

Get a grip on revenue cycle management

Key financial metrics detail your practice's economic health

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The financial health of a practice directly affects clinical performance. Optimal revenue cycle management (RCM) provides the financial assistance to competitively pay your top employees, purchase state-of-the-art equipment, and obtain continuing medical education for staff and physicians. Imagine a grocery store where you can buy an apple, take it home to eat, and receive a bill for it that you can pay 30, 60, or 90 days later. Then if the process of buying the apple was not ideally billed, you could refuse payment and ask for proper billing, ask if you really needed the apple, or ask for supporting reasoning on why the apple was required.

Of course, this is an outlandish example but it is iterative of the processes necessary in health care RCM. In this article on RCM, we will discuss some of the key performance indicators and benchmarks to pay observe. Future articles will look at factors that affect these benchmarks, management of accounts receivables, and the importance of payer mix.

Benchmarks need measurement

Without measurement, there is often little management. Financial operations require assessment of performance to available metrics to understand the RCM process and enhance profitability.

NET COLLECTION RATE

Net collection rate (NCR) measures the efficiency of reimbursement collection dependent on the payer's contractual obligations. NCR can be mathematically summarized as follows:

$$\text{NCR in Percent} = \frac{\text{Payments} - \text{Credits}}{\text{Charges} - \text{Contractual Adjustments}} \times 100$$

Measuring NCR allows a practice to examine revenue that should have been collected but instead was lost to untimely filing, lack of collection of deductibles and co-pays, bad debt, and other noncontractual factors. The NCR calculation should be based upon the date of service and visualized monthly over the last 12-month average.

DAYS IN ACCOUNTS RECEIVABLE

Days in accounts receivable (AR) is the approximate number of days it takes

claims from your practice to be paid. It is a key performance indicator of your practice's financial health. The longer claims are in AR, the longer it takes for your practice to be paid. A more extended period is akin to authorizing credit for the extra days waiting to be delivered. A practice should perform this measurement monthly as well.

A simple calculation is below:

$$\text{Days in AR} = \frac{\text{Gross Revenue}}{\text{Prior 3 Months' Gross Charges per Day}}$$

If your gross AR is \$1 million and your billed charges per day are \$25,000, your days in AR are 40 days.

AR BUCKETS AND AR GREATER THAN 120 DAYS

Usually, AR can be examined using an aged trial balance. The aged trial balance breaks out the AR in how much is outstanding over specific periods, generally categorized as 0 to 30 days, 31 to 60 days, 61 to 90 days, 91 to 120 days, and greater than 120 days. As revenue aging increases, it becomes more difficult to collect from patients and payers. The days in AR performance metric should be tracked overall and for

specific payer groups. Measurement by payer may find a problem particular to the payer, such as abnormal denial patterns, a credentialing issue, or just poor payer performance. Measurement overall allows examination of overall practice performance. **Tracking this via a percentage of AR greater than 120 days to the total AR helps to benchmark:**

$$\text{Percentage of AR} > 120 \text{ days} = (\text{AR} > 120 \text{ days}) \div (\text{Total AR}) \times 100$$

**CLEAN CLAIM RATE/
DENIAL RATE**

Billing appropriately the first time ensures optimal speed in payments and reduces repeat work that increases the cost of the billing process by office or RCM personnel. The resubmission of claims usually involves researching the issues with the claim, appealing the claim, and then often submitting the claim again by paper and mail rather than electronically, which further slows down payments. **To calculate the clean claim rate, use the following formula:**

$$\text{Clean Claim Rate} = \frac{\text{Number of Claims Appropriately Paid on First Submission}}{\text{Total Claims Submitted}}$$

Your clean claim rate may be increased through claim edit management systems that flag claims for corrections based on payer rule requirements or coding guidelines.

Time of service collections rate

Probably the most overlooked component of the RCM process is the collection at the time of service. For the dollar that is not collected at time of

service, estimates are that only 50% of the patient-owed payment will ever be collected. Collecting at time of service is probably the most critical part of RCM. It provides immediate reimbursement, reduces the cost of the future collections process, prevents surprise bills, and is informative for the patient when performed correctly. Amazingly, 36% of providers never discuss patient responsibility of payment or ability to pay before delivering care.¹ Medical practices should estimate the amount of payment at the time of service before the patient visit by knowing the procedures and evaluation and management code being performed at the time of service, assessing the patient's benefits, co-pay, coinsurance, and deductible. Patients should be contacted regarding their expected payment at the time of service to increase their ability to pay and eliminate the uncomfortable discussion in the office regarding the payment responsibility at late notice.

Benchmarks

You may not collect every dollar you are entitled to based on your work, but there are typical performance benchmarks many practices examine to understand RCM performance. These benchmarks may vary significantly with your specialty, subspecialty, and region. The Medical Group Management Association produces annual reports considered the gold standard for benchmarks among medical groups. The American Medical Association also has an excellent practice management section on its website.

Typical benchmarks for the performance indicators are:

- Days in AR should be less than 35 days, ideally less than 30.

- AR greater than 90 days: less than 15%
- AR greater than 120 days: less than 10%, ideally less than 5%
- Denial rate less than 3%, ideally less than 1% to 2%

Time of service collection rate: Sixty percent of patients (eliminate those without payments such as Medicaid or Medicare) have payment collected at time of service.

We hope that you utilize these indicators to get a feel for the essential performance of your revenue cycle management. In future articles, we will discuss more of the RCM process and how to optimize features to enhance your practice performance and increase the likelihood of better clinical performance. ■

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