company to single-digit write-offs

Your billing company is usually measured on A/R and collections, so that's what it manages. Change what it's measured on, and you change what it works on.

- **Set the target in writing.** Write-offs, not counting contractual adjustments, in the single digits as a share of what you're owed under contract, and a date to get there.
- **Ask for the same report every month.** Write-offs by reason and by insurer, next to what you were owed that month, so the trend is visible.
- **Make every write-off earn its place.** Ask which ones were appealed, which were worked and dropped, and which were never touched.
- **Review it together.** A short monthly call on the three largest write-off reasons tends to move them faster than any contract clause.

YOUR TURN

Run a write-off check this month

Ask for one month of data, then work through these steps with your billing lead.

- ☐ Get last month's write-offs, broken out by reason.
- ☐ Separate contractual adjustments (expected) from write-offs (earned but not collected).
- ☐ Get what you were owed under contract for the same month.
- ☐ Rank the write-off reasons by dollars and name an owner for the top three.

Your three largest write-off reasons, and who owns each:

What each person in your billing process sees

Every practice stands on three legs: the physicians who provide care, the staff who keep it running, and the work of getting paid. Two of them come with training. The third mostly doesn't.

Physicians	Staff	Billing management
Medical school, residency and board certification	Certifications and training programs for most roles	Little formal training and no standard process

Physicians train for years. Most staff roles have certifications and programs. Managing billing has little formal training, no standard process and no agreed way to measure results. So the work of getting paid, often called revenue cycle management, ends up shared across five seats, each judged on something different. None of them is doing the job wrong. Each just sees part of the picture.

SEAT 1 OF 5

The physician owner

MEASURED ON	Revenue, take-home pay, and patient care.
SEES	Deposits, the billing company's invoice, and a monthly A/R summary.
BLIND SPOT	What was owed under contract, and what was written off. Few owners are ever shown either.
ASK	<i>"What did we write off last month, by reason, and what share of what we were owed does that represent?"</i>

SEAT 2 OF 5

The practice administrator or COO

MEASURED ON	Smooth operations, staffing, and budget.
SEES	Payroll for the front desk, coders and the denials team, plus outside contracts.
BLIND SPOT	Those costs sit in different budget lines, so they're rarely added up as one cost of billing.
ASK	<i>"If we add every cost billing touches, what do we spend to collect a dollar?"</i>

SEAT 3 OF 5

The billing manager

MEASURED ON	Days in A/R, the share of claims accepted the first time, and keeping the queue moving.
SEES	Claims, denials and aging balances, one account at a time.
BLIND SPOT	There's no standard training or certification for managing billing, so the role is often judged by A/R alone. That scorecard can reward closing accounts quickly over collecting them. It's the scorecard's blind spot, not the person's.
ASK	<i>"Which write-offs would we have collected with more time, and what would that time cost?"</i>

SEAT 4 OF 5

The outside billing company

MEASURED ON	Its contract: often a percentage of collections, plus the A/R numbers it reports.
SEES	The claims it submits and the payments that come back.
BLIND SPOT	Work it doesn't do: coding, denials, collections and patient balances may stay with the practice. A low rate can simply move cost back in-house.
ASK	<i>"Exactly which steps are in your fee, which stay with us, and how do you report write-offs?"</i>

SEAT 5 OF 5

The CFO or investor

MEASURED ON	Margin, cash flow, and what the practice is worth.
SEES	Financial statements, where write-offs and billing costs can be netted out of revenue.
BLIND SPOT	The gap between what the practice is owed and what it collects, which is often where the largest value sits.
ASK	<i>"What's our total cost of medical billing as a share of gross annual revenue, and how does it compare with what's achievable?"</i>

Putting the picture together

Because each seat sees a different slice, the full cost only appears when someone asks for it in one place. For most practices, that should be the owner, with a one-page view each month:

Line	Why it matters
Owed under contract	The starting point. Without it, nothing else can be measured honestly.
Collected, and how fast	The share of what's owed that arrives within 30, 60 and 90 days.
Written off, by reason	The cost nobody reports, and often the biggest one.
All-in cost to collect	Billing company, outside contracts and in-house time, added together.
Total cost of medical billing	Write-offs plus cost to collect, as a share of what's owed.

The owner is usually the only person positioned to see all five lines, but only if they ask for them.

YOUR TURN

Bring the five seats together

One short meeting can surface most of what no single report shows.

- ☐ Share this guide with the other four seats before you meet.
- ☐ Ask each seat the question on its card, and write down the answer.
- ☐ Agree who owns the one-page monthly view.
- ☐ Put the first monthly review on the calendar.

Owner of the monthly view

First review date

4 • THE CHEAPER-VENDOR TRAP

When a lower rate raises the total

Remember the practice on page 2? Its new billing company really was cheaper. The trouble was what the lower fee didn't cover. Coding, denial management and collections came back in-house, and without one team owning the whole process, write-offs climbed until the all-in cost was nearly three times what it had been.

What would have prevented it wasn't a different vendor. It was asking, before the switch, exactly which steps the new fee covered, keeping one team responsible for each claim from visit to payment, and watching write-offs by reason every month. With those in place, a lower fee can be a real saving instead of a hidden cost.

The cheapest invoice isn't always the cheapest billing.

The principle behind it

Billing works best as one connected process, from the visit to the final payment. Every handoff between people, departments or companies is a place where a claim can stall or a balance can be dropped. The fewer gaps there are, and the earlier money is collected, ideally at or before the visit, the lower the total cost tends to be. Chasing a balance a month later costs staff time, and it is often the last thing a patient remembers about the practice.

YOUR TURN

Signs your total cost may be high

Check each one that's true for your practice.

- ☐ No one can tell you last month's write-offs by reason.
- ☐ Reports start from collections, not from what you're owed under contract.
- ☐ Coding, denials or collections sit with different teams or companies.
- ☐ Patient balances are mostly pursued after the visit, by statement.
- ☐ Your A/R looks healthy, but margin isn't growing with volume.

5 • GET PAID UP FRONT

Collect before the visit, not after the claim

A patient checks out, says she'll pay when the bill comes, and walks out the door. Three statements and a phone call later, the balance is still open.

Many practices start collecting from patients only after the claim is paid, by statement. By then the visit is weeks old, the balance is harder to collect, and every reminder costs staff time. Practices that collect best move the money conversation to before the visit, when the patient is most engaged.

Change the payment culture

- **Estimate before the visit.** Use the patient's coverage to estimate what they'll owe, and share it when the visit is scheduled.
- **Ask how they'd like to pay, not whether.** A deposit, a card on file or a scheduled payment plan are all ways to say yes.
- **Agree on terms and write them down.** When a patient needs time, set an amount at the visit and a schedule after it, and record what was agreed.
- **Refund quickly when the estimate was high.** Patients are more willing to pay up front when they trust that any overage comes back.

The cheapest balance to collect is the one settled before the patient walks in.

Know who's unlikely to pay, then talk to them directly

Not every patient is in the same position, so one script doesn't fit all. Before patients arrive, sort them into three groups and plan each conversation.

Ready to pay	Needs a plan	Unlikely to pay
Collect the estimate at or before the visit. Make it easy and routine.	Offer a scheduled payment plan, and settle the terms while the patient is on the phone.	Spot the risk early from payment history. Agree on small, specific commitments, and follow up personally rather than by statement.

Direct, respectful follow-through tends to work better than statements and collection agencies, and it protects the relationship. In the specialty practice where our founders built this approach, most patients on a payment plan paid their balance in full, and write-offs stayed very low.

Results reported by the practice. Results vary.

YOUR TURN

Move collection to the front

Check what your practice already does today.

- ☐ We give patients a cost estimate when the visit is scheduled.
- ☐ Front-desk staff have a script for asking how, not whether, a patient will pay.
- ☐ Payment plans are agreed and written down at or before the visit.
- ☐ We know which patients are likely to need a plan before they arrive.
- ☐ Slow payers get a personal call, not just another statement.

What share of patient balances do you collect at or before the visit today?

_____ %

A worksheet for your total cost of medical billing

Use 12 months of data. Start from what you're owed under contract, then add every cost billing touches. Estimates are fine for a first pass. You can type straight into this page in most PDF readers, or print it and fill it in by hand.

LINE	12-MONTH AMOUNT	% OF REVENUE
Gross annual revenue: what you're owed under contract, before write-offs	\$ _____	100%
Billing company fees	\$ _____	_____ %
Outside collections	\$ _____	_____ %
Insurance contract management	\$ _____	_____ %
In-house billing staff: front desk collection, coding, denials	\$ _____	_____ %
Billing software and clearinghouse	\$ _____	_____ %
Write-offs, not counting contractual adjustments	\$ _____	_____ %
Total cost of medical billing (all lines except the first)	\$ _____	_____ %

For each line's percentage, divide its amount by the first line. Add the percentages for your total.

How to read your number

Your total	What it usually means
Under 15%	On target. Keep watching it every month so it stays there.
15% to 30%	Worth a closer look. One or two fixes early in the process often move it a lot.
Over 30%	Billing is carrying more than it should, and it's likely one of the biggest gains available in your practice.

A rough guide. The right target depends on your specialty, size and payer mix. Now compare your total with the first guess you wrote down in section 1.

Over 15%, or not sure about a line? Schedule a free consultation and we'll work through the worksheet with you, using a few summary reports. No patient information needed. [Schedule a consultation at practicenow.com](https://www.practicenow.com) or call [801-230-9223](tel:801-230-9223).

Count each cost once. If your in-house billing team is in its own line, leave them out of everyone else's time. If your billing company's fee already includes software, don't add it again. If a balance went to a collection agency, count the agency's fee under outside collections and the part you never received under write-offs, not both in one line.

Tips for the hard lines

- **Gross annual revenue.** If you only have list-price charges, add your total payments and total write-offs for the year. That gets you close to what you were owed.
- **In-house staff time.** Ask each role how many hours a week go to billing work. Hours per week x hourly pay x 52 gives you the line. A rough count beats leaving it out.
- **Write-offs.** Ask for adjustments grouped by reason. Leave out the contractual adjustment. Keep everything else.

7 • YOUR IMPROVEMENT PLAN

A checklist for lowering your total cost

Knowing your number is the start. These are the steps that tend to bring it down, in the order that usually pays back fastest. Not every practice needs all of them.

STEP 1

See the whole number

Usually the first month

- ☐ Pull 12 months of what you were owed under contract, not just what you collected.
- ☐ Fill in the worksheet in section 6. Estimates are fine for a first pass.
- ☐ Start a one-page monthly view with the five lines from section 3.

STEP 2

Fix the biggest leak first

Often the next one to two months

- ☐ Set a single-digit write-off target with your billing company, and work the costliest write-off reason first.
- ☐ Rework denials that are still within the insurer's deadline to appeal.
- ☐ Check payments from your largest insurers against your contracted rates.
- ☐ Collect patient balances at or before the visit where you can, and agree on written plans for the rest (section 5).

STEP 3

Keep it fixed

Ongoing

- ☐ Give each line of the monthly view one named owner.
- ☐ Review write-offs by reason every month, not just A/R.
- ☐ Close the handoffs between coding, denials and collections, so one team owns each claim from visit to payment.
- ☐ Before your billing contract renews, confirm exactly what the fee covers.

The cheapest fix is usually the one made earliest: at the front desk, in the note, or before the claim goes out.

8 • WHAT TO DO NEXT

You know your number. Now see what it could be.

If you filled in the worksheet, you now have something most practices have never seen: a first estimate of your total cost of medical billing. The next question is what it could be for a practice like yours, given your specialty, size and payer mix.

That's where Practice Now starts. In a free consultation, we take a first look at a few summary reports you share and show you roughly where value is leaking and what it may be worth. If we work together, the first 30 days are an Assessment that confirms your true total cost of medical billing and ranks the fixes by impact.

About Practice Now

Practice Now was founded by clinicians and operators who grew a maternal-fetal medicine practice into a large regional specialty network: Berkeley Geddes, a serial entrepreneur who has built, scaled and sold more than 45 companies; Dr. John Elliott, a board-certified OB-GYN and maternal-fetal medicine specialist; and Mark Wright, Berkeley's business partner of 25 years. The ideas in this guide come from that work, not from a textbook.

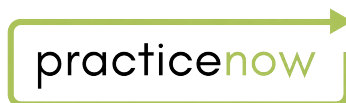
Our track record on total cost of medical billing is under 12%. At the practice our founders built, revenue has grown 30 to 40% a year since 2023.

Results reported by the practice. Figures are approximate.

Get a first look at your numbers.

Schedule a consultation at practicenow.com, or call [801-230-9223](tel:801-230-9223).

We review summary reports only. No patient information is needed for a first look.



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