Monitoring Revenue Cycle Management at Your Medical Practice

You've purchased the technology needed to keep tabs on your practice's operations. Now make sure you're looking at the right reports.

Today's interlinked practice management and EHR systems can spit out reports on almost every conceivable measure of practice performance.

Want to know the number of new patient visits last week? No problem.
Want to view those numbers by payer? Easy.
Curious about the number of work Relative Value Units (RVUs) each provider produces per square foot of leased clinical space in your satellite clinic versus the main office. It's just a click away.
Now, add in all those reports from your payers, local hospitals, bank, outsourced billing vendors — can you say "information overload?"
There truly is gold in that mountain of feedback, reports, charts, dashboards, and such. The problem is selecting the numbers that best reveal the status of your practice's financial health.
We asked practice management experts and health system leaders the key performance indicators they use to keep tabs on a medical practice's financial health. Here's what they told us.

Keeping tabs on financial indicators
A medical practice needs two things to stay in business: patients and income, says practice management consultant Elizabeth Woodcock. But you won't get the income if you can't bill for it and collect it successfully. Here are the indicators that every practice needs to watch:

Days in accounts receivable outstanding (DRO). This tells you how long it takes on average to collect a day's worth of gross charges. For example, Medical Group Management Association (MGMA) surveys found that it took 31 days on average in 2008 for family practice groups to get paid, and almost 41 days for orthopedic groups.
Persistently high DRO or a big increase from month to month can signal a host of problems, Woodcock says. They include:
- Excessive claims rejections caused by patient registration errors;
- Failing to confirm patient insurance status before each appointment or service;
- Lackadaisical collection of patient copayments, deductibles, and other amounts at the time of service;
- Tardy filing of claims;
- Errors in coding;
- Incomplete documentation of services; and
- Weak efforts to rework denied claims.
- Be sure to subtract patient credits before computing the days in accounts receivables.
"A big credit balance deflates your receivables artificially and leads you to think you are doing better than you are," Woodcock says.

Administrative errors can produce those high credit balances. A common cause is when patient copayments and deductibles collected at the time of service are not linked to a specific charge. The credits problem will only get worse as more patients move to health insurance plans with high deductibles, Woodcock says.
"At the typical small family practice, it would take just one person on the front desk who isn't trained to add $1,500 to $2,000 in unnecessary credits in one day," Woodcock says.

Aging accounts receivables — balance over 120 days. The longer an account remains unpaid the more likely it will turn into bad debt that the practice will have to write off, Woodcock says. It is not out of the ordinary to have 15 percent to 18 percent of accounts receivable older than 120 days, she says. Reviewing this aging debt by payer can be helpful because you need to know if the portion
owed by patients is increasing and why. Patient accounts are notoriously hard to collect and at higher risk of becoming bad debt the longer they go unpaid, Woodcock says.

**Net collection rate.** This number reveals your success collecting the money you are entitled to collect. Practices should be able to hit a 95 percent rate or higher, Woodcock says. This net amount does not include contract adjustments so what remains is mainly bad debt, charity care, or administrative errors — all of which the practice can prevent, she points out.

**New patients as a percentage of total patients.** A National Ambulatory Medical Care Survey found in 2008, that new patients accounted for 7.9 percent of visits to primary-care physicians, 16.2 percent of visits to medicine specialists, and 20.1 percent of visits to surgical specialists. Averages will vary by specialty and community; the rates also should be higher for new practices and new physicians.

"This number is important even for primary-care physicians who are established because patients move away, transfer, pass away," Woodcock says. "It should be a red alert if you aren't getting many new patients or this percentage starts falling."

**Collections per work RVU.** Charges and collections can vary quite a bit between practices, even in the same market. The target number also will depend on your specialty. Looking at collections in terms of RVUs reveals practice financial health much more clearly than the standard collections ratio, which is divided by charges. A favorable collections ratio could merely be the result of setting low fees, says Ashleigh Finley, director of business analytics for Halley Consulting Group.

"Comparing collections per production unit to the benchmarks for your specialty is what really shows how you are performing, and how well your practice is collecting for each unit of what you produce," Finley says.

**Time of service collections.** As more patients owe higher deductibles and copayments, it's critical to collect these amounts before the patient leaves the office. Unfortunately, it's a process many practices have yet to master. The research paper "Practice Perspectives on Patient Payments" by MGMA found that practices failed to collect time-of-service payments from patients about 30 percent of the time.

"Patients are much less reliable payers than commercial and public payers," notes Finley. "That money is very difficult to collect if you don't collect it at the point of service," she says.

MGMA's analysis of its cost surveys shows that 52 percent of better performing practices collect between 90 percent and 100 percent of patient copayments at the time of service, compared with just 44 percent of other practices surveyed.

**Expenses.** Finley suggests tracking certain expenses as a percentage of net patient revenue. At minimum, track and view monthly your physician compensation and benefits, staff costs, clinical supplies, and building and occupancy as a percent of net patient revenue.

Beware of viewing some costs categories too-narrowly. For example, staffing costs may be going up, but is physician production also increasing? Finley suggests looking at staffing costs as a percentage of the medical revenue or work RVUs each provider generates.

MGMA's examination of practices that bested their peers in profitability in 2007 found that the better performers had higher staff cost per full-time-equivalent (FTE) physician ($184,209 compared with $153,743), but also produced significantly higher medical revenue after expenses per FTE physician ($280,000 versus $214,860).

**Benchmarks: watch, but be wary**

Woodcock and Finley both suggest viewing the key practice performance and revenue numbers at least monthly, tracking trends from month to month, and comparing the data to benchmarks. External benchmarks can be obtained from MGMA, the American Medical Group Association, National Society of Healthcare Business Consultants, and many physician specialty associations.

Be careful with benchmarks, cautions Marc Halley, president and CEO of Halley Consulting Group.

Don't mix and match data, for example, pulling physician compensation from one survey and physician work RVUs from another survey; you may end up setting unreasonable expectations for your practice's physicians or staff.

Another benchmarking pitfall is looking at benchmarks that are not at the median. Extraordinary performance at the extremes may reflect a small sample size with unique circumstances that don't apply to your practice or community, Halley says.

"The best benchmark is your own internal trend," Halley says. "Your target needs to be what it takes for you to remain financial viable."

**Access a key indicator**

Gene Good, senior management consultant with Doctors Management, recommends adding access measures to your dashboard of key performance indicators.
"Seeing patients is how you generate income," Good says. "The number of patient visits and the receipts per patient visit determine your monthly income, so look at whether you are making full use of the physician's time to see those patients."

Good suggests viewing each month's performance indicators for:

**Scheduling capacity.** Compare the hours physicians want to work each week with the hours they are actually available to see patients. It's a number that can be obtained from the practice management system by calculating what percentage of each physician's and nonphysician provider's daily schedule was actually filled. Alarm bells should go off if the ratio falls below 80 percent, he says.

**No-shows.** On average between 5 percent and 7 percent of patients fail to show up for their appointments. Each missed appointment that goes unfilled by another patient is a direct hit to the practice's bottom line; in other words, it increases practice overhead for that month.

"Look at your system of patient recalls and patient reminders. Is your mechanism of getting in contact with patients effective? Are they getting appointment reminders one or two days prior?" Good asks. "Minimize no-shows and you maximize the physician's time."

To get at the causes of no-shows, look at two additional access measures: average time to next appointment and the results of periodic time-motion studies of patient flow. Good recommends performing a time-motion study of patient flow — from check in through check out — at least every other year.

"Do those things right — patient visits are beneficial and timely, appointment scheduling is timely, and you give timely responses when patients call for information — and you are keeping those patients for a long time," Good says.

**Talking to physicians**

Tracking data is only the beginning. In addition to reviewing the information, managers must work with staff and physicians where changes are needed. With more than 100 locations and almost 900 providers, engaging physicians was no easy task for Swedish Medical Group in Seattle. At one point, the hospital-owned system's financial department was producing 200 reports a month. Now, using an electronic dashboard powered by Athenahealth's Anodyne system, each physician in the group logs in monthly to view a personal dashboard. On a single computer screen are several performance indicators in a convenient graphical display which physicians can manipulate to get more information.

"We believe that physician engagement is essential so we are very transparent with them about what's going on in their practices," says Ray Williams, senior vice president of Swedish Medical Group.

A new physician's benchmarks might include progress against an expected growth rate of patient volume. Established physicians might view their progress on clinical production to reach desired compensation levels.

To encourage physicians to help the Swedish groups maintain patient access, all physicians see their patient volumes benchmarked to how many patients they wanted to see on average. Physicians also view work RVUs monthly and get two views of their payer mix: total charges and patient volume. Other indicators may vary by specialty. For example, primary-care physicians might view information about their RVUs, patient visits, and collections.

"If we can get the physicians to focus with us on quality improvement, customer service, and access then the economics will follow those three areas," Williams says. "That's where the alignment between the physicians and hospitals and health system can happen."

You may not have 900 physicians to align but just as much care should go into keeping them informed, adds Woodcock.

"Whenever you develop a report, pretend that you will not be sitting there when the doctor reads it," she says. "Use graphs, define key terms, and add a short summary explaining the report."

A regular diet of key indicators can produce better practice financial results. In other words, you may get what you measure.

**Four essential financial indicators**

"You can't manage what you can't — or don't — measure" goes the old business axiom. Among the important financial management indicators medical practices should keep an eye on are these four, shown with national medians for selected types of practices from the most recent Medical Group Management Association Cost Survey.

**Multispecialty**

Days in A/R: 34.79
Aging A/R over 120 days (Mean): 17.19%
Gross fee-for-service collection percentage: 56.15%
Adjusted fee-for-service collection percentage: 98.32%

**Family Practice**
Days in A/R: 32.69
Aging A/R over 120 days (Mean): 16.15%
Gross fee-for-service collection percentage: 75.26%
Adjusted fee-for-service collection percentage: 99.27%

**Cardiology**
Days in A/R: 34.58
Aging A/R over 120 days (Mean): 18.90%
Gross fee-for-service collection percentage: 43.35%
Adjusted fee-for-service collection percentage: 97.40%
*Not hospital owned

Source: MGMA 2011 Cost Surveys for Multispecialty and Single Specialty Practices

**In Summary**
Medical practices can choose from a seemingly infinite number of financial indicators. Experts suggest narrowing the list to the critical measures of financial stability, which include:
• Days in accounts receivable outstanding (DRO)
• Aging accounts receivables — balance over 120 days
• Net collection rate
• New patients as a percentage of total patients
• Collections per work RVU
• Time of service collections
• Expenses in major categories

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