

Key Metrics in Revenue Cycle Management

Measurements that Ensure Peak Financial Performance

Cash flow is just one factor in the financial health of a medical practice. There are other important metrics you should review when evaluating your practice's revenue cycle—and you don't have to be a financial wizard to understand them. Whether you're a clinician or a billing professional, you can use this guide to understand the four key metrics in revenue cycle management.

Key Metric #1: Days in Accounts Receivable

What this metric means

One of the most important metrics for any practice to measure is days in accounts receivable (A/R).

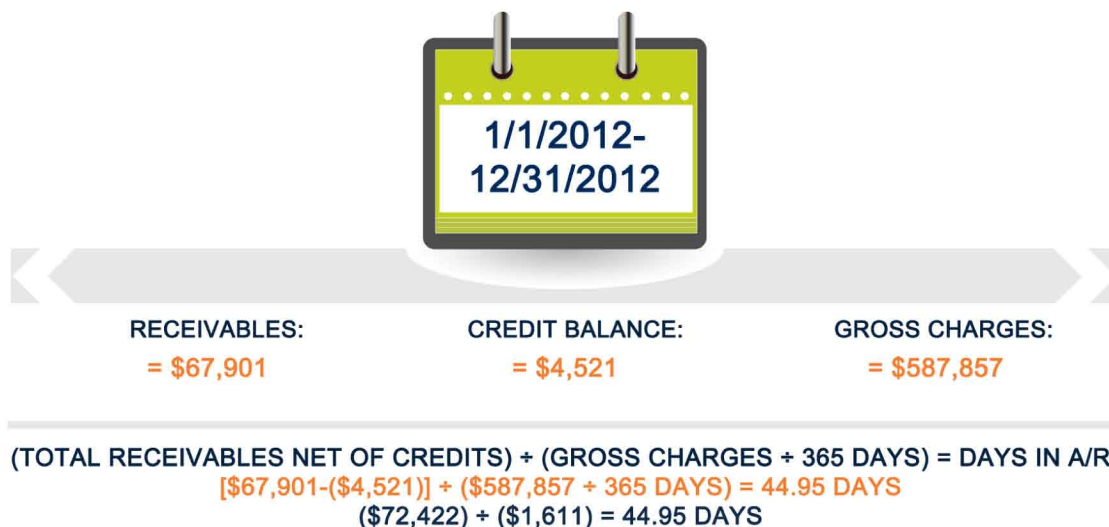
Practices are often unclear about how to correctly calculate and analyze important indicators such as days in A/R. This uncertainty is one of the biggest challenges practices face when examining financial metrics. So, here's a quick look at what days in A/R really means, and how to calculate it.

Simply put, days in A/R is a measure of how long it typically takes for a service to be paid by all financially responsible parties. To properly account for volume, the calculation features the outstanding money based on the practice's average daily charge. In sum, days in A/R represents the number of days that money owed to the practice is outstanding.

How to calculate days in A/R

To calculate days in A/R, divide your total current receivables, net of credits, by your practice's average daily charge amount. In order to net the credits, subtract the current credit balance (in effect, adding the balance because you are subtracting a negative number) from the current total receivables. For the average daily charge amount, divide total gross charges for the last 12 months by 365 days, representing the previous 12-month period. Depending on the specialty or certain circumstances (for example, a new physician), some practices may find it beneficial to calculate their average daily charge on a three-month basis instead of 12. In this case, the previous three months would be divided by 90. The key is to make a choice, and use the metric consistently over time.

Example:



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Measuring success

As a general rule of thumb, most practices can use these figures to gauge how well they're faring with their days in A/R:



Of course, like with any billing indicator, performance as measured by days in A/R is influenced by your payer mix and specialty, as well as the level of automation that is deployed.

Problems to avoid

Once you have calculated your days in A/R, it is important to recognize that what appears as a favorable figure might hide areas of underperformance, including:

- *Specific insurance carriers whose days in A/R are higher than they should be.* For example, if your entire practice's days in A/R is 44.95, but your Medicaid claims average 75 days, there is a problem with Medicaid that needs to be addressed. Therefore, make the same days in A/R calculation for each of your major payers so you can scrutinize the performance of all payers. If you don't break out days in A/R by payer, you may be missing potential trouble spots.
- *The impact of credits.* As noted in the calculation presented above, it is important to subtract the credits from receivables. Credits—monies that are owed by the practice to other parties—actually offset receivables. Unless credits are treated correctly, a practice will get a false—overly positive—impression of its performance.
- *A recognition of collection accounts.* In the healthcare industry, accounts sent to a collection agency are written off the current receivables. Thus, when calculating days in A/R, these monies are not accounted for in the equation. Submitting a large number of accounts to collections at once will cause your days in A/R to suddenly appear much better than reality—often masking poor performance. As such, some practices may find it beneficial to calculate and compare their days in A/R with—and without—the accounts sent to collections.
- *Appropriate treatment of payment plans.* Patients on a payment plan have been granted extended time to pay their accounts. In effect, the practice has allowed the days in A/R to rise by permitting the payer—the patient, in this case—to have additional time to pay the account. Because of this mandate, some practices may find it beneficial to create and designate payment plans as a separate payer. Days in A/R can be calculated with and without this new “payer”.
- *Claims that have aged past 90 or 120 days.* A good overall days in A/R also can hide elevated amounts in the older aging buckets. That's why it's so important to utilize the “A/R>120 days” benchmark discussed in the next section.

Days in A/R is arguably the best single indicator of the performance of the revenue cycle; to ensure that it appropriately reflects your performance, however, you must understand all of the inputs and nuances of this important metric.

Key Metric #2: Percentage of A/R Greater than 120 Days

What this metric means

The percentage of accounts receivable greater than 120 days old (A/R>120) is a measure of a practice's ability to get services paid in a timely manner. Keep in mind that this figure represents the amount of receivables older than 120 days, expressed as a percentage of the practice's total current receivables. A/R over 120 days is one of the categories typically included in an "aged trial balance" (ATB). It is not necessarily the only aging category to observe, but an excellent metric if choosing one aging indicator to monitor.

How to calculate the percentage of A/R greater than 120 days

To calculate the percentage of A/R greater than 120 days, take the dollar amount of your receivables, net of credits, that is greater than 120 days and divide that number by your total receivables, net of credits.

For example, let's say your A/R, net of credits, looks like this:

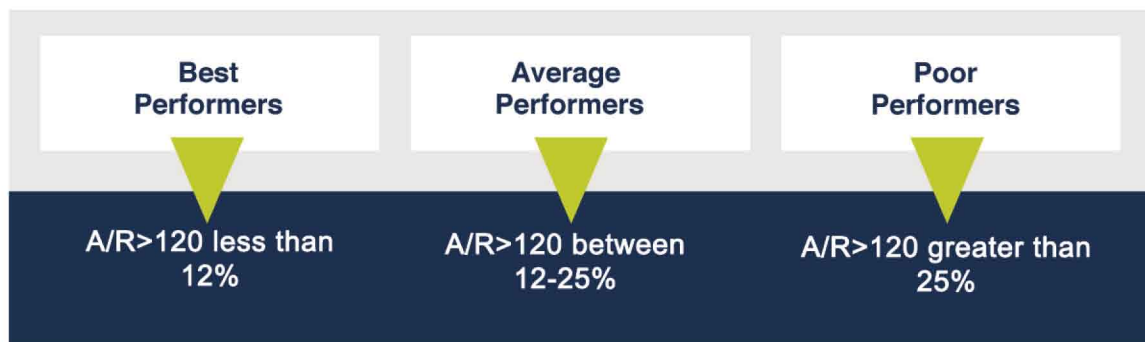
0-30	31-60	61-90	91-120	121-150	151+	Total
\$898,116 42.22%	\$496,256 23.33%	\$303,060 14.25%	\$171,937 8.08%	\$113,252 5.32%	\$144,418 6.79%	\$2,127,039
12.11%						

To calculate the percentage of A/R greater than 120 days, sum the receivables in the aging buckets greater than 120 days (in the illustration above, that equals \$257,670) and divide by total A/R (\$2,127,039 in the example above).

In this example, A/R>120 would be calculated by dividing \$257,670 by \$2,127,039 (also expressed as $\$257,670 \div \$2,127,039$). The result is 12.11 percent.

Measuring success

Practices can use these figures to gauge how well they're faring with their A/R>120:



Of course, like with any billing indicator, performance as measured by the percentage of A/R greater than 120 days is influenced by your payer mix and specialty, as well as the level of automation that is deployed.

Problems to avoid

Once you have calculated your A/R>120 days, it is important to recognize that a positive figure can hide areas of underperformance.

For this benchmark, it is critical to base your calculations on the actual age of the claim (e.g. date of service). Some systems allow users to age accounts based on the date of service while others use the date the charge is entered. Other systems re-age the service each time it changes hands from one financially responsible party to another. For example, when an invoice is sent to a secondary payer, the account re-ages to “zero”. While this protocol makes logical sense from a system perspective, it can give the user an inaccurate impression of performance—a false positive in many cases.

Here’s an example of the impact of different service dates: Let’s take a claim with date of service 01/15/2012 that is submitted to the carrier on 01/22/2012. On 03/01/12, the transaction re-aging approach would age this claim at 37 days compared to 44 days using the date of service approach. If this claim were to be filed and submitted to a secondary payer on 03/10/2012 and still not resolved on 4/10/2012, the recalculated aging of the claim at that point would be 31 days. Using the date of service approach, the aging of this claim would have been 84 days. If all transactions are treated in this manner, the percentage of A/R greater than 120 days is significantly impacted.

You can see that these two approaches provide vastly different numbers. With the transaction re-aging approach, you may not realize that you have a problem with aging accounts that needs to be addressed.

Credits, as well as the treatment of collections agency accounts and payment plans can influence this performance indicator in ways similar to the days in A/R indicator.

Key Metric #3: Adjusted Collection Rate

What this metric means

The adjusted (or net) collection rate is a measure of a practice’s effectiveness in collecting all legitimate reimbursement. That is, it shows the percentage achieved out of the reimbursement allowed based on the practice’s contractual obligations. This figure reveals how much revenue is lost due to factors such as uncollectible bad debt, untimely filing and other non-contractual adjustments.

How to calculate adjusted collection rate

Divide payments (net of credits) by charges (net of approved contractual adjustments) for a selected time frame. Ideally, this calculation should be based on matching the payments to the charges that created them. That way, the practice avoids comparing charges generated in the current month with payments and adjustments taken on claims from many prior months, which can lead to great fluctuations in this calculation’s results.

Particularly if the practice management system can’t match payments with their originating charges, a practice should perform this calculation using aged data, typically from six months back, so it ensures a majority of the claims used for the calculation have had ample time to clear.

Key Metrics in Revenue Cycle Management: Measurements that Ensure Peak Financial Performance

Example:



To calculate the adjusted collection rate, divide payments net of credits (\$485,698 - \$13,368) by charges net of approved contractual adjustments (\$842,985 - \$344,500), then multiply by 100. The total adjusted collection rate comes to 94.75 percent.

Measuring success

Most practices can use these figures to gauge how well they're faring with their adjusted collection rate:



Of course, like with any billing indicator, performance as measured by adjusted collection rate is influenced by your payer mix and specialty, as well as the level of automation you deploy in your practice's billing and collections cycle.

Problems to avoid

As with all financial metrics, there are pitfalls to be aware of as you calculate your adjusted collection rate. Two important ones are:

- *Including inappropriate write-offs in the calculation of adjusted collection rate.* One of the most common mistakes practices make is applying inappropriate adjustments to charges when posting payments. The most common inappropriate adjustment is lumping non-contractual adjustments and contractual adjustments together. Failing to distinguish between the two provides a misleading view of how well the practice actually collects the money it has earned. Non-contractual adjustments must be appropriately designated, computed separately and placed in applicable categories indicating the reason, such as "untimely filing," "failure to obtain pre-authorization," and so forth. Tracking non-contractual adjustments based on their reasons will help reveal sources of errors and find opportunities to improve revenue cycle performance.

- *Not having access to your fee schedules or reimbursement schedules for each payer.* Without this information, a practice cannot truly know what it should have been paid. As a result, more inappropriate write-offs may go undetected.

Key Metric #4: Denial Rate

What this metric means

The denial rate is the percentage of claims denied by payers. (Note that practices may measure the rate based on the percentage of charge line items denied.) The lower this number, the better a practice's cash flow—and the less staff a practice needs to maintain that cash flow. Employees don't have to intervene on clean, paid claims; only denied claims create the need for manual intervention.

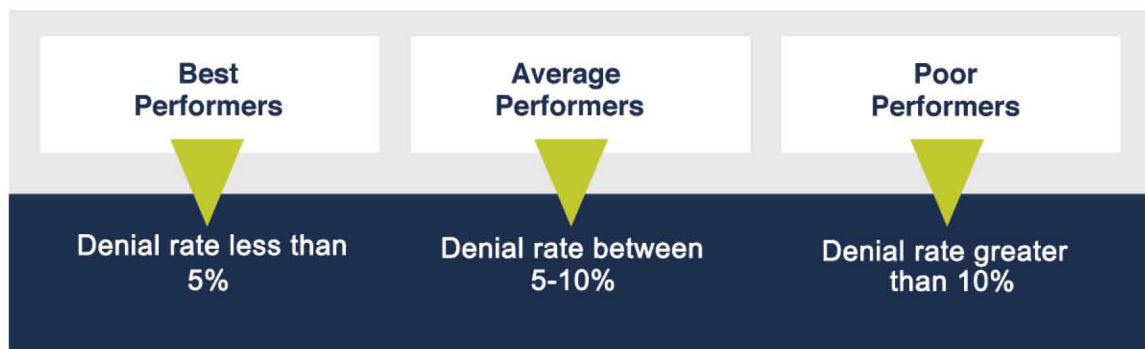
Keep in mind that automating processes can lower this ratio dramatically. For instance, real-time patient eligibility tools are one way to help decrease denials. Online claims editing capability [including Correct Coding Initiative (CCI) and Local Coverage Determination (LCD) compliance edits] can allow staff to quickly and efficiently correct "dirty" claims before they are submitted to payers and denied.

How to calculate your denial rate

Using a designated period of time—the last quarter, for example—total the dollar amount of claims denied by payers. The sum should then be divided by the total dollar amount of claims submitted by the practice during that period of time. Practices may want to use charge line items denied divided by total charge line items submitted.

Measuring success

Most practices can use these figures to gauge how well they're faring with their denial rate:



Of course, like with any billing indicator, performance as measured by denial rate is influenced by your payer mix and specialty, as well as the level of automation that is deployed. To fully understand what is driving your denial rate, you should do a denial rate analysis by payer, provider, remark code and category. Your clearinghouse should be able to provide you with these more detailed breakdowns.

Problems to avoid

Denials are technically those that are adjudicated and rejected by the payer to which a practice submitted the claim. Mistakes can be made in coding and charge entry—and the rules and regulations regarding claims processing seem to change every day. Therefore, the business office may never be perfect, but it should be able to catch mistakes before they go out the door. Well-run business offices edit charges—and reject claims—via internal systems before those claims are sent to a payer. Therefore, actually *encouraging* internal rejections (and having a system to identify and help correct them) is an industry best practice. A high internal claims rejection rate may actually predict a lower denial rate—and thus, improved cash flow.

If your clearinghouse or claims scrubbing engine can spot an error, such as your coder improperly using modifiers, the payback will be twofold: a denial will be prevented and a delay will be avoided in final posting of the paid claim—and time is money. Taking the initiative to catch coding errors and other mistakes internally is worth the effort because it will ultimately lower denial rates and produce a healthier cash flow and A/R.

Putting It All on the Bottom Line: Key Metrics for Payer Negotiations

When it comes time to negotiate fee schedules with your payers, knowledge is power. And power can mean better contracted rates for your practice.

Here are three metrics that may give you an edge during contract negotiations, and help you get the contract rates you deserve:

- **Average Paid Percent:** Compute by dividing the sum of your payments by the sum of your submitted charges. In an ideal world, every claim you submit for payment would be paid at 100 percent. However, there are many reasons why this is not the case. Some examples include claim-specific negotiated discounts, payment bundling, capitation, bad debt (ideally this would be below three percent) and previous payment discrepancies.

For an average practice, the paid percent will be between 35 and 40 percent. The higher the percentage, the better your revenue will be¹.

- **Compensation for Top Procedures:** This metric builds on average paid percent. Since you know the overall paid percent for each payer, you should consider how those payers are compensating you for your top procedures.

If at all possible, sort your payments by procedure and by payer simultaneously. This will allow you to look at the top procedures for each payer and what their paid percent is for those procedures. This allows you to compare individual procedure payment rates between different payers.

- **Average Reductions Percent:** A payer's average reductions percent is the sum of the payer's contractual and other reductions divided by the sum of your submitted charges. This metric lets you determine which payers are consistently shifting more dollars than normal out of your payments and into contractual or other reductions (excluding patient responsibility).

For the average practice, this figure is typically in the 47 to 53 percent range, but the lower the better¹. Ideally, your clearinghouse or practice management system will allow you to sort claims by the amount moved to "contractual and other reductions". If so, you can easily compare each payer to the average range and see how they are performing.

It Is Easy to Master These Metrics!

Whether you're a physician or billing professional, *Key Metrics in Revenue Cycle Management* helps you stay on target throughout the revenue cycle.

You don't have to be a CPA to understand these vital metrics. But to monitor them effectively, you need a clearinghouse and practice management solution that can streamline and automate key processes. When you find the right technology partner, your practice can easily monitor key revenue cycle metrics to ensure that you enjoy fewer denials, faster payment and greater profitability.

How Navicure® Can Help You With These Metrics

Although understanding metrics is the essential first step; monitoring is the second step and also required. To achieve peak financial performance, you should be able to rely on your clearinghouse to help streamline and automate the monitoring process.

Navicure, a leading Internet-based medical claims clearinghouse for physician practices, creates solutions which are designed to make accounts receivable management simpler and more profitable for physicians' practices. Navicure's applications such as the Analysis Channel, with its ready-to-use reports,

automates the monitoring process so all practice administrators can easily watch the revenue cycle and ensure a healthy cash flow.

With just a little understanding and the right technology partner, you can be well on your way to bringing in more revenue faster—and dramatically improving your bottom line.

Source

¹ Benchmark based on Navicure client statistical study on remit data (based on \$1.4 billion of submitted charges) received between January and December 2010

QUICK CALCULATION REFERENCE CHART

Days in A/R =

(Total Current Receivables Net of Credits) ÷ Practice's Average Daily Charge Amount

*Note: In order to net the credits, subtract the current credit balance (in effect, adding the balance because you are subtracting a negative number) from the current total receivables. To determine the average daily charge amount, take the total gross charges for last 12 months ÷ 365 days **or** total gross charges for last 3 months ÷ 90 days. Pick a timeframe (e.g. 3, 6 or 12 months) and use it consistently over time.*

A/R>120 =

Dollar Amount of A/R>120 from Date of Service ÷ Dollar Amount of Total A/R

Adjusted (Net) Collections Rate =

[Payments (Less Credits)] ÷ [Charges (Less Approved Contractual Adjustments)]

Note: This should be done for a selected time frame based on dates of service.

Denial Rate =

(Total Dollar Amount of Denied Claims) ÷ (Total Dollar Amount of Submitted Claims)

Note: Use a designated period of time (e.g. the last quarter).

Average Paid Percent =

Sum of Payments ÷ Sum of Submitted Charges

Compensation for Top Procedures =

Step 1: Sort Payments by Procedure and Payer Simultaneously

Step 2: Look at Top Procedures for Each Payer, plus the Paid Percent for those Procedures

Average Reductions Percent =

Sum of Payer's Contractual and Other Reductions ÷ Sum of Submitted Charges