Key Performance Indicators: Spotlight on Revenue Cycle Management

By Elizabeth Woodcock, MBA, FACMPE, CPC

The tumultuous environment of the past couple of years has certainly introduced vulnerability into your practice's revenue cycle. Reimbursement success emanates from a myriad of factors, but it can be tracked by a handful of standard indicators. Take the opportunity to measure three key performance indicators to keep your practice on track:

Days in receivables outstanding (DRO).

$$\text{Average Daily Charge} = \frac{\text{Total Calendar Year Charges}}{365}$$

$$\text{Days Receivables Outstanding} = \frac{\text{Total Current Accounts Receivable (A/R) - Credits}}{\text{Average Daily Charge}}$$

The result (DRO) should be in the range of 30 to 40. A practice with quick-processing payers like traditional Medicare may enjoy a lower number, while practices contending with Worker's Compensation may have to tolerate a higher number. Although nothing is perfect, DRO is arguably the single best indicator of revenue cycle management (RCM) performance.

Aged trial balance (ATB). Measure your receivables outstanding based on time. Most practice management systems report an ATB based on 30-day windows – the percent of your receivables that are 0 to 30, 31 to 60, 61 to 90 days old, etc. Aging is so critical to revenue cycle management because it predicts the probability of collection. Like the DRO, an ATB is dependent on your payers' processing times. However, overall, you should expect that less than 15% of your receivables be over 120 days. Keep in mind a few factors: time is based on the age of the receivables with a payer; once it reverts to another payer – like when you learn that BCBS has applied the balance to your patient's deductible – the receivable moves back to zero days. That means that the ATB does not reflect when services were rendered, but rather the movement of the receivable between responsible parties. Credits – monies you owe to another party – must be excluded from the ATB to get an accurate picture of your receivables.

Accuracy. Your practice can measure accuracy based on transactions that pass through all systems and end with payment (first pass (or "clean") claims resolution rate) or focus on those that don't (denial rate). The former is the inverse of the latter, so either gauge of accuracy is helpful. Select a time period and measure the claims that are resolved (or denied) and divide by the total number of claims submitted. There are some nuances in the reporting of this data – like that fact that moving the responsibility for the deductible to your patient is a "resolution" even though it did not get paid. In general, however, your resolution rate should be approximately 95%, and your denial rate should be about 5%. There are valid exceptions that may cause these rates to hover at 90% and 10%, respectively –payers like Medicaid managed care organizations are more challenging from a claims processing perspective. Some payers change the rules seemingly daily, making accuracy elusive. The key is to monitor the rates, while digging into the details to discover opportunities to improve accuracy under your control.

Other revenue cycle management metrics like those in Exhibit 1 can complete the picture but start with these three to ensure that your practice is staying within the guardrails of expected performance. Monitoring these key performance indicators helps avoid surprises that can harm a practice's revenue stream.

Exhibit 1: RCM Metrics

- Days in receivables outstanding
- Aged trial balance
- First-pass resolution rate; denial rate
- Charges and collections
- Credit balance
- Net collection rate

- Collections per relative value unit (RVU)
- Payer mix
- Bad debt percentage
- Credit balance

Risk Matters: Physician Health and Well-being

By Jeffrey A. Woods, JD

“Everybody perceives stress in different ways… and there's not one blanket way of handling stress. But, the most important thing is to understand that you are stressed and recognize how it manifests in you. Some people clench their teeth, some tighten their shoulders, some have GI upset and sleep changes while others get short tempered. We know that stress can manifest in the human body in physical ways that might make physicians become more vulnerable to illness themselves, including affecting the immune system or even causing heart attacks.”

~Charlene Dewey, MD

Every healthcare practitioner understands and feels the pressures of a career in healthcare. The pandemic threatened your safety and escalated stress and burnout. SVMIC is offering on a limited basis, a live session which provides an introduction into the professional health and wellness spectrum, focusing on valuable techniques to support and thrive in personal health and wellness while avoiding, preventing, and managing stress and burnout risks. Participants will learn approaches that enhance resilience while reducing and preventing stress in the workplace and at home and engage in reflective practices and activities that develop skills for improving wellness and interpersonal relationships. This session is a vital component to moving from simply surviving to thriving within the pandemic and after, and will be presented by Dr. Charlene Dewey, who is the Assistant Dean for Educator Development and Director for Professional Health at the Vanderbilt University School of Medicine/Medical Center. Look for schedule and registration information for our limited live seminar series coming soon in the Education section of your Vantage® portal.

Managing Missed Appointments

By Elizabeth Woodcock, MBA, FACMPE, CPC

Appointment no-shows can be incredibly frustrating, but the chief negative impact is on your bottom line. Like all practices, yours carries a tremendous amount of fixed expenses. That is, you are paying for your space, employees, insurance, technology, and many other costs, regardless of how many patients you see today. When one fails to show, the expenses don't disappear – but the revenue does. Consider some of these tactics to alleviate the impact on your practice from those troublesome and expensive missed appointments:

Confirm appointments. Ideally, ask patients how they want to receive their reminders. If that's too burdensome, your default mechanism should be texting. It's rare for anyone to pick up the phone from a number they don't know, so calling is an increasingly ineffective means to remind patients – and automatic emails often get caught in spam or junk filters. The cadence of text confirmations is important and may vary by patient population. For many, texting at seven and three days out, with a final reminder on the same day, proves to be the most effective strategy. The seven-day confirmation is an important one; if the patient is going to cancel, you want to give yourself the biggest window of time possible to

book another patient in that slot.

Manage your time-to-next-available appointment. Research has shown that the scheduling horizon is correlated with missed appointments: that is, the longer the wait, the higher the probability of a no-show. Strive to appoint patients within 30 days. If it takes months to get an appointment, additional capacity may be needed. If possible, consider recruiting a part-time advanced practice provider to help with routine maintenance of your established patients, or triaging your new patients with initial assessments, ordering of tests, and prioritization of time to appoint with you. At the very least, make sure you review any blocks that you've placed on your appointment template. If, for example, you hold certain appointment slots for new patients, be sure that they are released for general use if they aren't booked as of the day prior. The details of the block-and-release strategy vary by practice, but don't ever implement blocks without a corresponding protocol for the release of slots.

Use a waitlist. Many practice management systems have an integrated, automated waitlist function as a component of the scheduling module. If yours doesn't, consider a bolt-on solution. Once a slot becomes open, the software transmits texts to patients who have indicated their interest in being seen earlier. Make sure your solution allows you to control how many patients are being texted with each opened slot. Start with ten, and see if you need to increase or decrease, as the number depends on your patient population.

Penalize (or not?). Life is challenging for most patients, as the pandemic has adversely impacted the lives of many. Sending a $25 no-show charge may produce more frustration and ill-will than revenue. However, that doesn't mean that you should not reach out to the patient with a message that you missed providing them with the care that they deserve – and notifying them that if it happens again, there will be a $100 charge (or whatever amount you choose). Because sending out statements can be costly, if you determine that charging patient is your preferred method, consider contracting with a credit-card-on-file vendor and automatically debit the card in the event of a missed appointment. Alternatively, release patients with chronic failure-to-show from your practice altogether or indicate that you'll see them on a walk-in basis only. (For the latter, create a "Dr. No Show" template so that you can park the patient on the schedule in case they do show, but it will avoid cannibalizing an appointment slot.)

Roll with it. No-show rates vary between practices, from near 0% to rates that top 50%. Measure yours, ideally by day and session (morning v. afternoon, at minimum), and reengineer your template to accommodate it. If your no-show rate is, for example, 20% on Monday mornings, and you have 10 patients on the schedule, increase the number of available slots to 11 or 12. Consider what "safety valves" you have available; for example, if you have two providers in the office, call a "DNKA [did not keep appointment, pronounced 'dinka'] code" when all 12 patients show, indicating that you need help from the other team working that day.

Missed appointments are inevitable, but they can be managed. Consider these strategies – and more – to lessen any negative impact on your practice.

Better Safe Than Sorry – Your Duty to Report

By Matthew Bauer, JD

Physicians receive a plethora of correspondence during the normal course of their medical practice. Occasionally, physicians receive pre-suit demand letters or lawsuits (i.e., Summonses and Complaints) from patients and their attorneys. These legal papers require special attention as they typically require a response within a specified time frame. Additionally, under SVMIC's Policy, "[i]f a claim is made or lawsuit is brought against an **insured**, **insured** shall immediately forward to the Company every demand, notice, summons, or other process that he/she/it or his/her/its representative receives." Importantly, the failure or delay to report receipt of a claim or lawsuit could lead to a denial of coverage under SVMIC's Policy. Like any general rule, an insured's duty to report seems obvious and requires no explanation. However, as we shall see in the closed claim below, the devil is in the details regarding an insured's duty to report under SVMIC's Policy.

A sixty-year-old male patient with a history of mental health problems filed a Complaint with a Tennessee Circuit Court *pro se* (i.e., by himself without the assistance of an

attorney). The Complaint named seventeen physicians as defendants and was handwritten, poorly formatted, and mostly incoherent. To the untrained eye, the Complaint could easily have been viewed as an angry, rambling letter rather than a medical malpractice lawsuit due to its abnormal appearance. However, the Complaint did allege the physician defendants failed to treat the patient and prescribe him medication causing injury, and the patient filed the Complaint with the court clerk, thereby successfully commencing a lawsuit.

Surprisingly, all the physician defendants named in the Complaint happened to be SVMIC insureds. Of these seventeen physician defendants, thirteen called SVMIC to report the Complaint while four did not contact SVMIC. In fact, one of these four physicians was planning to write a responsive letter and send it to the Court. This letter could potentially have been construed as an Answer to the Complaint, and any affirmative legal defenses not asserted in the Answer could potentially have been waived. Some defenses have to be brought to the Court's attention in the initial pleading in response to the Complaint or they will not be considered by the Court at all. Due to the unusual circumstances of the lawsuit, SVMIC contacted these four physicians regarding the Complaint before the expiration of the deadline to file an Answer and before the one physician sent the responsive letter to the Court. SVMIC does not typically contact its policyholders regarding a new Complaint because doing so may waive procedural defenses if the policyholder has not been provided with proper notice or service of process. Furthermore, SVMIC does not usually know about newly filed lawsuits until they are reported by its policyholder(s).

SVMIC promptly hired defense attorneys for the seventeen physician defendants after the lawsuit was reported. The Complaint was defective both procedurally and substantively because (1) no pre-suit notice letters were sent to the physician defendants as required by statute, (2) the Complaint failed to state a claim upon which relief could be granted, and (3) no certificate of good faith was attached to the Complaint. Consequently, the defense attorneys filed a Motion to Dismiss based upon these procedural and substantive deficiencies, and after a hearing, the Court entered an Order dismissing the Complaint "as to all Defendants, on the merits and with prejudice" (meaning the Complaint could not be refiled).

Under SVMIC's Policy, insureds have a duty to promptly report claims and lawsuits to SVMIC. While this rule seems obvious, physicians do receive correspondence and legal papers from patients and their attorneys that may be difficult to understand and that may not be easily recognizable as a lawsuit. For this reason, SVMIC encourages its insureds to call the Claims Department with any questions they may have, and to report any correspondence or legal papers they may receive. By doing this, a claims attorney can discuss the situation with the insured, review the documentation, and appropriately handle the situation. SVMIC can be reached at 800.342.2239.

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