What Are the Most Valuable Revenue Cycle Metrics to Measure?

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For every physician, clinic, and healthcare organization, the first obligation is to deliver the best possible outcome for patients. Period.

But the truth is, the health of any organization itself is a key determining factor in how well they can care for others in the first place. Best outcomes are a full-circle proposition, from initial visit, through treatment, to communicating with insurance in the billing cycle. An effective revenue engine keeps organizations in the business of helping.

To ensure they receive reimbursement for care, manage denials, and work to increase revenue, healthcare organizations and practices of all sizes follow a process called **revenue cycle management (RCM)**.

Of course, a fundamental truth is that you can't manage what you don't measure. Here we'll discuss key revenue cycle management metrics to track, and some best practices to consider applying.

Why Monitor Revenue Cycle Management Metrics?

As the bridge between the clinical and business side of healthcare, the RCM process is awash with metrics that can help administrators get the most out of their cycles, such as:

- Increased revenue stream
- Improved reputation
- Enhanced "start to finish" quality of care

Insurance denials are a revenue stream killer. Not only do they impact the current bottom line, they can lead to patient frustration that could affect future revenue as well.

Practices that monitor their RCM metrics ensure more effectiveness in planning for future expenses, including potential opportunities to embrace new technologies like telehealth and expanded services. They also put themselves in a position to identify possible weaknesses in their current process to correct — especially when navigating changing regulations in care, payer schedules, and even new COVID protocols.

Revenue Cycle Metrics to Monitor

Like with any business in the private sector, there are massive amounts of data to crunch to help track viability and long-term financial — and other — goals for healthcare organizations. Tracking key performance indicators (KPIs) can assist data-driven decision making, and make it possible to benchmark the performance of the revenue cycle to measure success.

While the Healthcare Financial Management Association identifies as many as 29 possible standard metrics, here are a few key metrics to consider measuring consistently to determine how efficiently your RCM is operating.

Rate of First Pass Payment

Also known as clean claims ratio (CCR), this is the rate billing claims are confirmed and paid without denials on the "first pass." Claims that need to be submitted a second or even third time are an inefficient waste of resources. Experts suggest that organizations should be aiming to experience 80% CCR in order to ensure healthy billing practices.

By monitoring this KPI, healthcare providers can determine the quality of data being collected in the process, as well as the amount of time it takes to resolve issues. This can help drive down the cost required to generate payments that could add up to millions or even billions in savings a year.

Days in Accounts Receivable

One of the most important metrics for any practice to measure. The number of days in account receivable (A/R) represents the average length of time it takes for a claim to be paid. Potential cash flow issues or missed opportunities to invest and earn interest are just a couple results of practices waiting too long for payment. And according to the Medical Group Management Association's most recent poll, 49% of medical practice leaders say their time in A/R increased in 2021.

The ideal time for a claim in A/R is between 30-40 days with a goal of keeping it under 45. Once deadlines pass, it can be difficult to collect at all for the services rendered.

To calculate:

- Divide total current receivables by average daily charge amount
- Net the credits by subtracting the current credit balance from the current total receivables
- Get the average daily charge amount by dividing total gross charges for the past 12 months by 365

Net Collection Rate

More effective to track than gross collection rate, this is the percentage of the total amount an organization can realistically expect to collect for care and services.

Tracking this metric is key because it represents the efficiency of the RCM, the ability to mitigate missed payments, communicate with insurance payers and patients alike, and to submit clean claims in the first place.

While the COVID-19 pandemic has in part negatively impacted net collection rates, it's commonly accepted that a good collection rate ranges between 98.5% to 99%.

Claim Denial Rate

It's not just enough to aim for a high rate of first pass payment (CCR), it's also crucial to strive for a lower claims denial rate. Know the numbers to paint a better picture about what your revenue cycle is up against.

To calculate claim denial rate:

- Divide the total dollar amount of claims denied by payers by the total amount submitted (within the given period)

Claim denial rates above 10% indicate an unhealthy RCM process and financial flow. In this case, consider analyzing eligibility verification, coding, and credentialing functions.

Bad Debt Rate

This is the reimbursement for services healthcare organizations have potentially written off. Calculate this KPI by dividing amounts written off by allowed charges. Considering the growing amount of medical debt across the U.S. according to Forbes, it's critical to stay aware and ahead of this metric.

Collection Cost

Hospitals or clinics that are able to close claims quickly and reduce outside collection costs set themselves up to remain competitive. Not only are they able to offer more cost-effective services, they free up resources to invest in other key areas such as patient experience and necessary infrastructure.

Referral Rates

By accurately tracking referrals and new patient intake, organizations can get a clearer picture of not only the services provided, but the budgets that will be required as well. These referral rates can also provide insights on opportunities to improve service lines, which can in turn increase cash flow.

7 Revenue Cycle Management Best Practices

When healthcare leaders were asked what they believed the "root cause" of claims denials for their organization was, the majority (36%) answered "missing information."

Fact is, practices deal with insurance denials daily. But the weakest link in the revenue cycle can often be honest human error. Any number of clerical intake errors, duplicate claims, and lack of prior authorization can set the stage for difficult collection and reimbursement down the line.

While there's no way to 100% bulletproof a healthcare organization from all claim denials, identifying root causes and having methods for quick resolutions is a great first step. To that end, here are some best practices to consider incorporating.

1 .Understand payer fee schedules

Because each payer has its own fee schedule and billing requirements, practices must ensure patients are covered for services, provide proper patient information, and identify any necessary exceptions.

Since they account for much of a practice's revenue, it's important to **monitor major payers** routinely for underpayments. It's also a good idea to ensure the practice is receiving **contracted rates**, and is prepared to **negotiate contracts** as expiration dates approach.

2. Reduce claim denials

Practices can work to reduce denials by **confirming insurance**, **verifying eligibility** and **benefit coverage** prior to service.

Be sure to get a copy of the front and back of the patient's insurance cards for verification, and to **use valid procedure codes**. It's also important to stay current with new, changed, or deleted diagnosis codes.

3. Prioritize making corrections to existing claims

Not only does correcting claims help the organization see at least some reimbursement for services, it can help create a streamlined process to identify common mistakes for future processing.

4. Be timely and transparent with collections

Inform patients about payment policies prior to care when verifying insurance. If outstanding balances exist, inform patients of them routinely by phone or patient messaging applications.

5. **Claim value-based reimbursements**

Delivering high-value, highly reimbursable services (such as Chronic Care Management) can improve patient outcomes and increase revenue as well. As more practices move towards value-based care, it's important to stay on top of billing requirements and other ways to improve processes.

6. Chronic Care Management (CCM)

The Centers for Medicare & Medicaid Services (CMS) offers providers assistance in Chronic Care Management Services. This is another way to potentially help increase value-based reimbursements for patients with two or more conditions expected to last at least 12 months.

7. Partner with an expert RCM system

Consider partnering with an expert RCM service to help account managers better handle their day-to-day operations, quickly learn new regulations, and provide insightful analytics.

Vigilant Monitoring for Improved Care

In the end, the task at hand for healthcare is to ensure the highest level of patient care with the most positive outcomes possible. Those seeking care are often burdened with emotional or financial stresses.

By monitoring metrics within revenue cycle management processes, healthcare practices can take the next step to providing patients with more timely, transparent care — from initial visit, to treatment, to billing.

For more about revenue cycle management metrics and how Dean Dorton can help your practice assess their current process, connect with us today.

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