EXECUTIVE GUIDE

6 RCM Metrics Every Medical Practice Leader Should Know

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Introduction

When a sudden change occurs in business patterns, metrics used in revenue cycle management (RCM) help you understand the financial impact on your organization—the first step in determining an effective response. Still fresh in memory, the business slowdown that occurred during severe months of the COVID-19 public health emergency taught medical practices the necessity of becoming familiar with financial metrics. Even in the absence of unexpected change, metrics enable you to better understand your organization's financial performance and overall business direction.

This e-book offers a concise, practical look at six metrics (also called key performance indicators or KPIs) used in RCM. These metrics are simple, numerical keys to your business. Medical practice leaders will benefit from becoming familiar with these basic equations used to calculate essential RCM metrics—insights from these metrics that can help you run a medical practice more effectively.

WHY EXECUTIVES NEED TO BE INVOLVED IN RCM

Important opportunities are likely to emerge from analysis of your practice's revenue cycle. For example, you may determine that more automation is needed to run your practice or that front- or back-office workflows need updating.

Within any organization, teams will tend to focus on working their circumscribed, departmental duties. Communication between departments usually isn't sufficient to improve enterprise processes.

Your role as a leader enables a broader view of the revenue cycle and opens the door to change that can benefit the entire organization.

METRIC 1

A/R IMPACT (CHARGES AND PAYMENTS)

To assess financial well-being of your medical practice, you need to determine if charges are being entered and billed efficiently. How long does it take from the date of a patient encounter to process all charges? How long does it take for a claim to be sent out after charges are processed? Getting answers to these questions is the first step in managing the revenue cycle.

Your next consideration: How do charges correlate with payments? For any practice to be financially sound, charges need to go out and payments need to come in in a timely manner. The time it takes an insurance company to process and pay a claim, in relation to when the charge was billed, provides insight into your practice's cash flow.

The metric formula below can help you monitor the relationship between charges, payments, and accounts receivable (A/R).

A/R impact =

Open A/R + Charges − Payments − Adjustments + Refunds

Simply put, this equation identifies the total change in A/R at the end of each month. A positive amount indicates an increase in overall A/R; a negative amount indicates a decrease. An increase or a decrease is not inherently good or bad, but changes should be monitored and analyzed by a practice administrator. Reviewing A/R impact each month alerts you to any emerging trends related to open A/R.

Why are charges up and payments down?

A common question is, “Our charges were up for the month so why aren't our payments up as well?” Another way of asking the same question, “Why weren’t we paid more on the claims we submitted this month?”

In the simplified example below, charges in August increased, yet payments are down by $2M:

Month	Charges	Payments
July	$13M	$8M
August	$17M	$6M

Why? Most often, it comes down to timing. To get a better grasp on collections, ask yourself, “When were charges entered in the practice management system?”

In the business of medical care, there is a delay between when charges (claims) go out and when payment is received. In this example, payments for the current month result from the last two weeks of charges from the previous month (and the first two weeks of the current month), as indicated in the chart below.

Month	Charges	Payments
July	$5M	$1M
	$4M	$2M
	$2M	$3M
	$2M	$2M
	$13M Total	**$8M Total**
August	$2M	$1M
	$3M	$1M
	$6M	$2M
	$6M	$2M
	$17M Total	**$6M Total**

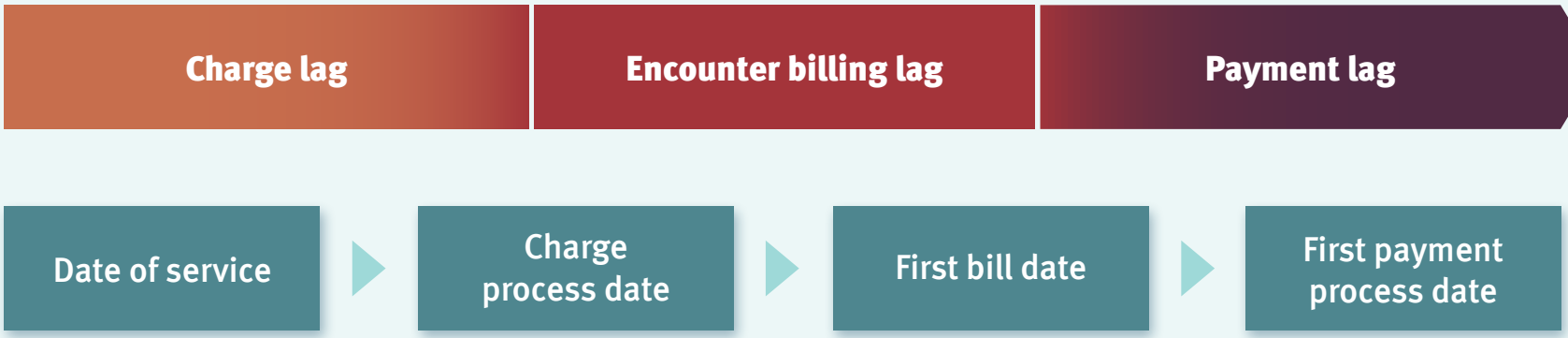
Because charges were lower in the **last two weeks of July and first two weeks of August,** payments will be lower for August— even though overall charges went up in August. In this example, charges were $4M higher in August compared to July but payments were $2M lower.

Managing denials and working A/R will have some effect on payment collection. However, the largest impact comes from the timing of charge entry into the practice management system and the efficient creation and submission of claims.

For a closer look at the impact of the timing of charges and payments, consider three lag metrics—charge lag, encounter billing lag, and payment lag.

LAG METRICS

These three metrics help better understand the efficiency of your practice's billing procedures. Each metric looks at a specific time segment between delivery of service and payment.



METRIC 2

CHARGE LAG

This metric measures the time it takes from delivery of service for a charge to be entered into the practice management system. Here is a definition:

Charge lag = the number of days between date of service and the charge process date

An increase in this metric may mean it's time to take a closer look at workflow. It may indicate providers are taking longer to sign off on charges. It may also be because medical coders are taking more time to review charges before they are entered into the practice management system.

METRIC 3

ENCOUNTER BILLING LAG

This metric also measures a specific time segment in the billing process. The formula is:

Encounter billing lag = number of days between charge process date and the first bill date

What can cause an increase in charge billing lag? Edits in the practice management system may stop encounters from being processed into claims. If so, billing staff needs to review these encounters and ensure corrections are implemented and claims go out the door.

While claim edits can be extremely effective in preventing denials, an increase in encounter billing lag may indicate billing staff are not reviewing encounters stopped by claims edits quickly enough.

Staff needs to be diligent about making changes based on the information in claim edits; otherwise using claim-editing technology is counterproductive.

Consider adding automation

If encounter billing lag is high or on the increase, consider whether enhanced automation may be warranted. As one example, the NextGen® Charge Review Rules Engine applies principles of artificial intelligence to improve the efficiency of medical billing. It serves as an automation partner by translating your staff's knowledge into highly customized rules for automated charge review. The NextGen Charge Review Rules Engine saves time by automatically fixing billing and coding errors at the front end of the revenue cycle process—between the EHR and the PM system.

METRIC 4

PAYMENT LAG

The formula for this metric is:

Payment lag = the number of days between first bill date and first payment process date

By monitoring payment lag, you can find out which payers are taking the longest to pay. You might learn to expect a 10- to 14-day payment lag from some payers versus a 21- to 30-day payment lag from others. This helps you set expectations for cash flow and enables business planning.

An increase in payment lag usually does not indicate a need to improve business operations, such as implementing a higher level of automation. Issues related to internal payer processes often cause this metric to change; the goal here is to monitor payer performance.

METRIC 5

DAYS IN A/R

This metric provides information on the average amount of time it takes for services to be reimbursed. It's a valuable metric for understanding overall business performance. An increase in days in A/R indicates it's taking your practice more time to receive payment. The formula is:

Days in A/R = total A/R divided by average daily charges for three months

Any substantial increase or decrease in days in A/R should be analyzed by practice administration. It may indicate a problem affecting adjudication of claims. Alternatively, the change could result from seasonal factors; for example, many practices experience increases in days in A/R early in the year when patients have not yet met their insurance deductibles.

Tip: When looking at days in A/R, consider the exact calculation being used. The number of days in a month varies: It may be 31, 30, 29, or 28 days. If you use a default 30-day month to determine days in A/R, days in A/R maybe overstated or understated.

For most practices, during severe months of the COVID-19 public health emergency, average daily charges went down quickly. In such a situation, total A/R does not go down as quickly. This causes days in A/R to increase for a time. If you experience an event that interrupts day-to-day function of your practice, for example flooding in the office, expect a short-term increase in days in A/R.

If your office staff performs end-of-the-year A/R clean up, it will lower total A/R. If adjustments are applied to many encounters, days in A/R will decrease. You can determine the amount of this decrease by lowering total A/R according to the adjustment amount and performing the calculation for days in A/R.

METRIC 6

DENIAL RATE

This metric measures the percentage of claims denied by payers. Information about denials can be used to improve billing processes. The formula is:

Denial rate = denial amount divided by charge amount

This formula gives insight into the financial impact of denials on your practice.

You can also calculate denial rate based on the number of encounters:

Denial rate = denial count divided by charge count

This formula enables you to monitor the impact of denials in terms of percentage of encounters denied. Denial count is as important as denial amount. The amount of time, and therefore cost, needed to work denials is going to depend on the count rather than the amount.

Most medical practices should target a denial rate of 5% or lower. This benchmark may vary, depending on your area of specialty and payer mix.

When you see increases in denial rate metrics, it's important to identify underlying trends. Denials can provide insight into payer behavior. Does the increase in denial amount or count result from the actions of a single, specific payer? Investigate possible causes and determine how your practice can address underlying issues or adjust to the change.

For example, investigation may reveal an increase in denials results from errors in demographics and eligibility. If so, additional training may be needed for front desk staff. If investigation reveals coding errors underly numerous denials, providers and medical coding staff may need additional training.

CLOSING THE LOOP

Using these six RCM metrics will help you identify where your practice is effective with regard to workflow, technology, and training, and what processes need to be improved. From a leadership perspective, once you've gained this insight, it's important to provide feedback to teams within your practice:

- Make sure staff are aware of any increase in denials, communicate the underlying reasons, and provide training to address the issues identified
- When issues in the workflow are identified, make training available for staff to improve processes
- Consider opportunities for automation in the workflow—is there a manual review process that can be replaced by or enhanced with a software solution?

With the right follow-up and communication to staff, understanding these six RCM metrics can be an important component in implementing meaningful change in running your organization.

NextGen RCM Services

NextGen® RCM Services provides professional expertise and hands-on support according to the specific needs of each medical practice we serve—from supporting your existing back-office staff to full, outsourced revenue cycle management (RCM).

We can help your practice:

- Cope with staff shortages
- Prevent denials
- Increase net collections
- Improve velocity of collections
- Reduce days in A/R
- Enhance the patient's billing experience

Key formulas

- **A/R impact =** Open A/R + charges – payments – adjustments + refunds
- **Charge lag =** the number of days between date of service and the charge process date
- **Encounter billing lag =** number of days between charge process date and the first bill date
- **Payment lag =** the number of days between first bill date and first payment process date
- **Days in A/R =** total A/R divided by average daily charges for three months
- **Denial rate =** denial amount divided by charge amount
- **Denial rate =** denial count divided by charge count

BETTER STARTS HERE.

Contact us at 855-510-6398 or results@nextgen.com

NextGen Healthcare is the developer of NextGen® Enterprise PM software, recognized as Best in KLAS in practice management for four years in a row.

Our RCM services team is the largest user of NextGen Enterprise PM and offers the broadest possible knowledge base, helping you configure, optimize, and get the most out of the software, including its automation capabilities. In addition, you will receive support from experts with deep knowledge of revenue cycle and billing requirements specific to your medical specialty.

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