# RCM Metrics

# Financial Performance and Cash Flow

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| **Business question / Challenge** | **Metrics to track** | **Possible actions** |
| What is our average revenue per patient visit, and how does it compare to industry benchmarks? | Revenue per Patient Visit | 1. Review and adjust fee schedules based on market data 2. Improve coding documentation through targeted education 3. Analyze service utilization patterns 4. Benchmark against industry peers 5. Monitor and optimize charge capture processes 6. Implement clinical documentation improvement (CDI) programs |
| How much revenue are losing due to adjustments made to patient accounts | Adjustments | Analyze payer contracts, optimize pricing, reduce write-offs, improve coding accuracy. |
| How quickly are we converting our services into cash? | 1. Days in Accounts Receivable (AR) 2. Payment Cycle Time | 1. Streamline billing processes through automation 2. Negotiate faster payment terms with payers 3. Implement automated payment reminders 4. Improve collection efforts through workflow optimization 5. Monitor cash flow weekly/monthly 6. Added: Implement real-time eligibility verification 7. Added: Enhance pre-registration processes |
| What percentage of our expected revenue is being collected within the designated time frame? | Net Collection Rate, Patient Payment Collection Rate | Improve billing accuracy, address denials promptly, enhance patient payment options, implement a robust collection process, review write-off policies. |
| Where are the bottlenecks in our collection process? | Days in Accounts Receivable (AR), A/R Aging by Service Line | Streamline billing processes, improve collection efforts, negotiate payment plans with patients, offer discounts for prompt payment, prioritize collection efforts based on aging and dollar value. |
| What are the root causes of aging accounts by payer/service type? | A/R Aging (30-60-90+ days), Collection Rate on Aged Debt | Implement a collection strategy for aged accounts, outsource collection efforts, review and update collection policies, identify and address the root causes of aging accounts. |

# Operational Efficiency

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| **Business question / Challenge** | **Metrics to track** | **Possible** |
| What is the total cost associated with collecting payments, and how can we reduce this cost without sacrificing service quality? | Cost to Collect, FTEs in Billing Department | Implement coding audits, provide ongoing training to billing staff, improve data quality, automate claim scrubbing processes, optimize front-end processes (registration, eligibility verification). |
| What is preventing our claims from being paid on the first submission? | First Pass Resolution Rate (FPRR), FPRR Excl. NR, Clean Claim Rate | Automate billing tasks, outsource certain RCM functions, negotiate better rates with vendors, improve staff productivity, reduce manual processes, monitor resource utilization. |
| How much revenue are we losing through delayed or missed charges? | 1. Charge Lag Days 2. Missing Charge Rate 3. Charge Capture Accuracy Rate 4. Late Charge Rate | 1. Implement charge capture automation tools 2. Conduct regular charge capture audits 3. Provide ongoing charge capture education 4. Monitor charge entry lag time 5. Develop charge reconciliation processes |
| What is our current denial rate? Which denial types should we prioritize for prevention? | Denial Rate, Denial Reason Analysis | Analyze denial trends, identify root causes, improve coding accuracy, enhance documentation, implement pre-authorization processes, provide targeted training to billing staff. |
| How many denied claims are successfully appealed, and what percentage of denied claims remain unresolved? | Appeal Success Rate, Unresolved Denial Rate | Improve appeal processes, provide documentation to support appeals, track appeal outcomes, monitor timelines for filing appeals, escalate complex cases to higher-level reviewers. |

# Patient Satisfaction

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| **Business question / Challenge** | **Metrics to track** | **Possible** |
| How do billing processes and payment options impact patient satisfaction and retention rates? | Patient Payment Collection Rate, Patient Complaints related to Billing, Patient Retention Rate | Improve communication with patients about billing, offer flexible payment options, provide clear explanations of charges, address billing disputes promptly, survey patient satisfaction. |
| Are patients experiencing any challenges with our billing process that could lead to dissatisfaction or delayed payments? | Patient Complaints related to Billing, Patient Payment Collection Rate | Review and streamline billing processes, provide training to staff on patient communication, implement patient-friendly billing statements, address patient complaints promptly and effectively. |

## Description of RCM Metrics

1. **Days in Accounts Receivable (AR)**

* **Description:** Measures the average number of days it takes for a healthcare provider to receive payment for services rendered. It reflects the efficiency of the revenue cycle process, from claim submission to payment receipt.
* **Calculation:** (Total Accounts Receivable / Average Daily Revenue)
* **Significance:** A lower number indicates faster payment cycles and healthier cash flow. A high number may signal issues with billing processes, claim denials, or collection efforts.

1. **Net Collection Rate**

* **Description:** Represents the percentage of total billable charges that are actually collected after contractual adjustments, denials, and write-offs. It reflects the overall effectiveness of the revenue cycle in converting charges into cash.
* **Calculation:** (Actual Collections / Expected Collections) x 100
* **Significance:** A higher rate indicates efficient revenue capture and minimal revenue leakage. A low rate suggests problems with coding, billing, contract management, or collection processes.

1. **Revenue per Patient Visit**

* **Description:** Measures the average revenue generated per patient visit. It provides insights into the financial performance of each patient encounter.
* **Calculation:** (Total Revenue / Total Patient Visits)
* **Significance:** A higher revenue per visit may indicate effective coding, billing, and service utilization. A lower number may signal undercoding, billing errors, or lower-value services.

1. **First Pass Resolution Rate (FPRR)**

* **Description:** Indicates the percentage of claims that are paid correctly on the first submission. It reflects the accuracy and completeness of claim submissions.
* **Calculation:** (Number of Claims Paid on First Submission / Total Number of Claims Submitted) x 100
* **Significance:** A higher rate indicates efficient billing processes and minimal rework. A low rate suggests errors in coding, billing, or documentation.

1. **Clean Claim Rate**

* **Description:** Represents the percentage of claims that are accepted by payers without any errors or rejections. It reflects the quality of claim submissions and the effectiveness of front-end processes.
* **Calculation:** (Number of Claims Accepted Without Errors / Total Number of Claims Submitted) x 100
* **Significance:** A higher rate indicates accurate and complete claim submissions. A low rate suggests issues with data quality, coding, or billing processes.

1. **Denial Rate**

* **Description:** Represents the percentage of claims that are denied by payers. It reflects the accuracy and compliance of claim submissions.
* **Calculation:** (Number of Claims Denied / Total Number of Claims Submitted) x 100
* **Significance:** A lower rate indicates accurate and compliant claim submissions. A high rate suggests issues with coding, documentation, or billing processes.

1. **Denial Reason Analysis**

* **Description:** Categorizes and analyzes the reasons for claim denials to identify trends and patterns. It provides insights into the root causes of denials and helps prioritize improvement efforts.
* **Calculation:** Categorization and reporting of denial reasons.
* **Significance:** Helps identify common denial reasons and implement targeted interventions to reduce denials.

1. **Appeal Success Rate**

* **Description:** Indicates the percentage of appealed denials that are successfully overturned and paid. It reflects the effectiveness of the appeal process.
* **Calculation:** (Number of Appealed Denials Paid / Total Number of Appealed Denials) x 100
* **Significance:** A higher rate indicates an effective appeal process. A low rate suggests issues with documentation, appeal strategies, or payer policies.

**10. Unresolved Denial Rate**

* **Description:** Represents the percentage of denied claims that remain unresolved after the appeal process. It reflects the amount of unrecovered revenue due to denials.
* **Calculation:** (Number of Unresolved Denials / Total Number of Denials) x 100
* **Significance:** A lower rate indicates successful resolution of denials. A high rate suggests challenges with appealing denials or payer policies.

**11. A/R Aging**

* **Description:** Categorizes accounts receivable based on the length of time they have been outstanding (e.g., 30, 60, 90+ days). It provides insights into the aging of receivables and the effectiveness of collection efforts.
* **Calculation:** Categorization of receivables by age.
* **Significance:** Helps prioritize collection efforts and identify accounts that may require more aggressive collection strategies.

**12. A/R Aging by Service Line**

* **Description:** Breaks down accounts receivable aging by specific service lines or departments. It provides insights into the performance of different areas of the organization in terms of revenue cycle management.
* **Calculation:** A/R Aging data broken down by service line.
* **Significance:** Helps identify service lines with higher aging accounts and implement targeted interventions to improve collection efforts.

**13. Collection Rate on Aged Debt**

* **Description:** Measures the percentage of aged debt that is successfully collected. It reflects the effectiveness of collection efforts on older accounts.
* **Calculation:** (Amount Collected on Aged Debt / Total Aged Debt) x 100
* **Significance:** A higher rate indicates successful collection of aged debt. A low rate suggests challenges with collecting on older accounts.

**14. Patient Payment Collection Rate**

* **Description:** Represents the percentage of patient balances that are collected. It reflects the effectiveness of patient billing and collection processes.
* **Calculation:** (Amount Collected from Patients / Total Patient Balances) x 100
* **Significance:** A higher rate indicates effective patient billing and collection processes. A low rate suggests issues with communication, payment options, or collection strategies.

**15. Patient Complaints related to Billing**

* **Description:** Tracks the number and nature of patient complaints related to billing processes. It provides insights into patient satisfaction and areas for improvement.
* **Calculation:** Tracking and categorization of patient billing complaints.
* **Significance:** Helps identify and address issues with patient billing processes and improve patient satisfaction.

**16. Patient Retention Rate**

* **Description:** Measures the percentage of patients who continue to use the organization's services over a specific period. It reflects overall patient satisfaction and loyalty.
* **Calculation:** (Number of Patients Retained / Total Number of Patients at the Beginning of the Period) x 100
* **Significance:** A higher rate indicates greater patient satisfaction and loyalty. A low rate suggests issues with service quality, billing processes, or patient experience.

**17. Payment Cycle Time**

* **Description:** Measures the time it takes from the date a service is rendered to the date payment is received.
* **Calculation:** (Date of Payment Received - Date of Service Rendered)
* **Significance:** A shorter time indicates more efficient billing and collection processes, leading to improved cash flow.

**18. Total Revenue**

* **Description:** The overall income generated from all services provided within a specified period.
* **Calculation:** Sum of all payments received for services.
* **Significance:** A key indicator of financial health and the ability to cover operational costs.

**20. Trends in Denial Reasons**

* **Description:** Analyzes the reasons for claim denials over time to identify patterns and systemic issues.
* **Calculation:** Categorization and tracking of denial reasons monthly or quarterly.
* **Significance:** Allows targeted interventions and process improvements to address recurring denial issues.

**21. Coding Accuracy Rates**

* **Description:** Measures the percentage of medical codes that are accurately assigned, reflecting coding expertise and documentation quality.
* **Calculation:** (Number of Accurate Codes / Total Codes Reviewed) x 100
* **Significance:** High accuracy reduces denials and ensures appropriate reimbursement.

**22. Pre-authorization Rate**

* **Description:** Measures the percentage of services requiring pre-authorization that receive it successfully.
* **Calculation:** (Number of Services Pre-authorized / Number of Services Requiring Pre-authorization) x 100
* **Significance:** Higher rates reduce denials related to lack of authorization.

**23. Service Level Agreement (SLA) Adherence**

* **Description:** Measures how well a vendor adheres to agreed-upon performance standards in a contract.
* **Calculation:** Tracking vendor performance against specified metrics.
* **Significance:** Ensures vendors are meeting expectations and provides grounds for renegotiation or termination if SLAs are consistently missed.