Benchmarking the Revenue Cycle

Top 10 Revenue Cycle Best Practice Solutions

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Considerations

- Patients are your priority; then develop process
- Avoid rework; doing it right the first time
- Front end versus back end
- Work with technology not against it
- Use of data collection
- Communication
- Policy and procedure
Delayed Charge Entry

Identify the length of time between the date of service and date of charge entry. If the lag time is outside the industry standard, you are delaying your revenue cycle and cash flow.

Create standards for coding and charge entry.

- 24 hours for office
- 48 hours for inpatient
Failure to apply coding initiatives

Conduct coding audits to ensure accuracy of coding. Provide coding workshops with providers addressing new medical policies, coding concerns, new codes and documentation issues.

Audit documentation tools to assist providers in meeting documentation standards.
#8 Best Practice

- Delayed payment and denial posting
  - Implement electronic remittance posting. Ensure payments and denials are posted daily. Process patient payments timely to ensure accurate patient statements.
  - Payment Posting – 100% Daily
  - Denial Posting – 99% Daily
  - Patient Statements – 100% Monthly
#7 Best Practice

- Increased self-pay accounts receivable; with the lowest collection percentage.
- Written policies on patient financial responsibility.
- Time of service collections
- Collect outstanding balances
- Display expectations
- Submit to collections at 90-120 days
#6 Best Practice

- Aging Accounts Receivable
  - Monitor A/R days: payer and self-pay
  - Prioritize outstanding A/R:
    - Balance Due
    - Payer Type
    - Age of Account
  - Cross train staff to ensure compliance and performance targets.
#5 Best Practice

- Metrics to measure success
  - Develop key performance indicators for critical areas of the revenue cycle.
  - Trend performance
  - Prepare to take action when negative
#4 Best Practice

- Staff to complete manual processes
- Integrated EMR and Practice Management
- Automated:
  - Eligibility verification
  - Appointment Scheduling
  - Reminders
  - Protocols
- Claims scrubbing
Lack of data

Good data to make decisions about how to improve key areas in the revenue cycle.

Monitor:
- % of Denied Claims
- Denial Reasons
- Denials by payer
- Aged accounts receivable
- Days in A/R
- Patient A/R
#2 Best Practice

Management of Electronic Claims
- Work claim rejections and denials
- Ensure each claim reaches the payer within the filing timelines
- Monitor claims submission through reporting

Claim submission – Daily
Rejections/Denials – Daily
#1 Best Practice

Practice Management System

Choosing and setting up a practice management system correctly

Flowcharting tasks:

- Insurance verification
- Accurate demographics
- Claim: scrubbing, coding and charge capture
- Maximize practice management features
Where are your pain points?

- Connecting physician compensation plans to revenue cycle performance
- Forming an accountability driven denials management program
- Removing credit balances from your liabilities
- Unique strategies to address accounts receivable and low dollar/high volume accounts
- Reducing bad debt through point of service collections
Performance Indicators
Pre-Registration

- Determine demographic updates
- Determine prior account balances
- Insurance benefit verification
- Determine patient copayment level
- Determine need for the visit/time allotted
- Patient expectations
- Appointment reminder process – New Patients
Registration

- Verify demographic
- Insurance card
- Medicare Secondary Payer Questionnaire
- Collection: copayment, deductible and/or outstanding balance
- Remind and/or educate on expectations
- Determine need for financial assistance

98% Accuracy
The insurance verification process is often the first opportunity to identify a high-risk patient:

- Insurance eligibility verified
- Coverage determined for service
- Financial obligations collected

Verification
Website 1-3 minutes
Telephone 3-10 minutes
Financial Counseling

- Instruct new patients regarding documentation required for discounted charges
- Counsel established patients regarding outstanding balances
- Plan enrollment/modifications

Time of Service Collections
- Copayment: 98%
- Others: 75%
Opportunities for Improvement

- Number of rejected claims for “No coverage at the time of service”
- Patient calls to the business office where patient is providing primary or secondary insurance information
- Patient statements showing copayment balances due
- Front office and Back office barriers
Clinical Visit

- Advanced Beneficiary Notice
- Pelvic and Pap
- EKG
- Mammogram

100% Accurate and Delivered
Charge Capture

- Ensure all charges are captured
- Determine charge capture by type of charges
  - Office, Surgical, Hospital, Nursing Home
- Perform Charge Capture Audits
  - Date of service to documentation
  - Documentation to date of coding
  - Coding to date of charge entry
  - Charge entry to date of billing

Two Business Days
Missing Charge Report
Coding

- Coding conventions
  - Diagnosis coding
  - Modifiers
  - Global days
- Coding Responsibilities
  - Provider Education
  - Claim edits/denials

Chart Audit – 95% Accuracy
Claim Submission

- Primary and Secondary Claims
  - Submitted Daily
- Claim Edits
  - Resolved within 24 hours
- Rebilling claims
- Medicare Advantage Claims
- Reconcile to avoid unbilled services
Opportunities for Improvement

- High volume of un-worked claim edits
- Greater than 10% of claims to paper
- High accounts receivable
- High volume of rejected claims
  - Rejected – opportunity to correct and resubmit
  - Denial – decision make; need to appeal
Accounts Receivable Follow Up

- Aged trial balance
- Workflow tools
- Aged accounts
- High dollar accounts
- Payer specific
- Small balance
- Denial management
- Outsource

Every 30 days
Over 90 days, 15-20%
Claim status, 12-60 per hour
Telephone follow up 6-12 ph
Appeal follow up 3-4 per hour
Patient Collections

- Statement cycles
  - Consolidated statement
- Patient friendly statements
- Online bill payments
- Dunning cycles and statement messages
- Return mail
Payment Posting

- Quantity versus quality
- Electronic remittance advices
- Transfer to secondary
- Contractual adjustments
- Line item posting
- Balance billing

75 - 125 transactions per hour
9 - 11 refunds researched per hour
Remittance Advice Review

- Identify incorrect billing information
- Ineffective procedures
- Compare remittance to accounts receivable
- Fee schedule review
- Staff training
### Estimated Denial % of Commercial Claims

<table>
<thead>
<tr>
<th>Payer</th>
<th>Denied Claims</th>
<th>Total Claims</th>
<th>Denial %</th>
</tr>
</thead>
<tbody>
<tr>
<td>{a}</td>
<td>{b}</td>
<td>{c}</td>
<td></td>
</tr>
<tr>
<td>Anthem</td>
<td>7</td>
<td>77</td>
<td>9.1%</td>
</tr>
<tr>
<td>SIHO</td>
<td>6</td>
<td>45</td>
<td>13.3%</td>
</tr>
<tr>
<td>United Health Care</td>
<td>0</td>
<td>9</td>
<td>0.0%</td>
</tr>
<tr>
<td>Blue Cross Blue Shield</td>
<td>0</td>
<td>10</td>
<td>0.0%</td>
</tr>
<tr>
<td>Omaha</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cigna</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
</tr>
<tr>
<td>Nippon</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
</tr>
<tr>
<td>Coventry</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Humana</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>APWU</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>156</strong></td>
<td><strong>12.2%</strong></td>
</tr>
</tbody>
</table>

{a} Unpaid or partially paid claims from sampled EOBs.
{b} Total number of claims from sampled EOBs.
{c} = {a} / {b}
Common Benchmarks

- Gross Charges
- Collections
- Encounters
  - Ambulatory Encounters
  - Hospital Visits
- wRVUs
- Compensation
- Gross and Net Fee-for-Service
  Collection Percentages
- Days in Accounts Receivable
- Distribution of Accounts Receivable
- Payer Mix
- Coding
- Referrals
- Staffing
- Overhead/Expenses
# Measuring and Analyzing the Revenue Cycle

## Snapshot of Leading Financial Indicators and Targets

<table>
<thead>
<tr>
<th>Billing Function</th>
<th>Expectation</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registration</strong></td>
<td>Demographic and insurance information obtained</td>
<td>98 percent accuracy</td>
</tr>
<tr>
<td><strong>Prior authorization</strong></td>
<td>Determine prior authorization for services</td>
<td>98 percent accuracy</td>
</tr>
<tr>
<td><strong>Time-of-service collections</strong></td>
<td>Collect copayments, patient accounts balances, deductibles, co-insurance</td>
<td>Copayment: 98 percent Others: 75 percent</td>
</tr>
<tr>
<td><strong>Coding</strong></td>
<td>Physician coding</td>
<td>Chart audits for coding accuracy Rejections for incorrect coding at 0-1 percent of visits Certified coders for surgical procedures All certified by (date)</td>
</tr>
<tr>
<td><strong>Claims/statements</strong></td>
<td>Support documentation for claims Edits completed Claim denial/rejection rate</td>
<td>100 percent 100 percent same day &lt; 7 percent</td>
</tr>
</tbody>
</table>
# Measuring and Analyzing the Revenue Cycle

## Snapshot of Leading Financial Indicators and Targets

<table>
<thead>
<tr>
<th>Billing Function</th>
<th>Expectation</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Charge entry</strong></td>
<td>Days lag (date-of-service to date-of-entry)</td>
<td>24 hours outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>48 hours inpatient</td>
</tr>
<tr>
<td></td>
<td><strong>Account follow-up</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every 30 – 45 days</td>
<td>100 percent accuracy</td>
</tr>
<tr>
<td></td>
<td>Percentage accounts receivable &gt; 90 days</td>
<td>15 to 20 percent</td>
</tr>
<tr>
<td></td>
<td>Net collection rate</td>
<td>97 percent or greater</td>
</tr>
<tr>
<td></td>
<td><strong>Payment posting</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cash posted and balanced</td>
<td>100 percent</td>
</tr>
<tr>
<td></td>
<td>Credit balance report</td>
<td>Fully researched</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and resolved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>within 60 days</td>
</tr>
<tr>
<td></td>
<td><strong>Collections</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient account sent to collections</td>
<td>Within 90 days</td>
</tr>
<tr>
<td></td>
<td><strong>Denials</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage denials due to referrals (specialists)</td>
<td>&lt; 2 percent</td>
</tr>
<tr>
<td></td>
<td>Percentage denials due to past filing limits</td>
<td>0 percent</td>
</tr>
<tr>
<td></td>
<td><strong>Management reporting</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reports available within 10 days after month-end</td>
<td>100 percent</td>
</tr>
</tbody>
</table>
Gross Charges and Collections

Caveats

- Charges are subjective due to fee schedule methodologies
- Often can affect Gross Collection %
  - Payments/Charges
- Adjusted Fee-for-Service Collection %
  - Payments/(Charges-Adjustments)
- Collections % vary by specialty
# Gross and Adjusted (Net) FFS Collections

<table>
<thead>
<tr>
<th>Physician</th>
<th>2013</th>
<th>2014</th>
<th>MGMA Median</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gross</td>
<td>% &gt; Median</td>
<td>Adjusted</td>
</tr>
<tr>
<td>Dr. W.</td>
<td>55.86%</td>
<td>16.26%</td>
<td>119.36%</td>
</tr>
<tr>
<td>APRN</td>
<td>57.80%</td>
<td>18.20%</td>
<td>98.95%</td>
</tr>
<tr>
<td>Practice</td>
<td>56.83%</td>
<td>17.23%</td>
<td>108.02%</td>
</tr>
</tbody>
</table>

*Gross FFS % = ((Collections-Refunds)/Gross Charges) x 100*

*Adjusted FFS % = ((Collections-Refunds)/(Gross Charges - Adjustments)) x 100*
### Practice Data

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Actual</th>
<th>Variance w Median</th>
<th>% Variance w Median</th>
<th>Count</th>
<th>Practice Type</th>
<th>Median</th>
<th>Std. Dev.</th>
<th>25th %tile</th>
<th>75th %tile</th>
<th>90th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months gross FFS charges in AR</td>
<td>1.86</td>
<td>0.47</td>
<td>25%</td>
<td>82</td>
<td></td>
<td>1.42</td>
<td>0.47</td>
<td>1.03</td>
<td>1.39</td>
<td>1.78</td>
</tr>
<tr>
<td>Days gross FFS charges in AR</td>
<td>56.53</td>
<td>13.93</td>
<td>25%</td>
<td>83</td>
<td></td>
<td>43.90</td>
<td>15.86</td>
<td>31.56</td>
<td>42.60</td>
<td>54.09</td>
</tr>
</tbody>
</table>

**Months of gross fee-for-service charges in accounts receivable** =

\[
\frac{(Total \text{ accounts receivable})}{(Gross \text{ FFS Charges}) \times (1/12)}
\]

**Days of gross fee-for-service charges in accounts receivable** =

\[
\frac{(Total \text{ accounts receivable})}{(Gross \text{ FFS Charges}) \times (1/365)}
\]
Unable to benchmark for practice due to large amount of credit balances in system.

Distribution of Accounts Receivable

- 0-30 days in AR: 37.31%
- 31-60 days in AR: 12.43%
- 61-90 days in AR: 8.43%
- 91-120 days in AR: 5.74%
- 120+ days in AR: 26.84%
Payer Mix Gross Charges

**Practice Charges**
- Commercial: 65%
- Medicare: 24%
- Medicaid: 5%
- Self Pay: 6%
- Other gov: 0%
- WC: 0%

**MGMA Mean Payer Mix**
- Total Gross Charges
- Commercial: 52%
- Medicare: 35%
- Medicaid: 7%
- Self Pay: 4%
- Other gov: 1%
- WC: 1%
### Staffing Levels

#### MGMA Table 35.6a Staffing, RVUs, Patients, Procedures and Square Footage per FTE Provider for All Family Practice Practices

<table>
<thead>
<tr>
<th>Staffing per FTE Provider</th>
<th>Practice Data Totals for Practice</th>
<th>Per FTE Provider Variance w/ Median</th>
<th>Variance w/ 25th %tile</th>
<th>Variance w/ 75th %tile</th>
<th>Median</th>
<th>75th %tile</th>
<th>90th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total provider FTE</strong></td>
<td>6.80</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total physician FTE</strong></td>
<td>5.00</td>
<td>0.74</td>
<td>-0.01</td>
<td>-0.10</td>
<td>0.65</td>
<td>0.75</td>
<td>0.83</td>
</tr>
<tr>
<td>Total nonphysician provider</td>
<td>1.80</td>
<td>0.26</td>
<td>0.00</td>
<td>-0.09</td>
<td>0.17</td>
<td>0.26</td>
<td>0.36</td>
</tr>
<tr>
<td><strong>Total supp Staff FTE</strong></td>
<td>23.00</td>
<td>3.38</td>
<td>-0.12</td>
<td>-0.59</td>
<td>3.10</td>
<td>3.50</td>
<td>3.97</td>
</tr>
<tr>
<td>Total empl support staff FTE</td>
<td>23.00</td>
<td>3.38</td>
<td>-0.09</td>
<td>-0.59</td>
<td>3.08</td>
<td>3.48</td>
<td>3.97</td>
</tr>
<tr>
<td>General administrative</td>
<td>2.00</td>
<td>0.29</td>
<td>0.11</td>
<td>0.06</td>
<td>0.13</td>
<td>0.18</td>
<td>0.24</td>
</tr>
<tr>
<td>Patient accounting</td>
<td>4.00</td>
<td>0.59</td>
<td>0.10</td>
<td>0.02</td>
<td>0.29</td>
<td>0.49</td>
<td>0.56</td>
</tr>
<tr>
<td>General accounting</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.09</td>
<td>-0.13</td>
<td>0.06</td>
<td>0.09</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Total business oper staff</strong></td>
<td>6.00</td>
<td>0.88</td>
<td>0.36</td>
<td>0.03</td>
<td>0.22</td>
<td>0.53</td>
<td>0.85</td>
</tr>
<tr>
<td>Medical receptionists</td>
<td>8.00</td>
<td>1.18</td>
<td>0.23</td>
<td>0.05</td>
<td>0.67</td>
<td>0.94</td>
<td>1.23</td>
</tr>
<tr>
<td>Med secretaries, transcribers</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.17</td>
<td>-0.25</td>
<td>0.09</td>
<td>0.17</td>
<td>0.25</td>
</tr>
<tr>
<td>Medical records</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.23</td>
<td>-0.39</td>
<td>0.17</td>
<td>0.23</td>
<td>0.39</td>
</tr>
<tr>
<td>Other admin support</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.20</td>
<td>-0.33</td>
<td>0.15</td>
<td>0.20</td>
<td>0.33</td>
</tr>
<tr>
<td><strong>Total front office supp staff</strong></td>
<td>8.00</td>
<td>1.18</td>
<td>-0.09</td>
<td>-0.47</td>
<td>1.06</td>
<td>1.27</td>
<td>1.65</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.25</td>
<td>-0.38</td>
<td>0.11</td>
<td>0.25</td>
<td>0.38</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>3.00</td>
<td>0.44</td>
<td>0.03</td>
<td>-0.32</td>
<td>0.22</td>
<td>0.42</td>
<td>0.76</td>
</tr>
<tr>
<td>Med assistants, nurse aides</td>
<td>2.00</td>
<td>0.29</td>
<td>-0.59</td>
<td>-0.93</td>
<td>0.59</td>
<td>0.89</td>
<td>1.23</td>
</tr>
<tr>
<td><strong>Total clinical support staff</strong></td>
<td>5.00</td>
<td>0.74</td>
<td>-0.63</td>
<td>-0.85</td>
<td>1.18</td>
<td>1.36</td>
<td>1.59</td>
</tr>
<tr>
<td>Clinical laboratory</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.25</td>
<td>-0.36</td>
<td>0.16</td>
<td>0.25</td>
<td>0.36</td>
</tr>
<tr>
<td>Radiology and imaging</td>
<td>4.00</td>
<td>0.59</td>
<td>0.40</td>
<td>0.34</td>
<td>0.11</td>
<td>0.19</td>
<td>0.25</td>
</tr>
<tr>
<td>Other medical support svc</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.14</td>
<td>-0.22</td>
<td>0.09</td>
<td>0.14</td>
<td>0.22</td>
</tr>
<tr>
<td><strong>Total ancillary support staff</strong></td>
<td>4.00</td>
<td>0.59</td>
<td>0.27</td>
<td>0.08</td>
<td>0.20</td>
<td>0.32</td>
<td>0.51</td>
</tr>
<tr>
<td>Total contracted supp staff FTE</td>
<td>0.00</td>
<td>0.00</td>
<td>-0.07</td>
<td>-0.10</td>
<td>0.03</td>
<td>0.07</td>
<td>0.10</td>
</tr>
</tbody>
</table>
## Staffing the Revenue Cycle

### Staff Workload Ranges by Activity

<table>
<thead>
<tr>
<th>STAFF ACTIVITIES</th>
<th>PER DAY</th>
<th>PER HOUR</th>
<th>PER TRANSACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance verification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Via Website</td>
<td>n/a</td>
<td>n/a</td>
<td>1 to 3 minutes</td>
</tr>
<tr>
<td>Via telephone call</td>
<td>n/a</td>
<td>n/a</td>
<td>2 to 10 minutes</td>
</tr>
<tr>
<td>Benefits eligibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Via Website</td>
<td>n/a</td>
<td>n/a</td>
<td>3 to 10 minutes</td>
</tr>
<tr>
<td>Via Telephone Call</td>
<td>n/a</td>
<td>n/a</td>
<td>5 to 20 minutes</td>
</tr>
<tr>
<td>Registration with insurance verification</td>
<td>60 to 80</td>
<td>9 to 11</td>
<td></td>
</tr>
<tr>
<td>on-site or pre-visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient check-in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With registration verification only</td>
<td>100 to 130</td>
<td>14 to 19</td>
<td></td>
</tr>
<tr>
<td>With registration verification and</td>
<td>75 to 100</td>
<td>11 to 14</td>
<td></td>
</tr>
<tr>
<td>cashiering only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment scheduling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With no registration</td>
<td>75 to 125</td>
<td>11 to 18</td>
<td></td>
</tr>
<tr>
<td>With full registration</td>
<td>50 to 75</td>
<td>7 to 11</td>
<td></td>
</tr>
<tr>
<td>Referrals (inbound or outbound)</td>
<td>70 to 90</td>
<td>10 to 13</td>
<td></td>
</tr>
<tr>
<td>Check-out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With scheduling and cashiering</td>
<td>70 to 90</td>
<td>10 to 13</td>
<td></td>
</tr>
<tr>
<td>With scheduling, cashiering, and charge entry</td>
<td>60 to 80</td>
<td>9 to 11</td>
<td></td>
</tr>
</tbody>
</table>
## Staff Workload Ranges by Activity

<table>
<thead>
<tr>
<th>Staff Activities</th>
<th>Per Day</th>
<th>Per Hour</th>
<th>Per Transaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation and Management codes</td>
<td>n/a</td>
<td>15 to 20</td>
<td>3 to 4 minutes</td>
</tr>
<tr>
<td>Surgeries and procedures</td>
<td>n/a</td>
<td>6 to 12</td>
<td>5 to 10 minutes</td>
</tr>
<tr>
<td><strong>Charge entry line items</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without registration</td>
<td>375 to 525</td>
<td>55 to 75</td>
<td></td>
</tr>
<tr>
<td>With registration</td>
<td>280 to 395</td>
<td>40 to 55</td>
<td></td>
</tr>
<tr>
<td><strong>Resolving pre-adjudication edits</strong></td>
<td></td>
<td></td>
<td>2 to 10 minutes</td>
</tr>
<tr>
<td><strong>Payment and adjustment transactions posted</strong></td>
<td>525 to 875</td>
<td>75 to 125</td>
<td></td>
</tr>
<tr>
<td><strong>Refunds researched and processed</strong></td>
<td>60 to 80</td>
<td>9 to 11</td>
<td></td>
</tr>
<tr>
<td><strong>Insurance account follow-up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research correspondence and resolve by telephone</td>
<td>n/a</td>
<td>6 to 12</td>
<td></td>
</tr>
<tr>
<td>Research correspondence and resolve by appeal</td>
<td>n/a</td>
<td>3 to 4</td>
<td></td>
</tr>
<tr>
<td>Check status of claim (telephone or online) and rebill</td>
<td>n/a</td>
<td>12 to 60</td>
<td></td>
</tr>
<tr>
<td><strong>Self-pay account follow-up</strong></td>
<td>70 to 90</td>
<td>10 to 13</td>
<td></td>
</tr>
<tr>
<td><strong>Self-pay correspondence processed and resolved</strong></td>
<td>90 to 105</td>
<td>13 to 15</td>
<td></td>
</tr>
<tr>
<td><strong>Patient billing inquiries (by telephone or</strong></td>
<td>56 to 84</td>
<td>8 to 12</td>
<td></td>
</tr>
<tr>
<td>correspondence)**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Frequency

**Monthly**
- Gross Charges
- Collections
- Encounters
  - Ambulatory Encounters
  - Hospital Visits
  - Surgical Cases
- wRVUs
- Overhead/Expenses
- Gross and Net Fee-for-Service Collection Percentages
- Days in Accounts Receivable
- Distribution of Accounts Receivable

**Annually/As Needed**
- Payer Mix
- Coding
- Square Footage
- Staffing Per Provider
- Compensation
What Do We Present Monthly?

- Gross and Net Fee-for-Service Collections Percentages (per provider and practice)
- Charges and Collections (per provider and practice)
- Encounters (per provider)
- Income Statement with comparisons to budget and benchmark
- Days and Months in Accounts Receivable
- Aging Analysis
Questions?

Thank You!